

**PROBLEM GAMBLING TREATMENT  
AND RECOVERY SERVICES  
TITLE 14 NYCRR PART 857**

**Notice: The following regulations are provided for informational purposes only. The Office of Alcoholism and Substance Abuse Services makes no assurance of reliability. For assured reliability, readers are referred to the *Official Compilation of Rules and Regulations*.**

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**857.1 Background and Intent:**

(a) In 2005 the Legislature transferred the treatment of Problem Gambling from The Office of Mental Health to The Office of Alcoholism and Substance Abuse Services. MHL section 32.02 enables the Commissioner to adopt regulations to ensure quality services to persons in need of problem gambling treatment. The provision of these services has been occurring through the NYS Office of Alcoholism and Substance Abuse Services. This regulation will provide guidance and standards for the continued provision of problem gambling services to New Yorkers suffering from problem gambling, and in need of treatment for their addiction.

(b) OASAS shall develop access to problem gambling treatment and recovery services, define what a problem gambling services is and develop minimum standards for problem gambling treatment.

(c) To ensure access to problem gambling services and establish core competencies for gambling treatment professionals and services providers.

(d) To educate the field of chemical dependency services and our partners in the mental health services about problem gambling treatment services.

### **857.2 Legal Authority**

(a) Section 19.09 (b) of the Mental Hygiene Law allows the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under the Commissioners jurisdiction.

(b) Section 32.01 of the Mental Hygiene Law states the Commissioner of the Office of Alcoholism and Substance Abuse Services may adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by article 32 of the Mental Hygiene Law.

(c) Section 32.02 of the Mental Hygiene Law states the Commissioner of the Office of Alcoholism and Substance Abuse Services may adopt regulations necessary to ensure quality services to those suffering from problem gambling.

(d) Section 32.07 of the Mental Hygiene Law states the Commissioner of the Office of Alcoholism and Substance Abuse Services may adopt regulations to effectuate the provisions and purposes of article 32 of Mental Hygiene Law.

### **857.3 Applicability**

Those outpatient providers or independent outpatient gambling treatment services funded or authorized by OASAS.

### **857.4 Definitions**

(a) Problem Gambling, is gambling behavior which causes disruptions in any major area of life (i.e. psychological, physical, financial, legal, social or vocational) as defined by

the National Council on Problem Gambling. The term “Problem Gambling” includes the condition known as “Pathological” or “Compulsive” Gambling and a less severe condition, “At Risk” Gambling.

(b) Problem Gambling Treatment and Recovery Services assist individuals who are affected by problem gambling including family members and/or significant others. These services may be provided in free-standing settings or may be co-located in chemical dependency clinics or other mental health settings. Each problem gambling outpatient service shall provide the following: screening, assessments, crisis intervention groups, and individual counseling, education, orientation to and opportunity to participate in problem and pathological gambling awareness and relapse prevention, and financial counseling. Financial support and counseling and mutual support groups may be provided on site or by referral.

(c) The Governing Authority shall determine and establish written policies, procedures and methods governing the provision of services to patients which shall include a description of each service provided, including procedures for making appropriate referrals to and from other services.

(d) Facility shall mean a stand alone clinic providing services for problem gambling only or a facility providing chemical dependency or other addiction services in addition to problem gambling services, authorized or funded by OASAS to provide said service.

(e) Clinical Supervision shall mean the interactive process of a supervisor and supervisee focusing on the implementation of practical skills regarding, evaluative, supportive and clinical areas through individual and group sessions which may include direct and/or observed sessions. The purpose and goals of clinical supervision are to monitor and

ensure the patient's well being, assist in professional development and monitor and evaluate job performance.

(f) Credential shall mean a CASAC (Credentialed Alcoholism and Substance Abuse Counselor) with a specialty in gambling, Problem Gambling Addiction Treatment Professional, including: a person with a New York Certified Gambling Certificate issued by the New York Council on Problem Gambling or a National Problem Gambling Certificate, issued by the National Council on Problem Gambling.

(g) Gambling Units of Service shall mean each individual, group and/or family session that is rendered. It may include more than one unit of service per day.

#### **857.5 Admission Procedure**

(a) Assess within 2 visits whether the potential patient is appropriate for admission to the service.

(b) Criteria: To be admitted to the service the individual must:

1. Be committed to addressing their behaviors and from gambling and/or working towards abstinence: or
2. Be a significant other who has been adversely affected by another individual's problem or pathological gambling behaviors. Significant others may be treated as patients in their own right and admitted to the service, regardless of whether the addicted person is in treatment, and/or they may be treated as part of a family program/service.
3. Meet the criteria for Pathological Gambling contained in the Diagnostic and Statistical Manual of Mental Disorders IV or most current version of the same or;
4. Meet the criteria for Problem Gambling (meets one to four DSM –IV or most current version of the same) or,

5. A gambling assessment tool, approved by OASAS must be used to determine eligibility criteria, and is available through the agency website.
6. The decision to admit an individual shall be made by a staff member who is authorized by the program to admit individuals for problem/pathological gambling which shall be documented in the patient record.
7. If denied services, a referral to the appropriate service shall be made and the decision not to admit the person to the services clearly documented and provided to the person.
8. A copy of the patient rights, the services rules and regulations, and a summary of HIPAA requirements shall be provided to the patient as well as a statement indicating the same was communicated to the patient and the patient understood them.
9. Patients may be admitted simultaneously to a chemical dependency outpatient program and a gambling outpatient program. If admitted for chemical dependency, and gambling is a secondary diagnosis the records can be kept together subject to all Federal and State confidentiality laws. If admitted for gambling only treatment services, under a separate problem gambling program reporting unit (PRU) the records shall be kept separate from the services chemical dependency records.

#### **857.6 Recordkeeping**

Programs must keep individual patient records for each patient who is admitted to the service. Patient records maintained by the program are confidential and may only be disclosed in conformity with HIPAA. The following must be included in patient records:

- (a) A notation that the patient received at admission a copy of the program's rules and regulations, including patient's rights and a summary of the HIPAA requirements, that treatment is voluntary, that such rules and regulations were discussed with the patient, and that the patient indicated he/she understood them.
- (b) The source of the referral.
- (c) Documentation of the decision to admit to the program, including admission criteria.
- (d) Documentation of the evaluation.
- (e) A completed gambling screening tool approved by OASAS.
- (f) Individual treatment plan, all reviews and updates.
- (g) Documentation of recommendations, referrals and services provided for the patient for other service needs including coordination with other agencies.
- (h) Any incoming or outgoing correspondence about the patient.
- (i) Discharge plan and summary.
- (j) Signed releases of consent forms if any.
- (k) Progress notes.
- (l) Documentation of contacts with a patient's family and/or significant other(s).

#### **857.7 Quality Improvement and Utilization Review**

(a) Each outpatient service shall establish and implement a quality improvement plan and utilization review plan in accordance with this section. Each outpatient service must document its quality improvement/utilization review process. The utilization review requirement may be met by the following:

1. The outpatient service may perform its utilization review process internally; or

2. The outpatient service may enter into an agreement with another organization, competent to perform utilization review, to complete its utilization review process.
3. The utilization review plan shall include procedures for ensuring that admissions are appropriate, retention and discharge criteria are met, and services are appropriate. The utilization review plan shall consider the needs of a representative sample of patients for continued treatment, the extent of problem or pathological gambling, and the continued effectiveness of, and progress in, treatment.
4. Each outpatient service shall establish a written quality improvement plan in accordance with this Section.
5. The quality improvement plan shall identify clinically relevant quality indicators that are based upon professionally recognized standards of care. This process shall include but not be limited to:
  - (i) no less than quarterly self-evaluations to ensure compliance with applicable law;
  - (ii) findings of other management activities, including but not limited to utilization reviews, incident reviews, and reviews of staff training, development and supervision needs;
  - (iii) surveys of patient satisfaction; and

(iv) data analysis of treatment outcome and/or program performance.

6. The outpatient service must have procedures for incorporating patient satisfaction, treatment outcome and performance measurement data into a quality improvement plan and must demonstrate that findings from these data sources have been used to monitor and improve program performance

### **857.8 Confidentiality**

All Records must be kept in compliance with State, Federal and Local Law, including HIPAA.

### **857.9 Staff**

(a) The Clinical Director in a stand alone facility or co-located in a chemical dependency program must hold a Gambling Counselor Certification or credential recognized by OASAS. (CASAC with a Gambling Specialty, Credentialed Problem Gambling Counselor, New York Council on Problem Gambling Certificate, or National Council on Problem Gambling Certificate). If they do not hold a certification, they must be able to document that they are pursuing certification. If the Clinical Director is pursuing such certification, the clinician providing the gambling treatment services must be receiving supervision from a Credentialed or Certified Problem Gambling person who has worked for a minimum of three years as a provider of alcoholism and substance abuse services, problem and pathological treatment services or mental health services and has at least one year of clinical supervisory experience. The Clinical Director shall have at least three years of full time clinical work experience in problem and pathological gambling

treatment, chemical dependency or mental health field, at least one year of which must be supervisory, prior to appointment as clinical director

(b) The Clinician providing the problem gambling treatment services must hold a Gambling Counselor Certification or credential recognized by OASAS. (CASAC with a Gambling Specialty, Credentialed Problem Gambling Counselor) or any other professional credential related to this field and recognized by OASAS, New York Council on Problem Gambling Certificate, or National Council on Problem Gambling Certificate. If they do not hold such a certification, they must be able to document that they are pursuing certification and apply for their credential within one year of providing this service.

The problem gambling clinician should be part of a multi disciplinary team of Qualified Health Professional.

(c) Staff:

1. The patient to primary clinical staff ratio can not exceed 25:1. This ratio relates to full-time equivalent (FTE) staff.
2. Programs are encouraged to utilize peer mentors who are not included in the clinical staff member-to-patient ratio. A peer mentor is someone who has direct personal experience with problem and or pathological gambling.
3. Each program must develop an ongoing staff training and development protocol that includes the following areas:
  - i. All clinical staff should be provided and document training both within the agency and in the community related to problem and pathological gambling

treatment techniques, crisis interventions, dealing with special populations, quality improvement, agency policies and procedures.

(d) Supervision requirements: The Clinical Director shall provide regular individual and/or group supervision of all clinical staff at a minimum of once a week for each FTE providing gambling treatment. Direct observation of the supervisee shall be provided on a regular basis, as appropriate. This clinical supervision must be documented. The Clinical Director shall provide group case conferencing on a monthly basis. This case conferencing must be documented.

#### **857.10 Additional Locations**

A provider of outpatient services may operate at one or more additional locations with the approval of OASAS. The additional location must be operated in the same county or in a county contiguous to the main location and must provide no more than 3000 gambling units of service per year. Supervision of additional locations must be addressed in the agencies policy and procedures.

#### **857.11 Treatment Planning and Program Requirements**

(a) The date of admission is the date of the first clinical service following the decision to admit the patient into the program.

(b) The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan. The evaluation should involve a face to face interview with the individual seeking services. All evaluation information must be conducted and signed by the responsible clinical staff member as outlined in the Staffing Requirements Section of this document.

1. The Evaluation must include the following information:
  - i. Presenting Problem
  - ii. Gambling History
  - iii. DSM-IV Diagnosis including all 5 axes. If the client does not meet the criteria for Pathological Gambling (312.31), a notation of how many criteria they meet should be noted.
  - iv. Current financial status including gambling debt and any previous bankruptcy or repayment plans-
  - v. Suicidal/Homicidal assessment.
  - vi. Chemical dependency assessment.
  - vii. Mental Health history and current mental health status (“e.g.” treatment history, psychiatric medications). Health and wellness status (“e.g”, last physical, diet, exercise) and current medical problems including medication use and compliance
  - viii. Legal History
  - ix. Educational and vocational history
  - x. Housing history
  - xi. Profile of family and relationship history which describes family dynamics and composition
  - xii. Strengths and assets of the patient
  - xiii Mutual Support and Recovery History
2. A treatment plan shall be established in collaboration with the patient within 30 days of admission, and shall establish personal goals and objectives and be signed by patient and clinician.

- i. The treatment plan shall address: Gambling Behaviors, Housing, Vocational/Educational, Financial, Legal, Relationship, Alcohol and Drug Use, Mental Health, Medical, Wellness, Family/Social issues and other indicated recovery supports.
- ii. In identifying the financial goals of the patient, consideration should be given to developing a financial management plan that may ~~or may not~~ include a restitution plan and connections with relevant financial assistance services
- iii. in conjunction with the patient, prescribe an integrated program of therapies and recovery oriented activities to meet the personalized goals and objectives, with target dates for achievement;
- iv. include each diagnosis for which the patient is being treated;
- v. include a description of the additional services, particularly the financial, medical, mental health and chemical dependency services needed by the patient and a plan for meeting those needs; and be reviewed, updated and signed every ninety (90) days by the clinician and patient. The updated treatment plan should be reviewed by the clinical team during the monthly case conference and signed and dated by the clinical supervisor within 5 days of the review. If the client is in treatment for more than four (4) ninety (90) day reviews, an updated comprehensive evaluation shall be completed and documented in the case record. This updated evaluation shall be reviewed at the monthly case conference meeting by the clinical team. Any

patient who is not responding to treatment, not meeting goals as defined in the treatment plan or is disruptive to the program shall be reviewed in case conference. Any decisions made must be documented in the chart and the treatment plan must be revised accordingly. If family members and/or significant others are admitted to treatment in conjunction with the problem/pathological gambler, treatment plans for all patients should identify personal involvement with coordination of services to be received.

3. Progress Notes shall be written within 24 hours of each patient contact and must provide a chronology of the patient's progress related to the treatment plan, be sufficient to delineate the course and results of treatment and indicate the patient's participation. Each progress note should address the patient's current mental status and risk assessment under a separate heading.

All individual progress notes should specify the date, type and duration of each visit, the date of the next scheduled session, and be written, signed and dated by the responsible clinician. Group progress notes should indicate the overall theme/topic of the group. Individual patient participation should be briefly described and placed in their chart

#### 4. Discharge Planning

A discharge plan shall be developed in collaboration with the patient and any significant other(s) the patient chooses to involve. If the patient is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law Section 22.11.

The discharge planning process shall begin upon admission, be closely coordinated with the treatment plan and be included in the patient record and should provide an individualized relapse prevention plan.

Included in the discharge plan should be an assessment of the problem gambling behaviors, financial, vocational/educational/employment/housing status, suicidal/homicidal assessment and relationships with others. The discharge plan shall include but is not limited to:

1. The patient's need for continued services to sustain recovery, mutual aid/support groups and/or other needs which have been identified in the comprehensive evaluation and over the course of treatment.
2. The family's need for continued services and support to sustain recovery.
3. Specific referrals and any initial appointments, if made, with identified providers of service.
4. Relapse prevention plan.
5. Individual Sessions: All patients should be seen regularly on an individual basis. As the patient progresses through treatment, individual sessions may occur less frequently. Open cases must be seen at a minimum of once a month for an individual session of at least 30 minutes in duration.
6. Group Sessions: It is recommended that patients participate in group sessions unless deemed clinically inappropriate by the responsible clinical staff member and the clinical supervisor. Group sessions should typically consist of 6-10 patients and never more than 12. Group sessions should last a minimum of one

hour. Referrals to recovery support services and mutual support groups should be made available to patients.

7. Family and Couples Counseling: Family and Couples counseling should be made available as necessary. Providers must document attempts to engage family members and significant others in treatment.

**857.12 Severability**

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provision or applications of this Part which can be given effect without the invalid provision or applications, and to this end the provisions of this Part are declared to be severable.