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Extending the RENO Model: Clinical and Ethical Applications

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The RENO Model, first published during 2004, described a science-based framework of responsible gambling principles for a range of industry operators, health service providers, community and consumer groups, and governments. These strategic principles serve as a guide for the adoption and implementation of responsible gambling and harm-minimization initiatives. This article extends the RENO Model core principles by describing how to apply these strategies to clinical practice. This discussion examines the central tenets of the model and includes a review of (a) the ethical principles that should guide the development, implementation, and practice of RENO Model responsible gambling activities; (b) a brief consideration of the various perspectives that influence the treatment of gambling-related problems; and (c) a discussion of

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key applied elements of responsible gambling programs. This article advances the argument that, to maximize positive outcomes and to avoid unintended harms, clinicians should apply science-based principles to rigorously evaluate the efficacy and impact of their clinical practice activities.

> "*Responsible gambling*" refers to policies and practices designed to prevent and reduce potential harms associated with gambling; these policies and practices often incorporate a diverse range of interventions designed to promote consumer protection, community and consumer awareness and education, and access to efficacious treatment. (Blaszczynski, Ladouceur, & Shaffer, 2004, p. 308)

The RENO Model advances a science-based framework for Responsible Gambling (RG; Blaszczynski et al., 2004). During the development of the RENO Model, we focused on the architectural building blocks of RG programs and paid limited attention to the clinical and ethical applications of the foundational elements. The purpose of this article is to build upon and extend the fundamental principles, concepts, and values of the RENO Model to applied (e.g., clinical or public policy) settings. This objective does not include reviewing the treatment of disordered gambling or revisiting the foundations of the RENO Model. There are many resources available that review and provide guidance for the treatment of disordered gambling (e.g., Gainsbury & Blaszczynski, 2011; Grant & Potenza, 2004; Ladouceur & Lachance, 2007; Ladouceur, Sylvain, Boutin, & Doucet, 2002; Petry et al., 2006; Shaffer & LaPlante, 2005).

Public health programs around the world have used the RENO Model as a guide to develop and manage RG programs. Consequently, we will provide clinical examples to illustrate how clinicians can use the RENO Model and ethically translate it to applied activities. In our original description of the RENO Model, we did not describe applications of the model for people working to resolve gambling-related problems encountered during their daily activities. This article will illustrate various clinical implications of the RENO Model and its many consequences for people working within the variety of applied gambling-related fields (e.g., psychotherapists, counselors, prevention workers, teachers, regulators, public policymakers, etc.).

During the discussion that follows, we encourage readers to bear in mind that RG is more than just a population-level program that can advance prevention objectives by deterring or managing gambling-related harms. For example, policymakers can use RG programs to leverage gaming licenses, require and shape training programs for industry employees, dedicate a percentage of gambling revenues to fund gambling-related services, limit marketing, restrict players from gambling under certain conditions, and much more. Despite these potential beneficial uses of RG, ultimately it remains a strategy for implementing a range of interventions at the population level designed to maintain an individual's gambling within affordable thresholds and to minimize harm. In this regard, many have come to view RG activities as a public health prevention program (Hare, 2009; Shaffer & Korn, 2002). Nevertheless, clinicians also can use RG principles in general and the RENO Model in particular to prevent, relieve, or attenuate an individual's gambling-related harms. Throughout this discussion, we consider the term *clinician* to represent people who work in applied areas: treatment, health planning, prevention, education, policy, and so forth.

How clinicians use RG principles in general, and are guided by the RENO Model in particular, will depend largely upon their philosophical position and their personal relationship with gambling (Collins et al., in press). For example, some clinicians might hold prohibitionist beliefs about gambling, encouraging them to suggest that abstinence is the only goal for gambling treatment. Alternatively, other clinicians might target controlled gambling as a treatment objective. In every clinical instance, clinicians must recognize how, and whether, their attitudes, beliefs, and financial resources influence treatment objectives.

Within the broad area of mental health, there has been a long-standing and meaningful gap between research findings and the application of these data in the clinical arena (e.g., Borkovec & Costonguay, 1998). Translating research findings into practice is a complex and often difficult task. The field of gambling is no exception. Despite the recent and steady increase in gambling-related publications (Shaffer, Stanton, & Nelson, 2006), the field is still in its youth. Clinicians often do not have time and ready access to academic publications, a detailed comprehensive overview of published research, or competing arguments that will allow them to critically assess the reported findings. Treatment providers face considerable challenges about how theoretical, complex statistical, and conceptual arguments can be translated into practical clinical utility. In addition, experienced clinicians might be reluctant to change; the structure of their clinical practice might restrict their perspective and their ability to change. Ultimately, clinicians face many barriers to translating research into practice and making the clinical changes necessary that reflect this evidence.

The RENO Model: Core Principles

The fundamental aim of the RENO Model (Blaszczynski et al., 2004) was to establish an integrated set of general principles and guidelines to provide public health workers, policymakers, gambling purveyors, and gamblers with the first strategic science-based framework to guide the development and implementation of responsible gambling initiatives. Taking the lead from the Boulder Model, a psychology-based guide that promoted a scientist–practitioner approach to training (Raimy, 1950), we originally offered the RENO Model to stimulate an enduring dialogue about responsible gambling concepts, and the variety of activities that derive from these discussions and considerations.

The RENO Model highlighted the varied terminology often used to describe categories of gamblers and nongamblers, and drew attention to the need to clarify the relative roles, objectives, responsibilities, and obligations of vested government, industry and community partners including welfare, academics and consumers. Of importance, the RENO Model identified the terminology confusion, absence of consensus, and conflicts of interests that were barriers to progress in the field. A set of five principles was advanced building upon the notion that a collaborative approach among all stakeholders was necessary to achieve an effective responsible gambling framework. The RENO Model adopted a

global perspective taking into account a public health approach that argued for responsible gambling policies and strategies to be driven by empirical research data.

The current article recognizes the need for a similar set of principles and guidelines that is geared toward application by frontline clinicians. This necessitates the translation of conceptual and theoretical frameworks into active practice. For example, the RENO Model described the need for collaborative efforts among stakeholders to implement programs that could (a) prevent and treat gambling problems, and (b) scientifically evaluate these efforts. The RENO Model also encourages collaborative efforts between treatment providers, patients, and other stakeholders (e.g., family) to (a) prevent the progression of any existing signs and symptoms caused by gambling and comorbid disorders, and (b) scientifically evaluate these efforts.

Responsible Gambling: From Concept to Practice

RG activities are not the first public health programs designed to prevent and reduce harm. RG is a public health concept emulating responsible drinking programs. In the United States, Responsible Drinking programs emerged "within months of Prohibition's repeal" when, ". . . distillers created a voluntary Code of Good Practice to ensure that distilled spirits advertising is responsible, dignified and intended for adults" (Distilled Spirits Council of the United States, 2014). As with RG programs, the Responsible Drinking initiative reflected the industry's attempt to manage the distribution of alcohol and its need to promote self-regulation and avoid government intervention. Since 1934, distillers have used a voluntary code of conduct to guide and promote responsible advertising and marketing activities associated with beverage alcohol (Distilled Spirits Council of the United States, 2011).

Essentially, responsible drinking programs emerged to help drinkers "know when to say when." Anheuser-Busch, for example, has been promoting alcohol responsibility since 1982 (Anheuser-Busch, 2014). Similarly, RG programs emerged as evidence of corporate social responsibility (CSR) and to deflect government oversight and regulatory activity that could restrict gambling industry activities. These RG programs emerged in response to increasing awareness of the negative consequences of excessive gambling. Community concerns were expressed toward governments for liberalizing gambling opportunities and the gaming industry's commercial motivations in marketing and promotion of player involvement and maintenance. Ultimately, both responsible drinking and gambling programs are public health efforts designed to provide strategies and parameters to help drinkers and gamblers regulate consumption to acceptable levels, and ultimately minimize potential adverse consequences. Since observers often consider gambling as an invisible disorder (e.g., Goldman, 1991), for example, compared with the excessive use of intoxicants, laypeople and clinicians alike have had difficulty recognizing gambling disorder and its negative effects within the context of public health policies.

The allocation of resources to meet gambling-related treatment demands should come from various funding agencies, including government and health care agencies, with RG interventions integrated within traditional health care services. For example, the mental health and substance abuse treatment programs should be expanded to incorporate gambling disorders within their scope of services. This initiative will be advanced by funding strategies that can increase awareness and training of clinicians working within these facilities to assess and treat gambling disorders, particularly those with comorbid conditions, and/or to refer to specialist gambling counselors. Nevertheless, some jurisdictions do not provide funding for RG activities; among those who do provide RG resources, there are many different funding models for RG activities. This circumstance complicates the delivery and integration of RG programs by government, industry, and treatment stakeholders. Without adequate resources, it is difficult at best to develop and implement RG resources. Alternatively, some jurisdictions, despite adequate funding, likely will fail to understand the RENO Model and its strategic design. To illustrate, jurisdictions committed to RG programs can fail to understand the role of science in developing and implementing responsible gambling programs. Government officials might think that activities logically intended to prevent and limit gambling-related problems should be integrated into their RG framework. However, as we know, social programs intended to achieve one set of objectives often fail and sometimes lead to outcomes quite different from what was intended. Research has shown, for example, that school-based drug prevention programs can fail to deter substance use (Ennett, Tobler, Ringwalt, & Flewelling, 1994). In some instances, drug use prevention efforts actually can lead to increased use (Rosenbaum & Hanson, 1998). Similarly, in the gambling arena, requiring gamblers to precommit to a level of losses can result in players establishing very high loss limits—and then playing to the established limit (see below). The possibility of unanticipated effects reminds us how very important it is to carefully and scientifically study any RG component activity—including providers—to assure that it is achieving its intended goal.

For both alcohol and gambling, tensions exist between those critical of the promotion, marketing, and consumption of such products on restrictivist grounds and those adopting a more liberal attitude toward availability and personal choice. Clinicians ought to gain a clear understanding of their moral, philosophical, ideological, and religious beliefs and how these might influence their practice and interventions. These are core issues discussed in this article.

Countertransference: Understanding Clinician Attitudes Toward Gambling

To make optimal use of the RENO Model, clinicians need to appraise, understand, and articulate explicitly their attitude toward any implicit assumptions held about gambling and the factors relevant to the development of gambling-related problems. Clinician attitudes toward gambling range from prohibitionist (e.g., gambling is an inherently dangerous product) to libertarian or laissez faire (e.g., gambling is a form of legitimate recreational activity within a civil libertarian context). These attitudes and beliefs can influence the conduct of treatment and involvement in promoting responsible gambling in both favorable and unfavorable ways. Countertransference develops when the therapist attitudes and beliefs influence the conduct of

treatment in ways that are not part of the therapeutic alliance. Weiner noted that

> When a therapist feels or acts toward a patient in ways that are neither part of the real relationship, rationally justified by the circumstances, nor part of the working alliance, appropriate to the terms of the treatment contract, he is manifesting countertransference. (Weiner, 1975, p. 244)

As a consequence, conflicts may occur with respect to agreed treatment outcomes.

In treatment, a common instance of countertransference emerges when a clinician working from a prohibitionist stance prematurely encourages clients to work toward a goal of abstinence before having identified and worked through their ultimate treatment objectives (e.g., abstinence vs. controlled gambling). Similarly, clinicians might only permit one or a narrow set of treatment goals with little regard for the full spectrum of treatment outcomes of interest to the client. Another common example of countertransference is terminating treatment when a client lapses or relapses by gambling again. Failing to consider and respect a client's interests, objectives, and choices is counterproductive and potentially harmful. Clinical supervision, adherence to professional ethics, and a nonjudgmental and neutral approach are some of the guidelines of achieving optimal outcomes for clients and limiting countertransference. Ethical considerations in the best interests of clients are the essential pillars upon which RG programs rest.

Clinicians need to be fully aware of their philosophical and ideological stance on gambling as it influences their involvement in RG initiatives. Treatment providers adopting a prohibitionist position toward gambling often will be confronted with a conflict of interest. RG represents a contradiction in terms if clinicians adopt the basic assumption that all gambling is harmful and therefore should be prohibited. Workers with this perspective should direct their efforts to the political sphere and leave treatment to those who are can manage their countertransference. On the other hand, clinicians with a libertarian stance must be careful to ensure that they are not advocating for a progambling "open slate" approach regardless of the impact of gambling; when they adopt this perspective they too will be confronted with a conflict of interest. Progambling treatment providers need to consider the balance between responsible gambling and civil liberties; they need to recognize that excessive gambling does generate harms to a proportion of consumers. Antigambling and progambling clinicians alike can work in collaboration with government and industry operators to promote RG programs, but to do so requires awareness of their countertransferential feelings. To avoid inadvertently harming clients, treatment providers must remain neutral.

Toward Clinical Practice

The use of large data sets representing samples of actual Internet gamblers and their gambling hold the promise of yielding macro-level behavioral algorithms that, in turn, inform patterns of play at the micro level (Braverman, LaPlante, Nelson, & Shaffer, 2013; Braverman & Shaffer, 2012; Coussement & De Bock, 2013; Dragicevic, Tsogas, & Kudic, 2011; Shaffer, Gray, Nelson, & LaPlante, in press; Wardle, Excell, lreland, Ilic, & Sharman, 2014). From big data sets we learn that Internet gamblers tend to wager more moderately than expected and their betting patterns tend to wane rapidly. However, there is a small group of Internet gamblers who fail to adapt; these people exhibit differential characteristics that can inform the clinical care provided to individuals by clinicians. For example, treatment providers can use the behavioral markers evidenced by those who fail to adapt to identify others at risk and then develop treatment programs matched to these risks. Similarly, there are large data sets from sources other than industry that also can inform clinical care (e.g., government studies focusing on geo-temporal distribution of people with gambling disorder; epidemiological characteristics of geographical areas related to gambling problems).

In the next section, we will describe four fundamental ethical principles that guide RG programs and clinical practices associated with the treatment of gambling-related problems.

Ethical Considerations: Toward the Practice of Responsible Gambling Programs

As technology advances and clinicians offer new health-related activities, different ethical issues confront us. For the behavioral sciences, technology has helped scientists to garner evidence to inform individuals about their unique and potential health risks. Just as biomarkers provide information about physical risks, behavioral data is establishing clues to individual mental health risks.

Research has provided interesting and useful criteria to classify people according to risk factors. This avenue raises important ethical and legal questions—including issues related to the domain of "gambling courts"—about the treatment of gamblers (Shaffer et al., in press). How and when do we inform people who have been identified as being at increased risk for developing gambling-related problems? Should we forcibly intervene to limit the gambling of people identified to be at such increased risk? Should we monitor gambling activity in the absence of gamblers' awareness? How can we protect corporate interests or others from misusing big data, such as identification algorithms for at-risk gamblers? These are complex public health, clinical, and public policy questions that rest upon ethical considerations.

There are guidelines for developing responsible gambling programs (Blaszczynski et al., 2011, 2004). The RENO Model and the suggested general principles and minimal requirements resources provide a practical framework for building an RG initiative. The RENO Model suggests (Blaszczynski et al., 2004, p. 307) that RG programs (a) ". . . commit to reducing the incidence and ultimately the prevalence of gambling-related harms," (b) ". . . inform and evaluate public policy aimed at reducing the incidence of gambling-related harms," (c) ". . . identify short- and long- term priorities thereby establishing an action plan to address these priorities within a recognized time frame," (d) use scientific research to guide the development of public policies, and (e) monitor and evaluate the RG plan to reduce the incidence and prevalence of gambling-related harms using scientific methods. Higher level ethical principles from the life sciences provide an integrative and broader framework for these issues that can help guide gambling purveyors, consumers, and public policymakers. At a recent Harvard Medical School continuing education conference, Boyd (2013) considered ethical principles for the treatment of addiction, in general. More specifically, Shaffer and his colleagues (in press) suggested that we consider these four *prima facie* ethical principles (Beauchamp &

Childress, 1989; Gillon, 1994) as guides for the development of programs and policies designed to promote responsible gambling and to protect players: (a) Autonomy, (b) Beneficence, (c) Nonmaleficence, and (d) Justice. We consider these fundamental ethical principles in the following discussion.

Autonomy

Autonomy (i.e., self-rule and the ability to make our own decisions) is a central ethical principle in health care and its practice. We must apply this principle equally to all of those who might be affected by a policy or responsible gambling program (Gillon, 1994). The autonomy principle guides how institutional review boards view, for example, informed consent and confidentiality with respect to both research and treatment. Correspondingly, the providers of gambling programs must disclose and provide consumers with information that permits them to make informed decisions about their play, and their chances of winning. Like informed consent for research participants, the process of informed decision-making provides gamblers with the information, odds, and potential costs and benefits about gambling—and affirms that they understand these options before beginning to play. Four primary activities lead to optimal choices in gambling (Blaszczynski, Ladouceur, Nower, & Shaffer, 2008): (a) providing relevant and objective information, (b) elucidating the benefits of responsible gambling as well as the potential social and personal costs associated with excessive gambling, (c) targeting additional materials for specific gambling subgroups, and (d) using a variety of communication mediums to disseminate materials.

The autonomy principle encourages clinicians to present interventions as options, permitting clients to choose how to respond to their circumstance rather than be coerced or influenced by the moral or philosophical perspective of the clinician. Clinicians may have an ethical obligation to disclose their personal philosophical position regarding gambling and what they consider should be the goals of treatment—abstinence and control, and their theoretical orientation in treatment as this will determine what techniques will be applied.

Programs designed to benefit disordered gamblers can, under some circumstances, violate the autonomy principle. For example, some proposed programs require that those seeking self-exclusion sign a declaration confirming themselves as a disordered gambler or forfeit program entry; similarly, some programs permit a third party to exclude a gambler. Despite well-intentioned attempts to benefit gamblers, these conditions or requirements risk violating the autonomy principle to the extent that it prevents self-excluders from having a say in whether they are considered disordered gamblers. Any clinical decision to violate autonomy must be made with great care, typically as a last resort after weighing all options.

Beneficence and Nonmaleficence

Gillon (1994) suggests that we consider beneficence and nonmaleficence together as these principles are twin pillars. In our efforts to be helpful and to do good (i.e., beneficence), we must make every effort to avoid doing harm (i.e., nonmaleficence). We also need to consider these two principles independently: When we have no obligation of beneficence, we still have an obligation of nonmaleficence (Gillon, 1994). To illustrate, RG programs must protect players from the limits and inaccuracies associated with risk factors. Further, these programs must consider whether the intervention directly or indirectly might produce any harm (iatrogenic effects). For instance, RG programs might implement interventions that annoy subscribers to the point that they switch by choosing to play in less safe gambling settings. When precommitment policies target a very small segment of gamblers and cause annoyance and irritation to the vast majority of gamblers, some of these players might shift their play to more risky activities. For example, in some jurisdictions, mandatory precommitment (i.e., identifying the amount of money patrons intend to allocate for their gambling activities during a period of time) did not meet its goal. Although unintended by the precommitment policy, some gamblers decided to increase the precommitted amount of money they planned to use for gambling—just in case they needed more than they usually do (Ladouceur, Blaszczynski, & Lalande, 2012).

In the clinical arena and in their daily practice, to "do good and avoid doing harm," evidence-based treatment should guide clinicians instead of clinicians having to rely only on personal experiences and approaches. The ethical consideration for clinicians is to inform clients about treatment risks and benefits, provide the best available treatment, and allow gamblers to choose which treatment and which treatment objectives are best for them.

The ethical consideration for government is to provide and financially support evidence-based programs that attend to the full range of gamblers and at-risk gamblers, while balancing the civil liberties of citizens with consumer protection responsibilities. This delicate balance varies from setting to setting. Further, cultural and public policy disparities influence these settings differently. For example, cultural norms sometimes hold gambling to be a risky and/or a nonvalue added, nonproductive product within the context of policies that permit increased availability. This is pertinent where gambling policy and health care delivery service decision makers fail to recognize gambling disorders as legitimate psychological conditions. The result of this perspective is failing to allocate sufficient attention to the regulation and management of gambling and its potential adverse consequences. Thus, clinicians are in the difficult position of having to adjust their efforts because of limited resources or inconsistent health care delivery models. The end result is that the RENO Model translates to practice inconsistently and with fragile reliability.

Justice

Justice, or fairness, is the ". . . moral obligation to act on the basis of fair adjudication between competing claims" (Gillon, 1994, p. 185). It covers decisions related to, and the allocation of, the fair distribution of scarce resources (distributive justice), respect for people's rights (rights-based justice), and respect for morally acceptable laws (legal justice). When the resources are plentiful, it is a relatively simple task to distribute things fairly; however, when resources are scare, then it becomes more complicated to share resources justly. For RG programs to be moral, prevention and treatment resources must be available to all players—regardless of the proximity or even presence of legalized gambling. When these resources are not available for everyone, then the most vulnerable should receive programmatic attention. To assure fairness, public health workers might need to implement

tiered RG programs. For example, to conserve resources the system might have to become more selective. To establish a stepped and just RG system, everyone should have the opportunity to be screened—following consent; then, subsequent evaluations become more focused on those identified as at-risk; finally, a tiered RG system should target more resources for the highest risk players who face the greatest harms.

Some public health workers or policymakers support gambling-related primary prevention and intervention programs for all players, regardless of the presence/absence of a particular risk profile or marker for gambling disorder. However, before doing so, we must demonstrate that any such interventions are safe and efficacious, evidencing little potential for harm to those not at risk. Vulnerable population segments (e.g., youth, gamblers with co-occurring mental disorders) require special consideration to assure that RG program elements and activities reduce and do not increase their risk level. A broad-based universal primary prevention strategy is not unlike the suggestion that everyone should be given statins to reduce inflammation regardless of elevated c-reactive proteins (Morrow, Sabatine, & de Lemos, 2008). However, a shotgun approach will raise many ethical concerns, particularly about the potential adverse effects that such a program might stimulate among those without gambling disorder risk factors (Shaffer et al., in press).

Finally, Gillon (1994) reminds us that, even when we agree about the ethical principles that form the foundation of gambling treatment and prevention programs, we still might ". . . disagree about their scope of application . . . about to what or to whom we owe these moral obligations . . ." Further, "we clearly do not owe a duty of beneficence to everyone and everything. . . . While we clearly have a *prima facie* obligation to avoid harming everyone, who and what count as everyone?" (p. 187). As the field advances, there are many ethical issues that will confront marker (e.g., behavioral and biogenetic) and algorithm-related practice for gambling. For example, how should players be informed of their marker status to maximize beneficence and limit malfeasance? What might players do with this information—both within the gambling setting and the community? What is the responsibility of the gambling purveyor who has identified risk to share such information with a player whether or not they have a program to prevent or alter the course of the risk? These important issues and practices should be discussed between the clinician and the client within a context of informed choice (e g., Blaszczynski et al., 2008). Each intervention needs to be tailored according to client needs.

Responsible Gambling: Different Perspectives

As some scientists are focusing on efforts to develop RG programs that can prevent or reduce adverse gambling-related events associated with population segments, others are working to translate these efforts to clinical practice. Clinicians are translating aggregate, population-level information to individual-level practice. Throughout this process, it is important to consider the perspective from which it might derive. For example, the government, gambling industry, and clinicians might each view RG differently. The community, family, industry, or player might offer different perspectives toward RG; similarly, scientists, ethicists, and health care providers might consider RG very differently. For example, players might view RG in terms of loss limits; the industry might view RG in terms of deposit limits, employee training, and technology design; and health care providers in terms of personal and family limits (e.g., Giroux, Boutin, Ladouceur, Lachance, & Dufour, 2008; Gray, LaPlante, & Shaffer, 2012; Haefeli, Lischer, & Schwarz, 2011; LaPlante, Gray, LaBrie, Kleschinsky, & Shaffer, 2012; Warren, Parush, Wohl, & Kim, 2014; Wohl, Gainsbury, Stewart, & Sztainert, 2013)

Ultimately, RG reflects a shared interest and responsibility. RG stakeholders include the gambler, gambling industry, community, regulators, and the government that either sponsors or regulates gambling. Often overlooked among the stakeholders are the clinicians who care for gamblers; they have a special stake in translating RG programs and policies into practice for their clients. Gamblers have a responsibility to themselves, their family, and their community to abstain or gamble within affordable limits. The industry has a special responsibility to offer a fair and honest game. The regulators need to make sure that gambling purveyors conduct the games fairly and properly with a maximum of integrity. The community provides the context for fairness and honesty, as well as the social setting within which gambling offers survive. Ultimately, the government determines what kind of gambling and gambling context will be permissible within a jurisdiction. Responsible gambling programs emerge from the interactive and synergistic influences of the many stakeholders that have an interest in gambling and its conduct. If any of the stakeholders fail to sustain their involvement with responsible gambling programs, there is a risk of programmatic bias and the consequent compromised program efficacy and impact. Under these circumstances, responsible gambling programs might not fulfill their objectives—and might not meet the ethical standards that provide the context for such programs (e.g., autonomy, justice).

Irresponsible Gambling Versus Disordered Gambling

From a clinical perspective, little has been written about the differences between irresponsible gambling and disordered gambling. The former reflects poor choices and the latter psychopathology. There is considerable overlap between these two patterns of behavior. Disordered gamblers often make irresponsible decisions about their gambling precisely because their disorder compromises personal responsibility. RG programs might not be able to distinguish irresponsible gamblers from disordered gamblers—after all, clinicians have considerable difficulty making this distinction (Ladouceur et al., 2002; Shaffer & Freed, 2005; Shaffer & LaPlante, 2005; Shaffer & Martin, 2011; Slutske, 2006). For example, an important study focusing on the diagnosis of alcohol use disorder among young people demonstrated that, when compared with a criterion standard interview, clinicians identified significantly fewer adolescent patients with problem use and abuse and no patients with dependence (Wilson, Sherritt, Gates, & Knight, 2004). There is no reason to think that practitioners are any more skilled at the diagnosis of gambling disorders than they are at diagnosing alcohol use disorders. In addition, unlike the many signs associated with alcohol and other substance use disorders, some observers have considered gambling disorders to be invisible (e.g., Goldman, 1991). Consequently, clinicians need assistance to improve the accuracy of their impressions and to identify the presence and nature of gambling-related disorders.

Irresponsible gambling shares conceptual and diagnostic difficulties with irresponsible drinking and irresponsible eating. Both of these circumstances feature the importance of using contextual issues (e.g., health status and social setting) to judge the nature and extent of negligence. For example, eating a diet featuring fatty foods might reflect irresponsibility, ignorance, or a holiday celebration. With each of these problems, clinicians need to manage their negative countertransference that can encourage an adverse view of excessive gamblers who suffer with a bona fide mental disorder (American Psychiatric Association, 2013).

For example, clinicians, family members, and gambling providers might view intemperate gamblers as irresponsible: reckless, rash, careless, thoughtless, foolish, impetuous, impulsive, delinquent, negligent, harebrained, derelict. For the most part, irresponsible behavior reflects observer value judgments—sometimes by legal determination—that reflect community value judgments. However, it is important to remember that within the criminal justice system, diagnostic decisions might be exculpatory regarding matters of responsibility. The American Psychiatric Association and its diagnostic manual have expressed considerable ambivalence about the exculpatory value of gambling disorder through its cautionary note.

> . . . [I]nclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling [now referred to as gambling disorder] or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency. (American Psychiatric Association, 1994, p. xxvii)

The line between irresponsible gambling and disordered gambling is thin and perhaps even semipermeable. Disordered gamblers often behave irresponsibly and irresponsible gamblers might occasionally cross the line into disordered gambling. Can clinicians distinguish one condition from the other? This is a matter of construct validity.

The problems associated with construct validity were evident during recent attempts to implement responsible gambling programs. For example, in a jurisdiction that expanded gambling to include casino gambling, this expansion prompted the state to legislate the development and implementation of responsible gambling activities. As public policymakers attempt to develop these programs, they are struggling to define basic constructs, such as "problem gambling." Some policymakers found it necessary to introduce a new construct that described patrons who were to be targeted by responsible gambling programs as "intensive" gamblers (Massachusetts Gaming Commission Public Meeting; Crosby, Cameron, McHugh, Stebbins, & Zuniga, 2014). They also experienced considerable difficulty defining the target of regulatory activities (e g., distinguishing between the time and money aspects of excessive gambling). Construct validity is a complex and difficult but essential task for scientists and public policymakers alike. Within the clinical arena, construct validity means that clinicians and treatment programs identify and deal with targets (i.e., constructs) that reflect what they intend to target. For example, clinicians might target and treat gambling disorder when the actual problem energizing excessive gambling is mania. Under this circumstance, the target treatment construct is not valid and confused with a co-occurring disorder (i.e., mania). There are many constructs that clinicians can confuse with gambling disorder. For example, in addition to mania, it is possible to mistake depression, personality disorder, or domestic disturbance as a primary gambling disorder. Questionable construct validity permits clinicians to act as if a disorder is present when it is not. Uncertain construct validity permits and perhaps encourages clinicians to compromise client autonomy (e.g., set limits on their behavior or freedoms) when there is little reason to violate personal liberty. Establishing construct validity is a special challenge for responsible gambling programs in particular. Most stakeholders design responsible gambling programs to target irresponsible gambling (IR). IR can emerge from bad judgment, judgment compromised by mental disorders—including personality disorders—ignoring financial obligations, limited financial status, unfair purveyors of gambling, and other influences. Gambling involvement includes breadth and depth gambling (LaPlante, Nelson, & Gray, 2014). Until we can establish clear definitions and validity for the constructs associated with excessive gambling, it is essential that public policymakers build programs guided by the ethical principles described earlier. Anything less increases the risk that responsible gambling programs might be ineffective or cause unintended harms.

Responsible Gambling Programs

According to the RENO Model, responsible gambling programs ought to be evidence-based initiatives designed to prevent the incidence and reduce the prevalence of gambling-related harms. However, not every program—or program activity—that is identified as a RG program meets this expectation. For example, some jurisdictions develop, introduce, and maintain activities as RG components despite not yet having or using empirical evidence (Ladouceur et al., 2012; Sheldon, 2014). Notwithstanding the apparent similarity, RG programs are different from more narrow treatment and harm reduction efforts because these programs focus on gamblers with known problems. Responsible gambling programs attempt to prevent the emergence of problems and reduce problems when these exist. Consequently, at times, RG activities can overlap with treatment and harm reduction activities, often yielding benefits such as treatment and prevention.

To structure a responsible gambling program, the developers will need to distinguish the strategies that will guide the program from the policies and practices that provide the template for its activities and operations. Once a responsible gambling program has been implemented, the various interest groups have an obligation to determine whether (a) elements of RG are being applied in practice, (b) they are effective and have impact, and (c) the program reflects the values of the community. The first of these obligations is a task of regulators and policymakers; the second is a task of scientists; and the third is a task of ethicists. All of these obligations are related to clinicians and how they practice.

The Practice and Efficacy of Responsible Gambling Programs: How to Apply and Use the RENO Model

It is essential to evaluate and determine the efficacy and impact of clinical programs. By impact, we mean how many people engage in the activity. The value of a program or clinical activity

is a function of both efficacy and impact. A program that has high efficacy but low impact is of little value—such programs do not attract many users. On the other hand, programs with high impact and low levels of efficacy have much more public health value—these programs influence many people. Needless to say, ideally, a RG program will meet both high efficacy and impact objectives. In the next paragraphs, we will describe the use of different RG program components and offer some indications about their efficacy. Clinicians have a major role to play during the development of effective RG programs and associated treatment activities.

There are a variety of RG activities that can illustrate the clinical application of the RENO Model. Some of these activities are managed and evaluated at the population level and others at the individual level. For example, educational kiosks within gambling venues can be used to inform players and employees about advertising and marking programs, credit restrictions, and employee training; these public health tools are illustrations of RG activities that target gambling populations and typically fall outside the domain of RG activities that target individuals. Alternatively, some program activities are associated with individual or small group (e.g., family) level of practice. To illustrate RG activities that apply at the individual level and can be interpreted within the context of the clinical applications of the RENO Model, next, we will review the status of four common program elements: (a) precommitment (including loss limits and win limits) and budget management, (b) self-exclusion, (c) treating comorbid conditions, and (d) evaluating treatment outcomes.

Precommitment

During a review of the precommitment literature, Ladouceur et al. (2012) indicated that limit setting was used by approximately 30% of participants across studies. Of those who utilized this responsible gambling tool, most set monetary limits; time limits were rarely set. Analysis of card data led to the conclusion that limit setting resulted in a reduction of spending for about 50% of the participants. However 40% spent more demonstrating potential unintended negative effects of precommitment. The researchers concluded that methodological limitations "preclude any conclusive statement on the effectiveness of precommitment systems on gamblers" (p. 227). The existing research demonstrates that, in some case, setting limits effectively reduces harmful gambling behaviors; however, for others, spending increases (Ladouceur et al., 2012). Consequently, the data regarding the effectiveness of precommitment remains inconclusive.

Self-Exclusion

Self-exclusion is a program mainly developed and used by the gambling industry to limit access to gambling opportunities for patrons. Blaszczynski, Ladouceur, and Nower (2007) note the following four self-exclusion-related principles: (a) The gaming industry recognizes that a proportion of patrons gamble excessively and have difficulty controlling gambling behaviors; (b) The operators have a responsibility to provide a safe gaming environment and to assist in minimizing gambling related harm; (c) Gamblers must accept personal responsibility for limiting gambling behaviors to affordable levels; and (d) Self-exclusion is not a treatment designed to address psychological processes but can be beneficially embedded in a comprehensive professional intervention.

Self-exclusion programs allow gamblers—whether disordered or not—to voluntarily exclude themselves from gambling establishments. The main goal of self-exclusion is to help problem gamblers cease or limit their gambling activities. Individuals who self-exclude from a particular venue authorize the staff to deny the self-excluder venue access and remove the self-excluder if detected on site.

Despite the growing use of self-exclusion strategies, few programs have been evaluated (e.g., Ladouceur, Jacques, Giroux, Ferland, & Leblond, 2000; Ladouceur, Sylvain, & Gosselin, 2007; Nelson, Kleschinsky, LaBrie, Kaplan, & Shaffer, 2010). Some earlier studies conducted in North America have shown that the self-exclusion program had a positive impact on the majority of participants within the first 6 months of enrollment. We can summarize the main results of self-exclusion program evaluations as follows: (a) The urge to gamble was significantly reduced; (b) The perception of self-control over gambling was significantly increased; (c) The intensity of negative consequences from gambling was significantly decreased in the areas of daily activities, social life, work, and mood; (d) Scores on the instruments used to identify and diagnose gambling disorders (e.g., SOGS and DSM) showed significantly reduced problems with gambling; and (e) The most significant finding was that only about 30% of the participants complied with their initial agreement and remained abstinent during their self-exclusion period. Over time, self-exclusion programs exert declining impact on some of the participants. For example, about 40% of the self-excluded patrons returned to a casino at least once. People who remained in the program for a greater length of time believed more strongly in the self-exclusion program's effectiveness and were more convinced the program had helped them than those who participated for shorter periods (Ladouceur & Lachance, 2007).

Despite these benefits, we need to raise important questions about self-exclusion as an effective intervention. The overall results (Ladouceur & Lachance, 2007) indicate that, over time, participants perceive the self-exclusion program as less effective in helping disordered gamblers. By the 6-month follow-up, more than half of the participants had returned to a casino or breached their contracts. Some participants reported that they were not identified when they returned to the casino, raising questions about the viability of the program. Many had unclear expectations for the program, and the responsibility for gambling often shifted from the individual to the industry.

In view of these findings, self-exclusion is a procedure that, in certain cases, can reduce gambling-related problems. To increase the impact of self-exclusion interventions, we suggest that clinicians address three important issues. First, clinicians should discuss self-exclusion as one option among many and tailor involvement with self-exclusion to each client's individual needs. Second, clinicians and self-exclusion program managers need to monitor program participants to identify self-excluders motivated to enter gambling establishments and improve their compliance with the program. This will require improved methods and measures for identifying participants at risk. Third, clinicians need to identify and advance measures that reflect program effectiveness and impact. For example, clinicians need to be vigilant toward the pro-

gram's capacity to attract or repel participants. In addition, there is a need to establish evaluation activities that will provide measures of program efficacy. Efficacy and impact are the twin pillars of program value. An effective program that attracts few people is not particularly valuable; alternatively, a program that attracts many and offers a small positive effect has great public health value.

Treating Comorbid Conditions

While assessing clients, clinicians need to take into account and accurately assess the direction of causality between comorbid psychiatric disorders and gambling. There is a substantial body of evidence indicating that an association exists between gambling and a number of Axis I psychiatric disorders, namely substance use, depression, suicidality, and anxiety-related disorders. Several studies have identified a number of psychiatric morbidity, soft neurological signs, and personality traits as risk or predisposing variables for the onset of gambling disorders. Conversely, studies have shown gambling-related harms to predate the manifestation of psychiatric symptoms and/or conditions, suggesting that gambling might be responsible for the onset of these problems. For example, hazardous alcohol use, alcohol use disorders, and depression have been found to predict gambling-related problems and gambling expenditure (Abbott, Williams, & Volberg, 2004) while retrospective studies (i.e., recollection about age of onset) have shown that anxiety disorders, major depressive disorders, and alcohol/drug abuse appear to precede the emergence of pathological gambling (Kessler et al., 2008). Indicators of alcohol dependence and anxiety have also been found to predict progression from nonproblem gambling to at-risk gambling, and individuals with an anxiety disorder were 4 times more likely to develop new onset cases of moderate-risk/ problem gambling a year after assessment (Billi, Marden, & Stone, 2012; Billi, Stone, Abbott, & Yeung, 2015).

Research also suggests that impulsivity among kindergarten children can predict gambling behaviors among sixth graders (Pagani, Derevensky, & Japel, 2009) and adults (e.g., Shenassa, Paradis, Dolan, Wilhelm, & Buka, 2012). Impulsivity, a feature of ADHD and risk taking among children, has been found among early adolescence to predict gambling problems and gambling frequency during later adolescence (Dussault, Brendgen, Vitaro, Wanner, & Tremblay, 2011; Vitaro, Brendgen, Ladouceur, & Tremblay, 2001); similarly, impulsivity and anxiety influence the later development of gambling problems among adolescents (Vitaro, Wanner, Ladouceur, Brendgen, & Tremblay, 2004). In addition, impulsivity among early adolescents has been found to predict depressive symptoms and gambling problems during later adolescence; these factors are interactive and can influence each other during subsequent years (Dussault et al., 2011). Finally, those with undercontrolled temperament at age 3 experience higher rates of gambling problems at age 32 (Slutske, Moffitt, Poulton, & Caspi, 2012). Similarly, sustained ADHD throughout childhood and young adulthood experience greater gambling problem severity (Breyer et al., 2009).

However, there is evidence that a proportion of gamblers exhibit alcohol, depression, and anxiety as a consequence of gambling in the absence of any premorbid psychiatric disorders (Blaszczynski & Nower, 2002). Similarly Chou and Afifi (2011) reported that problem gambling predicted the later incidence of mood disorders, generalized anxiety disorder, PTSD and alcohol use or dependence, and compared to nongamblers, recreational, at-risk, problem and pathological gamblers were at increased odds to develop a mood, anxiety, or substance use disorder later on in a graded relationship (Parhami, Mojtabai, Rosenthal, Afifi, & Fong, 2014). Consequently, while the majority of gambling disorders are preceded by existing psychiatric disorders, intemperate gambling can precede the emergence of psychiatric disorders (Pilver, Libby, Hoff, & Potenza, 2013). This body of evidence emphasizes the importance of taking exceptional care about the sequence of signs and symptoms associated with gambling and psychiatric disorders during the diagnostic process.

Accordingly, from a RG perspective, there is an ethical and science-based requirement for clinicians to obtain firm evidence about the sequence of events that can inform formulations about the confluence of factors related to the direction of causality. It is important to avoid the temptation to diagnose and classify any individual reporting the presence of gambling-related harms as someone with a gambling disorder. It is similarly important to avoid relegating the presence of a comorbid psychiatric condition as sequelae secondary to gambling disorder. These kinds of conclusions might not be accurate and/or justified. This is an important consideration particularly among those jurisdictions where continued funding is based on the number of gambling clients serviced and where pressures are placed on clinicians to maintain client numbers. The political pressure to label individuals as gambling disordered to secure continued funding for treatment services is an approach anathema to the fundamental principles of the RENO Model, and not in the best interest of the clients and their management.

Conversely, gambling-related addiction is often under- or undiagnosed among patients already in the treatment system for other problems (Kessler et al., 2008). Furthermore, because some private insurers do not routinely reimburse for a diagnosis of gambling disorder, clinicians who see clients with gambling problems might be motivated to substitute as a primary diagnosis one that is more readily reimbursable (e.g., Hyman, 2010; Pomerantz & Segrist, 2006)—or less stigmatizing. Accurate diagnosis and correct case formulation taking into account distal and proximal factors contributing to a disorder is paramount to the development and implementation of effective therapies that are in the best interests of the client. Misdiagnosing cases in response—deliberate or otherwise—to political dictates or funding needs is not ethical and should be avoided.

Evaluating Treatment Outcomes

One of the most important commitments for the conduct of effective practice is for clinicians to work within a client-centered relationship that strives for shared treatment goals. A patient-centered collaborative and informed choice for treatment objectives and methods will maximize the chances of a successful conclusion to any intervention. In this regard, it is highly relevant to establish at the outset of treatment, the domains and parameters that will determine and operationalize what constitutes a positive outcome for treatment. Assessing variables limited to gambling expenditure, frequency, and urge intensity strength are not necessarily sufficient. These variables are highly dependent upon the extent to which clients have access to gambling funds; these

measures also are dependent upon the monitoring and restriction of gamblers' behavior by significant others. In the majority of cases, once gamblers enter into treatment, access to money is restricted either because they have exhausted available funds or significant others have taken control over their personal finances. In these cases, a reduction in expenditure, urges, and frequency can be inaccurate and misleading markers of gambling. Similar to other addictions, urges diminish significantly if there is no possibility of consuming the substance or activity and therefore no conflict in self-regulatory choices. To illustrate, smokers do not have urges during the early to mid section of long-haul flights, but these urges escalate when approaching landing and the prospect of having a cigarette becomes possible. We suggest that, in addition to the outcome variables mentioned above, stakeholders need to consider the temporal desynchrony between changes in gambling behavior and improvement in quality of life, relationship, and decreased psychiatric/psychological symptomatology that is consequent to the effects of excessive gambling losses. This circumstance might reduce the pace of improvement in some sectors of the client's functioning.

Given potentials for relapse during the longer term, clinicians ought to obtain empirical evidence supporting the effectiveness of their treatment across greater timeframes than assessments carried out immediately upon treatment completion. For example, follow-ups at 3, 6, and 12 months will provide significant information about clients' therapeutic gains and their risk for lapse or relapse. The basic principle is to clearly establish and delineate the specific goals of treatment (control vs. abstinence), operationally define what variables will accurately and validly reflect successful outcomes (gambling involvement and/or personal and interpersonal morbidity), administer appropriate clinical scales at pretreatment and follow-up timeframes as a means of measuring clinical outcomes, and using timeframes that monitor treatment effectiveness over the long term. Information from collaterals to confirm the reliability of self-report data should be pursued where possible. Only by eliciting reliable and valid data and the application of evidence-based techniques will it be possible for clinicians to evaluate the outcomes of any clinical intervention and gain confidence that what they are offering achieves its stated objectives.

Clinicians often claim that they do not have the necessary resources or maintain a heavy clinical load that precludes the administration of clinical measures and follow-up assessment. Resources for responsible gaming are particularly scarce in comparison to other expressions of addiction. For example, public funding for substance abuse services is substantially greater than the total public and private funding for problem gambling services. However, from an ethical and scientific perspective, the onus remains on the clinician to guarantee that the intervention offered is in the best interest of the client (beneficence), does no harm (maleficence), and is not only based on empirical evidence but also administered in a competent and effective manner. The latter dictates the need for clinicians to keep abreast of recent clinical and scientific developments that can influence treatment methods, and to evaluate their own performance to ensure that they can maximize opportunities for optimal client outcomes (justice: informed choice and decision making regarding comparative efficacy and effectiveness of treatment interventions offered). Within the realm of behavioral health services, treatment interventions are dynamic procedures and techniques that are exposed to continued evaluation and improvement through the process of reiterative research. Health services and funding bodies ought to support and allocate resources to continued professional development and monitoring of longer term clinical outcomes.

Conclusions

This article extends our previous RG work (Blaszczynski et al., 2011, 2008, 2004) by providing a guide to the clinical application of RG principles. Derived from the RENO Model, this article discusses a variety of RG applied activities. Importantly, a review of the RENO Model core principles reveals that RG programs do not always follow the RENO Model, sometimes ignoring science and its evidence base in favor of conventional wisdom. Clinicians attempting to utilize RG programs are often hamstrung by a lack of resources; many governments have not adhered to the RENO Model's recommendations to provide adequate support. Although the gap between evidence-based practice and treatment as usual is narrowing, there remains a long way to go (Carroll, 2012). This circumstance can place RG efforts focusing on the prevention and treatment of gambling-related problems at considerable risk. Furthermore, failing to integrate the ethical and practice guidelines offered by the RENO Model can diminish the safety, well-being and effectiveness of RG programs.

Clinicians must be aware of their ethical responsibilities that include a mandate to respect client autonomy, do no harm, deliver benefits, and be fair. Furthermore, the ethics of clinical practice demand that clinicians pay attention to scientific evidence. However, countertransferential impulses toward both clients and evidence, as well as a range of attitudes toward gambling regularly challenge these ethical objectives (e.g., Bernard, Murphy, & Little, 1987; Collins et al., in press; Exeter, Rodgers, & Sabel, 2014; McGowan, 1997; Moleski & Kiselica, 2005; Orford, 2002; Pope & Vetter, 1992; Shaffer et al., 2001; Walker & Clark, 1999). These feelings toward gambling, legal and illegal, must not interfere with the primary needs of clients.

Most RG programs have selected and integrated only a few strategies upon which to rest the program (e.g., commitment, self-exclusion, evaluation of mental disorder, and some attempt to evaluate program outcomes). However, there are many other strategies and tactics that can be integrated into RG programs (e.g., opt-out strategies; messaging, advertising, incentives, perks, etc.).

Attempts to define client needs must include a careful evaluation of the distinction between responsible gambling, irresponsible gambling, and gambling related to other mental disorders. Once the targets of an RG program are identified and operationalized, prevention and treatment strategies and tactics can be defined. Also, program evaluation becomes possible because the touchstones of the program are visible and provide the objectives against which evaluation efforts can be implemented and conducted.

Finally, well-defined RG programs will need to collaborate with other stakeholders to provide the best available evidence-based clinical interventions to gamblers so they can avoid developing gambling problems, limit the progression of any existing problems, and attenuate any problems that might already have developed. Just as the RENO Model encouraged the development and implementation of RG programs that could prevent and treat gambling-related problems, the RENO Model encourages clinicians to provide treatment that prevents the progression of gam-

bling and comorbid gambling-related signs and symptoms. To assure the success of this objective, the RENO Model encourages clinicians to rigorously evaluate the efficacy and impact of these efforts to assure their success and to avoid doing harm.

Keywords: responsible gambling; ethics; treatment; RENO model

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