

## Chapter 20

**Substance Abuse and Problem Gambling****Introduction**

Substance abuse and abuse-related problems continue to be among society's most pervasive health problems. Some 100,000 people die each year in the United States as a result of alcohol and illicit drug use, and related acquired immunodeficiency syndrome (AIDS) account for at least another 12,000 deaths. Also, nearly 14 million Americans, or one in every 13 adults, abuse or have been diagnosed with substance dependence or abuse.

Several million more adults practice risky drinking that could lead to problems with alcohol or other substances. Such behaviors include binge drinking and heavy drinking. A reported 53% of Americans say that one or more of their close relatives have a drinking problem.

Substance abuse, alcohol abuse, and dependency are significant public health problems that have high economic costs. It costs every man, woman and child in the United States nearly \$1,000 annually to pay for health care, law enforcement, motor vehicle crashes, crime, and lost productivity due to substance abuse. The estimated societal cost of drug abuse in this country in 1998 was \$148 billion for productivity losses, related particularly to incarceration, crime, drug abuse-related illnesses, and premature death.

Substance abuse, including tobacco use and nicotine addiction, is associated with a variety of other serious health and social problems. Epidemiological evidence reveals that 72 conditions requiring hospitalization are wholly or partially attributable to substance abuse.

Not everyone chooses to drink alcohol. Of those who do, most have little or no trouble limiting their intake to amounts that produce no serious health or social consequences. Millions

of other Americans, however, consume alcohol in quantities and frequencies that place them and others at risk for alcohol-related disease, crime and unintentional injuries. People who drink even relatively low amounts of alcohol contribute to alcohol-related death and injury in occupational incidents and operating vehicles.

Alcohol use is associated with more than 45% of all motor vehicle deaths. Available data indicate that roughly one-third of victims of homicide and suicide, and 22% of victims of fatal boating accidents, were intoxicated at the time of death. In addition, the triggering effect of alcohol consumption in sexual assault and victimization has been documented by both experimental and population-based research since the late 1970s.

People aged 60 and older also face risks for alcohol-related problems, although this population generally consumes comparatively low amounts of alcohol. However, "adverse alcohol-drug interaction can be a major problem that causes hospital admissions among older patients, since many older patients take multiple medications. In addition, many cases of memory deficits and dementia now are understood to result from the effects of alcoholism...." (*Healthy People 2010*).

In 1997, the Iowa Department of Public Health conducted the Iowa Substance Abuse Prevention Needs Assessment: Public Survey and in 1999 published the *Iowa State Plan for Substance Abuse Prevention* (state plan). According to the survey, risks at the individual level, such as attitudes favorable to the use of alcohol, tobacco and other drugs, as well as peer use, were directly associated with actual substance use behaviors for adults and children.

Other variables not included in the risk and protective areas are also associated with

substance use behaviors, such as job stress and money worries.

Iowa's Drug Control Strategy and Plan, the first of its kind, was the collaborative work of the following state agencies:

- Office of Drug Control Policy (ODCP)
- Iowa Department of Corrections (IDOC)
- Iowa Department of Economic Development (IDED)
- Iowa Department of Education (IDOE)
- Iowa Department of Human Rights – Criminal and Juvenile Justice Planning (IDHR – CJJP)
- Iowa Department of Human Services (IDHS)
- Iowa Department of Public Defense – Iowa National Guard (the National Guard)
- Iowa Department of Public Safety – Governor's Traffic Safety Bureau (IDPS)
- Iowa Department of Public Health (IDPH)
- Iowa Department of Transportation (IDOT)
- Workforce Development (WD)

The strategy and plan, along with the Iowa Youth Survey, form the basis for many of the goals and objectives of this chapter.

Since the *Healthy Iowa 2000* process began, a disparity of services for Iowans with different risks of addiction has been recognized. As a result, specific treatment programs increased for women with children, young girls, and youth. Culturally specific programs continued and are a continuing focus. Special population and ethics training also continue to be certification requirements for prevention specialists and treatment counselors. In addition, treatment and prevention expanded due to the steady increase of methamphetamine use and abuse.

Materials in many languages are also more available, such as in Spanish, Asian languages, and Braille. The Iowa Substance Abuse Information Center (ISAIC), a clearinghouse for information materials, is working with immigration services to make translation more available. For example, the Iowa Gambling Treatment Program has brochures in Spanish and 11 Asian languages, and its media campaign is designed to appeal to multiple cultures and socioeconomic groups. Other media campaigns

by ISAIC are designed to reach multiple cultural groups and are adaptable to local needs.

Disparity still exists, however, and will require diligence and collaborative efforts to be successfully recognized and addressed. Funding must continue in order to expand ISAIC's culturally specific information and other resources, and to make those materials available to the public. Interpreters are also needed at the point of service; however, there is currently no funding to pay for their use.

Chapter 20 team members recognize the importance of cultural competency in the provision and administration of services to substance abuse and problem gambling patients. As also reflected in Chapter 12: Mental Health and Mental Disorders, there has been significant changes in Iowa's population. Steady growth has occurred during the past five years in the Latino/Hispanic, African-American, Asian, Pacific Islander, and Eastern European communities. The needs of these populations are specific and varied, and substance abuse and problem gambling require cultural competency on an ongoing, systematic basis.

The *Iowa State Plan for Substance Abuse Prevention* determined other disparity-specific targets for increased prevention. These include women of childbearing age and senior citizens, as well many of the K-12 substance abuse curricula such as Drug Abuse Resistance Education (D.A.R.E.) that is developed outside Iowa but implemented extensively here and geared for Caucasians.

It is not yet cost-effective for publishers of these materials to develop materials geared for other groups. Funding for their development has moved from the substance abuse field to those involved with violence prevention, mental health treatment, and criminal justice.

Problem gambling was not addressed in *Healthy People 2000* or in *Healthy Iowans 2000*, nor was it addressed in the original draft of *Healthy People 2010*. However, with the growth of legalized gambling across the country and the wide variety of gambling available to Iowans, a pattern showing the relationship between gambling and substance abuse is developing.

The Iowa Behavioral Risk Factor Surveillance System (BRFSS) annually surveys about 5,000 households by telephone. The survey is designed to collect information on health risk behaviors to monitor prevalence among Iowa residents aged 18 and over. Three gambling questions were added in 1998:

- Have you gambled in the last 12 months?
- Has the money you spent gambling led to financial problems?
- Has the time you spent gambling led to problems in your family, work or personal life?

Approximately one-third of respondents admitted to gambling in the previous year. Around 1% experienced problems in finances or relationships, a consistent percentage since 1998. However, in 2003, 1.6% of respondents who had gambled in the past 12 months said the money they spent gambling had led to financial problems; and 1.7% reported the time spent gambling had led to problems in family, work or personal life.

The BRFSS data reflect the results of an Iowa prevalence study (Volberg, Rachel A., *Gambling and Problem Gambling in Iowa: A Replication Survey*, Des Moines, Iowa, Iowa Department of Human Services, 1995). This survey of Iowans aged 18 and older indicated more than two-thirds had gambled in the previous 12 months. Iowa estimations align with prevalence rates throughout the world and show 1% of Iowans to be current probable pathological gamblers, while 2.3% are current problem gamblers. This 3.3% total amounts to about 72,600 adult Iowans (2000 census) who exhibit signs of problem gambling. "Current" means meeting the criteria in the past 12 months.

The essential features of pathological gambling include 1) a continuous or periodic loss of control over gambling; 2) a progression in gambling frequency, amounts wagered, preoccupation with gambling, and obtaining money with which to gamble; and 3) a continuation of gambling involvement despite adverse consequences (DSM-IV, American Psychiatric Association, 1994). The term "problem gambling" refers to people who fall short of the diagnostic criteria for pathological

gambling but are assumed to be in a preliminary stage in the development of such pathology.

Indeed, the essential feature of pathological gambling is recurrent behavior that disrupts personal, family and/or vocational activities. Problem gamblers may be preoccupied with gambling and continue to gamble despite efforts to control or stop it. They may "chase" losses, make increasingly larger bets, or take greater risks to undo earlier losses. They may lie to conceal the extent of gambling and resort to antisocial behavior such as forgery, fraud, theft, or embezzlement.

Problem gamblers may also engage in "bailout" behavior, turning to family or others for help with a desperate financial situation caused by gambling (See 312.31 Pathological Gambling Criteria in the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, Washington, D.C. American Psychiatric Association, 1994). The *Diagnostic and Statistical Manual Medical Disorders, 4<sup>th</sup> Edition (DSM IV)*, estimates the prevalence of pathological gambling range to be from 1% to 3% of the adult population.

In the 2002 Iowa Youth Survey, 1% of respondents answered that money spent gambling led to financial problems; and 1% answered that the time spent gambling led to problems in family, work, school, or personal life. Such data indicate a need to inform young people about the risks of gambling too much. Growing up in a state where gambling is so accessible makes prevention key to avoiding the costs of excessive gambling.

According to Iowa Gambling Treatment Program data for 1998-2001, 23% of clients in gambling treatment reported they had received treatment for a drinking and/or drug problem, and 61% reported using tobacco. Thus, the title of this chapter now includes problem gambling.

People affected by problem gambling may lose excessive amounts of money and engage in behavior that damages personal, family and vocational pursuits.

Identifying the hidden nature of problem gambling is a necessary part of *Healthy Iowans 2010*. To assess people correctly, more awareness is needed of problem gambling and

its signs and symptoms. In counseling, for example, problems at first glance may appear to be marital or related to alcohol, anxiety or depression, but excessive gambling may be the most significant contributing factor. Assessing problem gambling can be difficult without sufficient knowledge of the financial and health risks of a life filled with gambling and its stress.

Hidden problems include mental health problems, violent and abusive actions, family abuse, inadequate screening, vehicle injuries and deaths, crime, suicide, and low work productivity.

The prevention and treatment of abuse of alcohol, other drugs, and problem gambling require that all abused substances, including tobacco and marijuana, be discovered and addressed. Prevention and treatment of tobacco addiction, for example, is equally important to a comprehensive substance abuse program because research recognizes tobacco as a gateway to other drugs.

Almost all long-term studies show a pattern of going from tobacco and alcohol to marijuana, and, as children get older, to other drugs. However, smoking and drinking at young ages are not seen as the cause of later drug use, and movement toward other drug use is not inevitable.

In an analysis of 1991-1993 data from the National Household Survey on Drug Abuse for people who have ever smoked or drank, "...the risk of moving on to marijuana is 65 times higher than for a person who has never smoked or drank. The risk for moving on to cocaine is 104 times higher for someone who smoked marijuana at least once in his or her lifetime than a person who never did" (Preventing Drug Use among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse).

Although all goals and action steps for tobacco are listed in the tobacco chapter, this chapter will include recommendations for alcohol, tobacco and other drugs.

Abuse does not occur in a vacuum. Prevention and treatment are necessary in order to reduce abuse of alcohol, tobacco, other drugs, and problem gambling. Efforts must be maintained and strengthened, especially in light

of the emergence of methamphetamine (meth). It is also necessary to provide cultural, linguistic and age appropriate approaches. In many situations (e.g., job training, employment, parent training, general education) elements of physical health are necessary for successful living.

Based on population, Iowa is the 30<sup>th</sup> state, yet ranks 6<sup>th</sup> in meth use, according to preliminary data from the 2001 Arrestee Drug Abuse Monitoring (ADAM) project. No other Midwest or eastern state ranks as high or higher. The question frequently asked is, "Why Iowa?"

Meth traffickers discovered that Iowa is a relatively new market where they do not face a lot of competition. Iowa covers 55,875 square miles of Midwest landscape, with 56% of Iowans living in urban areas and 44% in rural, non-metropolitan areas. Of the 99 counties, only 20 have U.S. Office of Management and Budget designation as Metropolitan Statistical Areas. The remaining 79 counties are primarily agricultural. Iowa has three interstate highways, multiple U.S. and state highways, and numerous county roads. Its wide open spaces, accessibility to anhydrous ammonia (an agricultural fertilizer) for manufacture, and network of roadways for delivery may explain the high rate of meth use.

The 2002 Iowa Youth Survey indicated that amphetamine and/or methamphetamine was the second most prominent illicit drug of choice among adolescents. Of students in grades 6, 8, and 11 responding to the survey, 1% reported current use of meth and 4% had used it at some point. Special populations (students enrolled in alternative schools) reported that 52% were current users and as many as 82% had tried it.

Data submitted by treatment programs to the Iowa Department of Public Health's Substance Abuse Reporting System (SARS) indicate that prior to 1994, methamphetamine was listed as the primary substance of abuse less than 3% of the time. Since 1999, SARS data shows a steady increase in the primary use of meth, from 8.3% to 13.2%. Of those, 65% are men and 45% are women. In 2002, 39% of people in treatment programs who listed meth as their primary substance of abuse were under aged 25. Only alcohol and marijuana are reported more frequently than meth.

Examination of SARS data for client screenings and admissions also indicate that the second most prevalent primary substance of abuse, excluding alcohol, is amphetamine and/or methamphetamine. After a significant reduction in 1999, the percentage of youth and adults screened or admitted to substance abuse treatment programs with amphetamine and/or methamphetamine as the primary drug of abuse increased in each of the past three years. That proportion was 15.8% in 2002; 17.3% in 2003; and 18.7% in 2004.

The Des Moines site of the Arrestee Drug Abuse Monitoring (ADAM) project saw an increase in the number of arrestees testing positive for meth, from 5.3% in the second quarter of 2000, to 38.5% in the third quarter of 2001. Additional findings include:

- Female arrestees are beginning to test positive for meth at a consistently higher rate than males;
- Males of all ages are using meth;
- Two years ago, meth use by women was greater among those aged 36 or older. In 2002, the trend switched to include more women, more usage, and younger ages;
- Des Moines has had an increase in meth-related drug and property charges among male arrestees, with property being used more often as an exchange for drugs. Unlike the male arrestees, women using meth are arrested more frequently on drug charges than on property charges. Women combine meth, alcohol and driving at a higher rate than men; and
- An average of 72.8% of male and 74.5% of female arrestees reported previous treatment, including inpatient and outpatient substance abuse and mental health treatment.

The Iowa Division of Narcotics Enforcement documented a 37.31% increase in the number of grams of methamphetamine seized between 1994 and 2004. State and local law enforcement seized 1,155 meth labs in 2003, and the number was expected to increase in 2004. Through September 2004, 964 labs were seized. The amounts of meth seized in Iowa during 2003 increased to over 157,000 grams, or 352 pounds, more than twice the previous record quantity of 73,365 grams seized in 2001, and 39,863 in 2000.

Statistics from the Iowa Department of Public Safety and Corrections include:

- 90% of offenders in drug court are meth addicts.
- A 33% increase in the number of indictable misdemeanor and felony drug charges were adjudicated from 1998 to 2000, with a 17% increase in convictions.
- An 81% increase in the number of reported drug offenses involving meth manufacture or distribution occurred between 1995 and 2000.
- New prison admissions for drug offenses increased by 164% between 1995 and 2001; and admissions for meth-related drug offenses grew by 416%.

Since 2000, the Iowa Department of Public Health received funding and implemented programs and services to address Iowa's methamphetamine problems. The grants included: Meth Awareness (education programs for retailers, staff and public); TCE Meth Treatment (jail-based treatment) and TCE Prevention (expand prevention programs statewide); and Behavioral Health Data Infrastructure (WITS and I-SMART systems). Also, the State Treatment Needs Assessment Program (STNAP, household drug survey, Woodbury County ADAM, IDPH/CJJP data comparisons) and the State Incentive Grant have expanded prevention programs statewide.

In addition, more behavioral research for sustained behavior change, and more programs for women and clients who also have mental problems, is needed. To ensure that multiple service needs are met, increased cooperation and coordination are required from government, faith communities, community-based services, organizations in the private and non-profit sectors, and community members.

In February 2003, Governor Vilsack signed Executive Order 27, which urges Iowa to "move purposefully to swiftly implement the Olmstead Decision." This order says that discrimination can occur when people with disabilities cannot obtain needed services unless they live in an institution or when a state's disability services do not offer consumers real choices. The decision imposes a legal mandate to initiate many of the concepts in Chapter 4: Disabilities.

For those seeking recovery from substance abuse and/or problem gambling, every effort should be made to administer programs, services and activities in the most integrated setting appropriate to the needs of people with disabilities and long-term illnesses.

Chapter 4, Disabilities, requires a commitment, which Chapter 20 Substance Abuse and Problem Gambling supports, to provide programs, services and activities in the most integrated setting appropriate to the needs of people with disabilities and long-term illnesses, and to reduce barriers to community living for such persons. Such a commitment should assure that:

- Local public health partners have the knowledge and resources to provide information about federal, state and local resources that support community living for persons with disabilities;
- Community services staff receive adequate and appropriate training that focuses on how to meet the needs of persons with disabilities and improves staff sensitivity to the needs of all Iowans;
- Persons with disabilities have access to all public health facilities;
- Programs recognize and act on the fact that persons with disabilities are part of their customer base;
- Procedures and programs support and promote community living for persons with disabilities; and
- Funding of community-based services prevents unnecessary institutionalization.

To implement the Olmstead Decision in Iowa, institutional biases in policies and regulations must be identified and overcome. Barriers to real choice must be identified and modified to improve services for people with disabilities who are affected by substance abuse and/or problem gambling.

In 2002, the Iowa legislature reduced the maximum legal blood-alcohol concentration (BAC) level to .08% for drivers aged 21 and older. By then, increased access to the state-approved Driving While Under the Influence program for Iowans arrested for OWI was provided by the Iowa Substance Abuse Program

Directors Association, the Iowa Department of Public Health, the Iowa Department of Transportation, and the Iowa Department of Education. Licensed substance abuse treatment agencies were able to conduct the program independently of community colleges.

The Iowa Department of Public Health evaluated client lengths of stay in treatment and modified them based upon their impact on outcomes. Evidence based, best practice models were used (e.g., motivational interviewing) to improve outcomes. The Department will continue this process through 2010.

## Goal Statements & Action Steps

### 20–1 Goal Statement

**Establish a systematic process and begin to assess the infrastructure of the alcohol, tobacco and other drugs service system in Iowa and its impact on quality prevention, early intervention, and treatment.** Baseline: Data from program money spent and services provided from the Iowa Substance Abuse Program Directors Association, Substance Abuse Reporting System, and Iowa's Drug Control Strategy and Plan.

### Rationale

The alcohol, tobacco and other drugs prevention and treatment agencies in Iowa are in financial trouble. No significant increase in funding in years has made it difficult for agencies to maintain infrastructure, recruit and retain qualified staff, and to implement new research-based programming that meets the needs of underserved and high risk clients.

In 1991, the Iowa Department of Public Health's Division of Behavioral Health and Professional Licensure provided \$13.6 million in state and federal funds to subsidize alcohol, tobacco and other drugs treatment for low-income Iowans. With that money, 15,273 clients received subsidized services, accounting for 58.6% of clients who received similar treatment statewide during that year.

In 1998, \$15.4 million became available from state and federal sources to subsidize treatment for low-income Iowans for alcohol, tobacco and other drugs. Of the total available, \$1.1 million, or 7%, was paid to a state contracted managed care company to oversee the state treatment program. This resulted in \$14.3 million for client treatment, from which 24,396 clients received subsidized services, accounting for 63.6% of the total clients served statewide that year.

In 1991, the average funding per public-pay client was \$888. In 1998, the same average funding was \$585 per client. Had the average funding per client been adjusted according to the Consumer Price Index, \$1,055 per client would have been provided in 1998 just to maintain the 1991 funding level.

In 2003, the Iowa Department of Public Health's Division of Behavioral Health and Professional Licensure provided \$19.2 million for substance treatment from federal and state funding to help low-income Iowans or those with no source of income or insurance. The number of clients receiving such treatment for alcohol, tobacco and other drugs was 23,335, with an average funding of \$823 per client.

Alcohol, tobacco and other drug abuse prevention and treatment in Iowa have been further burdened by the methamphetamine (meth) crisis. An influx of meth clients merged into a system already stretched beyond its limits. Additionally, treatment for meth takes longer and requires more intense case management than for non-meth treatment.

To develop a baseline for this goal, the following areas must be assessed:

- Client waiting lists for services;
- Available funding, including federal, state and local money;
- Average cost of service per client, per service level (including outpatient and residential services);
- Personnel issues, including salary ranges and available benefit packages;
- Staff retention;
- Educational levels of substance abuse treatment and prevention professionals; and

- Cultural issues, including urban versus rural issues in each area.

### **20–1.1 Action Step**

By 2007, develop an infrastructure plan to evaluate, identify and develop a mechanism to measure capacity of public and private providers. (An Iowa Department of Public Health action step.)

### **20–1.2 Action Step**

By 2007, develop a plan to identify, evaluate and address the ability of providers to recruit and retain qualified professional staff. (An Iowa Department of Public Health, Iowa Substance Abuse Program Directors Association, and Iowa Department of Education action step.)

### **20–1.3 Action Step**

By 2007, identify and leverage additional funding to increase alcohol, tobacco and other drugs prevention and treatment to underserved and high risk populations, including women, youth, the elderly, minorities, adults in the criminal justice system, and other multi-problem clients. (An Iowa Department of Public Health, Iowa Substance Abuse Program Directors Association, and Iowa Department of Correctional Services action step.)

### **20–1.4 Action Step**

By 2007, enhance the Iowa Drug Control Strategy published by the Governor's Office of Drug Control Policy to be the state plan for substance abuse. Consolidate substance abuse prevention, treatment and law enforcement goals from the various existing plans. (A Governor's Office of Drug Control Policy and Iowa Department of Public Health action step.)

### **20–1.5 Action Step**

By 2006, empower and enhance Iowa's substance abuse prevention and treatment system to meet the needs of culturally diverse populations. Establish a statewide committee to develop strategies and best practices that address the needs of diverse and minority populations. (An Iowa Department of Public Health action step.)

**20–2 Goal Statement**

**Increase by 3% youth aged 12 to 17 who never used alcohol and annually monitor and evaluate the increase.** Baseline, 2002: 84% of 6<sup>th</sup> graders, 63% 8<sup>th</sup> graders, and 29% of 11<sup>th</sup> graders reported never using alcohol.

**Rationale**

Statistics show that delaying use of all drugs reduces the likelihood of drugs becoming a problem at a later age. Reducing high-risk use before addiction further reduces physical, social, emotional, legal, and intellectual problems for the moment and a lifetime. (National Longitudinal Alcohol Epidemiologic Survey, Journal of Substance Abuse; and Hawkins, et al, Journal of Studies on Alcohol, 1997.)

**Iowa Youth Survey on Substance Abuse  
Grades 6, 8, 10, 11: 1990-2002 (Selected Years)**

	1990	1993	1999	2002
6 <sup>th</sup> Grade Responses				
Never used alcohol	57%	78%	81%	84%
Never used tobacco	88%	89%	92%	95%
Never used marijuana	98%	98%	98%	99%
Never used other drugs	98%	96%	99%	99%
8 <sup>th</sup> Grade Responses				
Never used alcohol	30%	51%	58%	63%
Never used tobacco	67%	67%	74%	83%
Never used marijuana	93%	93%	89%	91%
Never used other drugs	95%	92%	97%	98%
10 <sup>th</sup> Grade Responses		11 <sup>th</sup> Grade Responses		
Never used alcohol	14%	28%	25%	29%
Never used tobacco	47%	49%	46%	58%
Never used marijuana	80%	83%	65%	66%
Never used other drugs	89%	89%	93%	94%

Source: Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning. Note: 1996 data is not available due to sampling problems in some counties and the requirement of active parental consent. Note: Eleventh grade replaced tenth grade on the 1999 and 2002 surveys.

Youth receive mixed messages from the media, parents, school, church, law enforcement, and the community. They currently take many courses on substance abuse. A consistent, culturally appropriate, research-based course on alcohol, tobacco and other drugs (supported by

multiple resources within the community) would increase the use of a common terminology and age-appropriate expectations.

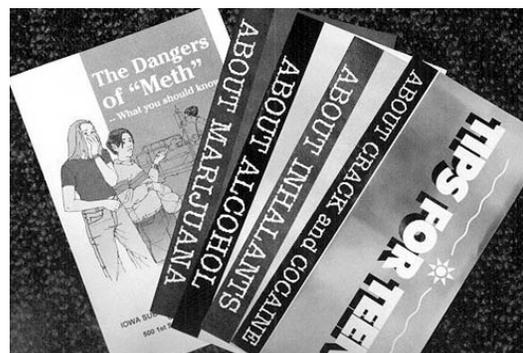
Drug and alcohol use of Iowa youth in grades 6<sup>th</sup> through 12<sup>th</sup> has self-reportedly declined, according to the Iowa Youth Survey. Based on these trends, additional improvements can be anticipated. Analysis of statewide data identify gaps, provide a comparison of results by districts, and indicate the scope of prevention.

Substance use among Iowa children relates closely with family problems. Data from the Iowa Youth Survey links many family-related risk indicators to substance use among children. These include adults and other family members with substance abuse problems, abuse and neglect, teen pregnancy, violence, and low socioeconomic status. Without help, children in substance abusing families are likely to have problems with substance abuse themselves. To break the cycle, their needs must be recognized and handled.

Iowa’s demographics are changing; therefore, professionals must be continuously sensitive and responsive to the needs of youth specific to their race, religion, ethnicity, gender, age, sexual preference, or disability.

**20–2.1 Action Step**

By 2008, help Iowa institutions of higher learning develop and implement courses on alcohol, tobacco and other drugs for students who plan careers working with youth. In particular, target future counselors, teachers, social workers, law enforcement officers, and other students. (A Prairielands Addiction Technology Transfer Center, Iowa Law Enforcement Academy, and Iowa universities action step.)



**20–2.2 Action Step**

Beginning in 2006 and through 2010, help school districts implement a revised health course for grades K-12 that is culturally and language sensitive and that covers alcohol, tobacco and other drugs, including methamphetamine. (An Iowa Department of Education and Iowa Department of Public Health action step.)

**20–2.3 Action Step**

Through 2010, annually review sources of funding and recommend to the governor appropriate administrative avenues for disbursement of substance abuse money that is consistent with the state plan. (A state plan agencies action step.)

**20–2.4 Action Step**

By 2007, promote and refine community planning models that emphasize positive youth development and are culturally competent. (An Iowa Department of Public Health, Iowa Department of Human Rights/Criminal and Juvenile Justice Planning, and Iowa Department of Education action step.)

**20–2.5 Action Step**

By 2007, develop and maintain a baseline of the number of children and youth who have substance abuse problems or who live where there is substance abuse. (An Iowa Department of Public Health, Consortium for Substance Abuse Research and Evaluation, and Iowa Department of Education action step.)

**20–2.6 Action Step**

By 2007, develop and maintain a baseline to determine the number of children and youth in the target population who receive each of the following substance abuse services: screening, prevention, referral, and treatment. Assure that these programs are culturally and language sensitive. (An Iowa Department of Public Health, Iowa Department of Education, Consortium for Substance Abuse Research and Evaluation, and Iowa Department of Human Services action step.)

**20–2.7 Action Step**

By 2007, determine if research and outcome-based programs and services are available to meet the level of need, including culture and language, in the target population. (An Iowa Department of Public Health action step.)

**20–2.8 Action Step**

By 2010, improve alcohol, tobacco and other drugs assistance through the following:

- By 2005, establish, and through 2010 provide updates, a user-friendly state directory that includes various technologies to help Iowans access programs and services;
- Make research and outcome-based services more accessible to the target population; and
- Identify and implement goals to increase services currently unavailable to the targeted population.

(An Iowa Department of Public Health action step.)

**20–2.9 Action Step**

By 2010, evaluate results of other action steps of goal 20–2 to successfully increase the percent of youth aged 12 to 17 who have never used alcohol. (An Iowa Department of Public Health action step.)

**20–3 Goal Statement**

**Reduce to 15% alcohol and other drug-related death and injury, and chronic disease rates of Iowans.** Baseline, 2005: 20%.

**Rationale**

Drinking and driving fatalities have continued to decline, from 29.9% in 1995 to 25.4% in 2000. According to the Iowa Department of Transportation, alcohol impairs the driver's ability to brake, steer, change lanes, use one's judgment, and adjust to road conditions. The Department supports a continual decline in the incidence of driving after the consumption of alcohol.

Iowa requires drivers who have been cited for Operating while Intoxicated (OWI) to attend a 12-hour, risk reduction class. Research by the Iowa Consortium for Substance Abuse Research and Evaluation shows that this initial class for first-time offenders is effective, and that second-time offenders are likely to re-offend.

As previously cited, the cooperating agencies involved in the Iowa State Plan for Substance Abuse Prevention (state plan) need a common language to deal with prevention, intervention and treatment in order to encourage low-risk alcohol quantity and frequency choices consistent with the law.

The alcohol beverage industry wants to reduce the risk for liability lawsuits and protect its viability ("Does Server Intervention Training Make a Difference?" Alcohol Health and Research World, summer 1987; and "Training Bar Personnel to Prevent Drunken Driving: A Field Evaluation," American Journal of Public Health, August 1987).

The sale of alcohol and other drugs on the Internet concerns some health, law enforcement, and federal drug enforcement agency officials, as well as parents.

Adults and youth need help to reduce risks. Participants in the 1997 Iowa Substance Abuse Prevention Household Survey reported they would like to be better informed and receive information through the media.

Prevention and treatment professionals must be sensitive and responsive to the needs of the people they serve. Service outcome is impacted depending on how race, religion, ethnicity, gender, age, sexual preference, and disability are taken into account.



Source: Iowa Department of Transportation

### 20–3.1 Action Step

By 2010, reduce multiple driving offenses from drinking and/or drug use by developing graduated sanctions for first and second offenses of Operating while Intoxicated (OWI). This includes components of the current OWI educational class, assessment and treatment. (An Iowa Department of Public Health and Iowa Department of Education action step.)

### 20–3.2 Action Step

By 2010, implement a cross-discipline training program with the cooperating agencies in the state plan that includes a minimum 6-hour substance abuse course. The course will use a lifestyle risk reduction curriculum and work with developers to assure that it is culturally and language appropriate. (An Iowa Department of Public Health action step.)

### 20–3.3 Action Step

By 2010, implement a mandatory minimum 6-hour Training Intervention Procedures for Servers (TIPS) curriculum for management and employees of establishments with Iowa liquor licenses in cooperation with the alcohol beverage distribution industry. Work with developers to assure that the TIPS curriculum and/or trainers are language appropriate for participants. (An Iowa Commerce Department/Alcohol and Beverage Division and beverage industry action step.)

### 20–3.4 Action Step

By 2010, enact into legislation a minimum of six hours of lifestyle risk reduction substance abuse training for commercial drivers. (An Iowa Department of Transportation, Iowa Department of Public Safety, and Iowa legislature action step.)

### 20–3.5 Action Step

By 2010, evaluate resources to deal with the impact of Internet sales of alcohol, tobacco, prescription drugs, and other drugs. (An Iowa Department of Public Health action step.)

### 20–3.6 Action Step

By 2010, develop, implement and evaluate a statewide media campaign to encourage and reinforce lifestyle risk reduction to support the lifestyle risk reduction course. Work with developers to assure the media campaign is culturally and language appropriate. (An Iowa Department of Public Health action step.)

### 20–3.7 Action Step

By 2007, establish a baseline and increase by 10% the number of workplaces in Iowa using work site alcohol and drug policies and programs. (An Iowa Department of Public Health and Workforce Development action step.)

## 20–4 Goal Statement

**Increase to 425 the number of Iowans aged 65 and over who receive screening, prevention, referral, and /or treatment for risks such as poverty, deficient nutrition, social isolation, alcohol, tobacco, prescription drugs, and other drugs abuse, problem gambling, and violence. Through early intervention for “late onset,” include prescription drug abuse in “substance abuse.”** Baseline: 325 current.

### Rationale

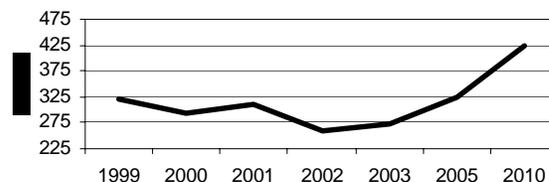
Iowa’s population is aging. Consequently, the pervasiveness of substance abuse among people aged 60 and older from many ethnic

backgrounds is only beginning to show itself. Alcohol and prescription misuse affects 17% of older adults. However, health care providers overlook substance abuse and misuse among older people, mistaking symptoms for dementia, depression or other problems common to older adults. Also, older adults are more likely to hide their substance abuse and less likely to seek professional help.

Many relatives of older people with substance abuse problems are ashamed and choose not to recognize and address it. Lack of English fluency may also keep some from seeking help. The result is thousands of older adults who need services and do not receive them. Many older Iowa residents are isolated and only have contact with the service providers coming into their homes. Therefore, providers need to be trained to recognize this type of abuse and make appropriate referrals.

It is also important for the community to understand the problems that older residents face. Such problems include loneliness, depression, isolation, and substance abuse. Given the opportunity, many older residents want to be and can be productive.

**The Number of Persons 65 and Older Receiving Substance Abuse Treatment 1999-2003, 2005 and 2010 Targets**



Source: Iowa Department of Public Health  
Note: Scale is adjusted to highlight data.

### 20–4.1 Action Step

By 2007, train health care professionals who have access to the older population on diversity and identification of alcohol, tobacco and other drug problems, and continue this training for new employees (based on Substance Abuse among Older Adults – Choosing to Change: A Client-Centered Approach...for Older Adults). (An Iowa Department of Public Health, Iowa

Department of Elder Affairs, and area agencies on aging action step.)

### 20–4.2 Action Step

By 2007, in partnership with the Iowa Department of Elder Affairs, identify and train staff of volunteer pilot agencies (e.g., Meals on Wheels) and staff at complexes for elderly people about identification of problems and diversity. Provide referral information and ensure that training is ongoing for new volunteers and/or new employees. (An Iowa Department of Public Health, Iowa Department of Elder Affairs, and local treatment providers action step.)

### 20–4.3 Action Step

By 2006 and through 2010, implement ongoing strategies to raise community awareness of the complexity of health issues, including alcohol, tobacco, prescription drugs, and other drug abuse by Iowa's elderly. Use evidence-based best prevention practices and measure the extent of increased awareness. (An Iowa Department of Public Health action step.)

## 20–5 Goal Statement

**Increase the availability of 24-hour residential treatment from 517 beds to 542 beds for quality treatment and support for lowans addicted to alcohol, tobacco and other drugs.** Baseline, 2004: Substance Abuse Reporting System, Iowa Department of Public Health, 25,972 clients received subsidized services from state and federal funding an average of 20.6 days for primary residential care. Of the number of lowans needing treatment, "...slightly more than 9% are dependent on some substances, using the DSM-III-R criteria for dependency. The estimated total of persons who are dependent on any drug except tobacco, by the DSM-III-R criteria, is 191,500. This figure represents about 9.3% of the adult population of Iowa. In other words, about one out of every 11 adult lowans has some form of substance dependence, usually alcohol. Another 18.3% fell into the potentially dependent category, meaning that an estimated 377,200 additional adult lowans consume alcohol in a way that puts them at

some risk for developing dependency" (Iowa Adult Household Survey of Substance Use and Treatment Needs).

## Rationale

A general consensus of Iowa substance abuse treatment professionals is that a treatment gap exists. A "treatment gap" is the difference between the number of people who need treatment because of illicit drugs and alcohol abuse and the capacity of the system to provide that treatment. The number of people receiving treatment yearly in Iowa is reported to the Substance Abuse Reporting System of the Iowa Department of Public Health, Division of Substance Abuse. However, the number of persons who need drug and alcohol treatment can only be estimated through household surveys and reviews of client waiting lists for services and trends in treatment lengths of stay.

Given the financial, infrastructure and staffing problems of treatment agencies, it is difficult for them to expand services in order to reduce the treatment gap and implement appropriate research-based models for treatment of multi-problem clients. Successful outcomes are further hampered by the lack of supportive rehabilitative services, including employment and safe, drug-free living environments.

A number of activities are needed, such as: annual tracking of demographics by ethnicity, race, gender, primary language, and success rates; a systematic developmental plan to meet the needs of Iowa's diverse population; program assistance to become culturally competent and acquire training and consultation to successfully recruit, hire and retain professionals from diverse populations; and program assistance to provide their professionals and staff with ongoing training on working with people of racial and ethnic cultures.

### 20–5.1 Action Step

Through 2010, maintain and implement a statewide plan for substance abuse treatment to assure that all Iowa populations have access to appropriate research-based treatment. Since 2004, community reinvestment training activities have been provided to ensure appropriate treatment for multi-problem clients

and persons with emotional and physical challenges, including evidence-based best practices such as motivational interviewing and screening and assessment services consistently based on ASAM PPC-2R and DSM IV criteria for substance abuse and dependency. (An Iowa Department of Public Health, Governor's Office of Drug Control Policy, and Iowa Substance Abuse Program Directors Association action step.)

### **20–5.2 Action Step**

Through 2010, continue to develop and implement appropriate research-based models of substance abuse treatment for multi-problem clients, including all people with disabilities and those who are incarcerated. Also, implement best practices models for substance abuse, including exploration of nutrition and healthy lifestyle development. Ensure cultural competency in services provided to ethnic minority groups system-wide. (An Iowa Department of Public Health and Iowa Department of Corrections action step.)

### **20–5.3 Action Step**

By 2009, establish two additional drug court programs in Iowa, including a model that applies drug court principles to rural counties. (An Iowa Department of Public Health and Iowa Department of Corrections action step.)

### **20–5.4 Action Step**

By 2010, increase the availability of vocational rehabilitation for unemployed substance abusers to eliminate relapse and re-arrest at follow up, to 51% and 88% respectively, as reflected in Iowa's outcomes monitoring system. (An Iowa Department of Education action step.)

### **20–5.5 Action Step**

By 2010, establish two safe living environments for substance abuse clients who do not meet the criteria for 24-hour primary residential care but who need appropriate housing for the recovery process. (An Iowa Department of Public Health, Iowa Department of Corrections, and Iowa Department of Human Services action step.)

### **20–5.6 Action Step**

By 2006, establish a minority advisory committee/group within the Iowa Department of Public Health to track annual demographics by ethnicity, race, gender, primary language, and treatment outcome and success rates. (An Iowa Department of Public Health action step.)

### **20–5.7 Action Step**

By 2010, develop and implement a systematic plan to meet the needs of Iowa's diverse population. Assist programs to become culturally competent through training and consultation to successfully recruit, hire and retain professionals and to provide their professionals and staff with ongoing training on working with people of racial and ethnic cultures. (An Iowa Department of Public Health action step.)

### **20–6 Goal Statement**

**Enact legislation requiring insurers to provide coverage for mental illness and addiction as is done for any other chronic illness.** Baseline: See Rationale.

### **Rationale**

A recent national study reveals that public expenditures nationally for mental health services and substance abuse treatment over a 10-year period (1991-2001) totaled \$67.4 billion in 2001, while private spending came to only \$36.6 billion. The percentage of public funding continues to increase, with a smaller percentage provided by private sources (including private health insurance). Substance abuse treatment costs paid by private insurance fell by an average rate of 1.1% annually over the 10-year period, declining from 24% in 1991 to 13% of expenditures in 2001.

In FY2003, 55% of the cost for substance abuse treatment in Iowa was from public sources, while 28% was from self-pay; 15% from private insurance; and 3% from other sources. In FY 2004, the cost of treatment borne by public funding and self-pay increased to 56% and 31% respectively. However, private

insurance expenditure decreased to 13% and other sources decreased to 2%.

The federally legislated Mental Health Parity Act of 1996 requires insurers to provide the same annual and lifetime spending limits for mental health as for other health care benefits. However, it is up to states to address coverage minimums. Mental health and substance abuse parity laws vary greatly among the states.

A recent Substance Abuse and Mental Health Services Administration (SAMHSA) report suggested the cost of parity could be minimal. The impact on premiums can be controlled by limiting the scope of the parity law to biological-based illnesses, limiting the number of providers covered by the law, and using aggressive managed care practices. Most studies that suggest low costs (e.g., less than 1%) assume aggressive managed care, according to an Iowa Insurance Division and Iowa Department of Public Health briefing paper. Eventually, other information will be available from the Governor's Enterprise Plan on Health.

Access to needed substance abuse and mental health treatment has been a concern for some time and parity would increase access to treatment statewide if those 23,000 plus Iowans who access needed treatment annually had health insurance coverage.

### **20–6.1 Action Step**

By 2010, promote the HAWK-I expansion of mental health and substance abuse treatment to achieve parity. (An Iowa Department of Public Health and Iowa Department of Human Services action step.)

### **20–6.2 Action Step**

By 2010, establish as an alternative to parity mental health standards that insurers would be required to demonstrate prior to discharging or denying admission to the severely mentally ill or addicted. (An Iowa Department of Public Health and Iowa Department of Human Services action step.)

### **20–6.3 Action Step**

Through 2010, monitor parity legislation in other states and its impact on costs. (An Iowa

Department of Public Health, Iowa Department of Human Services, and Iowa Insurance Division action step.)

## **20–7 Goal Statement**

**Assure that the proportion of Iowans experiencing problems with gambling does not increase above the Behavioral Risk Factor Surveillance Survey (BRFSS) baseline.** Baseline, BRFSS: 1.6% of respondents who had gambled in the past 12 months said the money they spent gambling led to financial problems; 1.7% reported the time spent gambling led to problems in family, work or personal life.

## **Rationale**

Iowa legal gambling includes use of slot machines; casino table games such as blackjack, craps and roulette; video blackjack, poker and keno; pari-mutuel betting; sports betting; cards; scratch tickets and pull tabs; lottery; stocks; and commodities. Iowa also regulates bingo, raffles and pools; games of skill and chance; social gambling; contests, casino nights and commercial promotions.

Iowa has three racetracks and 10 casinos, with the strong likelihood that more facilities will open well before 2010. Three Native American casinos also are located in Iowa. Illegal sports wagering and Internet gambling also occur. Access to Internet gambling by young and old alike adds a new dimension to gambling and problem gambling.

The Iowa Gambling Treatment Program (IGTP) in the Iowa Department of Public Health provides services for people affected directly or indirectly by problem gambling. Its mission is to promote and protect the health of Iowans by reducing the effects of problem gambling through education, awareness and treatment.

The IGTP program is funded through the gambling treatment fund that, effective July 1, 2004, received 0.5% of the gross lottery revenue and 0.5% of the adjusted gross receipts from the riverboat casinos and the racetracks, an increase from 0.3% in previous years. The Iowa Lottery portion is estimated at \$1 million and the

gaming industry portion at \$5 million. Up to \$6 million is appropriated to the department. As in past years, money from this fund has been diverted for other purposes. Just under \$1.7 million was diverted from addictive disorders programs in 2005.

The availability of about \$4.3 million is expected for gambling treatment, prevention, awareness of problem gambling, and services for more Iowans. The existing outpatient structure has proven to be an effective safety net and needs to continue as the basic approach for counseling families and gamblers affected by excessive gambling. Additional funding will be used to increase treatment and crisis services as more gamblers and family members seek help.

Little federal money has been devoted to problem gambling. However, recent success was achieved when the Midwest Conference on Problem Gambling and Substance Abuse was held in August 2004. Four states (Iowa, Kansas, Missouri, and Nebraska) applied for and received a \$50,000 federal grant from the Center for Substance Abuse Treatment under the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The Iowa Racing and Gaming Commission, its licensees, and the Iowa Lottery cooperate with the Iowa Gambling Treatment Program to address problem gambling. An annual Responsible Gaming Education Week is sponsored by the gaming industry. The industry also supports National Problem Gambling Awareness Week in March, which has been sponsored in part by the Association of Problem Gambling Service Administrators.

The Iowa Lottery developed Iowa-specific public service announcements when budgets were tight. The gaming industry promotes the 1-800-BETS OFF helpline in its advertisements and signs. It also provides links to the [www.1800betsoff.org](http://www.1800betsoff.org) web site. Effective July 1, 2004, state law required a process to allow a person to be voluntarily excluded for life from all state licensed casinos. Also, any money or thing of value that has been obtained by, or is owed to, a voluntarily excluded person by a licensee as a result of wagers made by the person after the he or she has been voluntarily

excluded shall not be paid to the person but shall be deposited into the gambling treatment fund.

The Iowa Gambling Treatment Program and its 1-800-BETS OFF Helpline are excellent resources for Iowans to find help with problem gambling. The helpline links callers to treatment and education from providers throughout the state 24 hours a day.

Of those who seek help through the Iowa Gambling Treatment Program, about 800 gamblers annually receive counseling for their problem. Assessment, screening and counseling hours for gamblers and concerned persons total almost 16,000 annually. In addition, about 1,000 crisis counseling hours are provided annually to others faced with desperate situations. Some are admitted for treatment.

**Clients Receiving Counseling Services from Agencies Contracting with the Program**

Fiscal Year	Gamblers	Concerned Persons	Total Clients Served
2004	821	117	938
2003	790	129	919
2002	742	100	842
2001	802	142	944
2000	933	120	1053
1999	781	142	923
1998	826	190	1016
1997	741	229	970
1996	675	209	884
1995	412	150	562
1994	284	99	383
1993	216	66	282
1992	238	104	342
1991	233	129	362
1990	236	115	351
1989	202	90	292
1988	202	75	277

Gamblers’ activities affect their families, friends, employers, and others – and these persons must also be considered. The Iowa Gambling Treatment Program annually provides counseling to over 100 concerned persons on

how to handle the consequences of problem gambling. Even if other Iowans consult with clergy, family counselors, and social workers, only a fraction gets help.

Public awareness and prevention became limited when program funding was substantially decreased. Television spots about excessive gambling declined markedly and resulted in a dramatic decrease in 1-800-BETS OFF helpline calls. The following chart, “Media Expenditures, Calls and Clients,” portrays how much advertising, especially television, increases calls to the helpline. Over 4,000 calls were handled in 1998 compared to fewer than 1,400 in FY2004.

A 1998 evaluation of the advertising program for the 1-800-BETS OFF helpline showed overwhelming support for the messages.

- 97% of Iowans agreed that a clear message was provided.

- 93% agreed messages were a valuable resource.
- 94% agreed that advertising the 1-800-BETS OFF helpline should continue.

The effective statewide purchase of multi-media messages, especially on television, increases calls to the 1-800-BETS OFF helpline. An advertising agency coordinates the creation and placement of messages for television, billboards, print, and radio. Client numbers would likely increase to above 900 if more television messages aired to stimulate calls and connections to treatment providers. Direct services are assisted when funding is provided to supportive services such as multi-media marketing, information and training. Iowa must continue to use technology and improve education on problem gambling and its effects on gamblers, family members, and friends.

Iowa Gambling Treatment Program (Iowa Department of Public Health)  
**Media Expenditures, Calls, and Clients by Fiscal Year**

The chart shows Expenditures for Educational Messages about Problem Gambling and the 1-800-BETS OFF Helpline, Helpline Calls from Gamblers and Concerned Persons, and Clients Receiving Counseling Services

Fiscal Year	Expenditures for Educational Messages				TOTAL	Helpline Calls	Clients Served
	Television	Radio	Print	Billboards			
Fiscal Year 2004	\$120,708	\$-	\$-	\$112,384	\$233,092	1357	938
Fiscal Year 2003	\$151,639	\$-	\$-	\$135,470	\$287,109	1587	919
Fiscal Year 2002	\$162,157	\$-	\$-	\$130,960	\$293,117	1557	842
Fiscal Year 2001	\$389,689	\$-	\$-	\$142,187	\$531,876	2189	944
Fiscal Year 2000	\$494,758	\$117,094	\$253,930	\$99,022	\$964,804	2470	1053
Fiscal Year 1999	\$499,585	\$148,576	\$233,594	\$95,160	\$976,915	2355	923
Fiscal Year 1998	\$905,458	\$248,411	\$219,813	\$98,175	\$1,471,857	4156	1016
Fiscal Year 1997	\$277,505	\$158,250	\$62,545	\$111,241	\$609,541	4336	970
Fiscal Year 1996	\$1,045,474	\$175,816	\$120,374	\$108,128	\$1,449,792	4496	884
Fiscal Year 1995	\$82,360	\$44,200	\$-	\$88,046	\$214,606	1304	562
Fiscal Year 1994	\$-	\$-	\$-	\$-	\$-	140	383
Fiscal Year 1993	\$-	\$-	\$-	\$-	\$-	243	282
Fiscal Year 1992	\$-	\$-	\$-	\$-	\$-	228	342
Fiscal Year 1991	\$-	\$-	\$-	\$-	\$-	172	362
Fiscal Year 1990	\$146,163	\$-	\$26,000	\$29,000	\$201,163	323	351
Fiscal Year 1989	\$253,429	\$38,684	\$44,743	\$53,921	\$390,777	343	292
Fiscal Year 1988	\$-	\$-	\$-	\$34,480	\$34,480	337	277

The Department contracted with the Harvard Medical School to review 1998-2001 participant data. “The Iowa Department of Public Health Gambling Treatment Services: Four Years of Evidence” (2002) reported that among gamblers who completed the program and for whom records were available, 74% were abstaining from gambling six months later. Also, 49% of those who received “substantial” treatment were abstaining from gambling, as were 36% who received some treatment. Among the small sample studied from admission to follow-up, 85% of treatment completers, 88% of partial treatment completers, and 65% of others significantly reduced the amount of money they lost per week.

The study described the adverse consequences identified by clients at the time of screening/admission to treatment services:

1. Economic Factors

- Declaring bankruptcy, 23.7%
- Credit card debt, \$7,726
- Total debt, \$34,639
- Gambling debt, \$14,084
- Amount lost weekly \$522
- Most lost in one week (last 6 months), \$1,929
- % of money lost legally (weekly), 94%
- % of money lost illegally (weekly), 4%
- Work days missed due to gambling (last 6 months), 2.10
- Jobs lost due to gambling (last 5 years), 0.22

2. Social Factors (%)

- Arrested in lifetime, 40.5%
- Arrested for gambling, 8.9%
- Arrested in past 12 months, 14.1%
- Attend gamblers anonymous meetings, 17.2%
- Treated for substance abuse, 22.8%

3. Health Risk Behaviors (at least daily, %)

- Tobacco use, 60.8%
- Compulsive work, 5.9%
- Food abuse, 4.0%
- Alcohol use, 3.7%
- Compulsive sex, 2.1%
- Illicit drug use, 1.7%
- Compulsive spending, 1.3%

- Prescription drug use, 1.1%
- Physical harm to self, 0.3%

Slot machines accounted for 58% of losses; casino table games for 14%, and video poker for 10%. No other game accounted for more than a small fraction of losses.

The Harvard Medical School Division on Addictions contracted to perform more client follow-up analysis to provide an outside, objective review of what works best in preventing and treating problem gambling. As mentioned earlier, crises annually account for hundreds more service hours to many Iowans. “The Iowa Department of Public Health Gambling Treatment Services: Four Years of Evidence” data shows a relationship between crisis contacts related to problem gambling and exposure to a casino. Crisis contacts are via telephone calls or office visits by persons in need of urgent help who are not admitted as a client.

Areas of higher crisis contacts related to problem gambling tend to cluster around gambling venues. For example, the northern region of Iowa, which is devoid of gambling establishments, had the lowest concentration of crisis contacts. Counties with the highest concentrations of crisis contacts (Woodbury, Dubuque, Polk, and Ringgold) are located within 50 miles of at least one gambling establishment, and most are in areas of exposure to multiple venues. Counties within a 50-mile radius of a casino had a statistically significant higher rate of population-adjusted crisis contacts than counties outside that radius.

When additional gambling facilities open, preparations must be in place for more client services. Additional funding must first go toward providing direct client services prior to launching any new initiative. Preventing unhealthy gambling should be a top priority because it is key to avoiding future costs. Promoting healthy gambling should be a major focus, along with providing accurate information about the nature of gambling for those choosing to gamble.

In addition to outpatient counseling (individual, group and family), providers offer education on problem gambling and prevention

to at-risk groups (senior, underage, cultural) at no charge. Sessions have been held for banking, finance, insurance, school, human service, and health care organizations. Mental health, chemical dependency, medical fields, and the criminal justice system benefit as well. A listing of annual education hours follow.

**Education and Public Awareness Hours Provided by Agencies**

Fiscal Year	Hours	Fiscal Year	Hours
2004	1925	1996	1692
2003	1922	1995	2084
2002	1717	1994	642
2001	1657	1993	720
2000	2853	1992	944
1999	3000	1991	4072
1998	3233	1990	2473
1997	2201	1989	2365

Priorities are to reduce health disparities by people with disabilities, minorities, migrants, immigrants, refugees, and their families. They also include providing infrastructure that focuses on prevention and awareness of problem gambling within these populations, as well as appropriate and effective education and outreach.

The educational component of gambling services informs families, employers, churches, community groups, and others affected by the hidden nature of excessive gambling. Local presentations combined with multi-media messages designed for an array of demographic, multi-cultural, racial, and age groups encourage people to seek help in the early stages, prior to needing more intensive counseling. A statewide multi-media effort must continue with funding at or above the current level, and include outreach by treatment providers and local educational presentations.

Presentations focus on such topics as:

- Screening for problem gamblers by counselors, clergy, health care providers, and financial and credit entities can better identify people who hide their problem gambling behind alcohol and other drug use. For example, a good

screening question is, "Have you ever borrowed money or borrowed on a credit card to gamble or pay off gambling debts?"

- The Lie-Bet Screening Instrument has been deemed valid and reliable for ruling out pathological gambling. Questions include 1) Have you ever felt the need to bet more and more money? and 2) Have you ever had to lie to people important to you about how much you gambled? A "Yes" to either item indicates a need for further assessment. (Johnson, E.E., Hamer, R., Nora, R.M., Tan, B., Eistenstein, N., & Englehart, C. 1988. The lie/bet questionnaire for screening pathological gamblers. *Psychological Reports*, 80, 83-88.)
- Suicides and suicide attempts are often related to problem gambling. Some motor vehicle injuries and deaths may result from people facing insurmountable gambling debts. Driving while in a drowsy state due to long hours of gambling may also cause accidents.
- Violent and abusive actions may result from losses, debts and time spent gambling.
- Family problems also often result from gambling. Families need answers to questions, such as "What steps should be taken when someone close has a gambling problem? How does one intervene? How does a person get help?"
- Crimes to support problem gambling include embezzlement, theft and fraud. The Iowa Division of Criminal Investigation must continue its deterrence of illegal gambling, including illegal sports betting, illegal slot machines, and other criminal activities.
- Information provided to the judicial and correctional system needs to be more focused on problem gambling, which can be well hidden. Gamblers sometimes use secret post office boxes for bills or forge signatures on second mortgages and loans.
- Employers experience lower productivity from workers with gambling problems. Information on problem gambling should be provided at the workplace because it alerts key people to this behavior and to the time and money spent by those with a gambling problem.

- Prevention designed to give students an alternative to drinking should be careful about using "casino nights." Since a portion of the population is susceptible to developing problem gambling, there should be alternative activities other than gambling to interest young people. Caution should be taken in substituting one problem behavior for another. Young people must also be informed about problem gambling and the negative results on educational and career opportunities, as well as relationships.

Also, community education needs to cover problem gambling and its effect on the community by helping answer questions such as:

- What are the criteria for responsible gambling? Is it a percentage of take-home pay?
- What are the limits of social gambling? How does one know if one's gambling is okay?
- Regarding seniors and gambling, how much gambling is okay? Do seniors know where to get help?
- How can people be assured they're not gambling too much? Are there factors that predispose someone to gamble excessively? Are young people more at-risk than adults or senior citizens?
- Is gambling on credit okay? Easy access to money, particularly, at casinos, can trigger an impulse to gamble to win back previous losses.

One form of measuring success is by beneficial changes in health or reductions in risk factors; another is to assess improvement in providing services. Progress reviews should be periodically conducted on problem gambling and affected populations, including women, adolescents and racial and/or ethnic groups. It is important to recognize and address emerging issues such as changing demographics, advances in preventive therapies, and new technologies.

Establishing state health goals and monitoring progress on problem gambling could motivate action to improve Iowans' health in this area as well as in other affected areas. There are so many unanswered questions in the field of problem gambling that an evaluation team or other entity should be established.

There is a continuing need to:

- Determine if the whole population is being reached. The reality is that the message will not matter for some who will continue have a gambling problem.
- Determine if more outreach and/or local messages are necessary to get more people into programs and other services.
- Determine if more funding should be invested in education to keep a message in front of potential clients and to prevent them from ever needing more intensive counseling.
- Determine alternative educational methods to reach young people, the elderly, and the general public with the message of preventing excessive gambling.
- Examine the best methods to do more prevention among high-risk groups.
- Examine the best methods to teach no-risk or low-risk gambling guidelines to the public.
- Examine the need for law enforcement and probation when appropriate. Unlike substance abuse, gambling clients are usually self-referrals with no outside force keeping them attending.
- Explore the development of a mentoring program for counselors to staff hard-to-reach cases and share best practices in gambling treatment. Follow up with clients who received gambling services and can assist in learning what works best.
- Explore the need for gambling-specific counselor certification and gambling-specific program certification.
- Continue to provide statewide conferences and other training events.

Training over the Iowa Communications Network features experts in problem gambling. Sessions reach a variety of interested people, including counselors, clergy, human resource personnel, mental health clinicians, social workers, and health care professionals. Specialists have made presentations during the Governor's Conference on Substance Abuse.

The Iowa Gambling Treatment Program web site, <http://www.1800betsoff.org>, provides Internet users with statistics, reports and resources for gamblers and persons affected by problem gambling. Materials such as billboards, posters and brochures are posted, some in collaboration with other entities. For example:

- The link “Niagara Multilingual Prevention and Education Problem Gambling Program” contains information in 11 languages.
- An article in the *Journal of the American Medical Association* covers pathological gambling.
- The Association of Problem Gambling Service Administrators link provides excellent information on services in other states.
- National Problem Gambling Awareness Week materials are posted at [www.npgaw.org](http://www.npgaw.org).
- The Iowa Lottery developed Iowa-specific public service announcements.
- “Your First Step to Change” (2002) is a guide compiled by the Massachusetts Council on Compulsive Gambling and the Harvard Medical School Division on Addictions. The guide has three sections: Facts About Gambling, Understanding Your Gambling, and Thinking About Change. An interactive version of the guide is also available on the web site.

The web site [www.1800betsoff.org](http://www.1800betsoff.org) and other technological improvements facilitate access to care, provide general health promotion and prevention guidance, and help keep up with the fast pace of gambling. Support and recovery groups also provide peer support.

The Iowa Substance Abuse Information Center maintains a gambling treatment library and distributes problem gambling videotapes, brochures, curriculum guides, and other materials. Brochures are available in 11 Asian languages and Spanish.

Public awareness, training, education, and counseling are essential components to manage the effects of gambling. Providers are prepared to answer statewide calls with counselors and staff. By attending ongoing training specific to gambling treatment and prevention, providers are qualified to present the most current information on problem gambling and prevention.

The Iowa Gambling Treatment Program in the Iowa Department of Public Health is the primary entity to coordinate efforts and address challenges. An advisory committee provides guidance on the program structure and services.

### 20–7.1 Action Step

By 2010, increase by 10% over fiscal year 1998 education and public awareness time spent on problem gambling. Education declined to 1,925 hours in 2004 as a result of a decrease in funding. Using a minimum 0.5% tax on the proceeds of legalized gambling in Iowa, hours should begin to increase and go beyond the 1998 level of 3,233 hours. (An Iowa Department of Public Health action step.)

### 20–7.2 Action Step

By 2010, increase by 10% from the 1998 level of 1,016 the number of clients receiving counseling. (An Iowa Department of Public Health action step.)

### 20–7.3 Action Step

Through 2010, increase 1-800-BETS OFF helpline calls by buying more multi-media messages. Increase calls to the 1998 level of 4,156 and use a portion of the minimum 0.5% tax for this step. (An Iowa Department of Public Health action step.)

### 20–7.4 Action Step

Through 2010, conduct follow-up on clients to show results and calculate client recidivism. (An Iowa Department of Public Health action step.)

### 20–7.5 Action Step

Through 2010, using a minimum 0.5% tax, adequately fund the full continuum of services, including education, prevention, early intervention, and treatment. (An Iowa Department of Public Health action step.)

### 20–7.6 Action Step

Through 2010, monitor the following established process, including the number excluded and the wagers deposited: Effective July 1, 2004, state law requires a process to allow a person to be voluntarily excluded for life from all state licensed casinos, and any money or thing of value that has been obtained by, or is owed to, a voluntarily excluded person by a licensee as a result of wagers made by the person after the person has been voluntarily excluded shall not be paid to the person but shall

be deposited into the gambling treatment fund. (An Iowa Gaming Association and Iowa Department of Public Health action step.)

## **20–8 Goal Statement**

**Increase to 115 and sustain state, county, community, and neighborhood collaborative groups to reduce problems of alcohol, tobacco, other drugs, and problem gambling.** Baseline, 2004: 85.

### **Rationale**

Collaborations are essential to ensure the highest and most successful prevention and treatment. Some government collaborations exist, but too often services overlap or the same programs are funded through several agencies. To simplify funding and share information, collaborations must expand.

Substance abuse prevention specialists and community leaders continue to collaborate to form or maintain SAFE community coalitions. There were 106 active SAFE community coalitions in 2005. Many of them mentor nearby communities in the process of organizing and mobilizing to broaden substance abuse prevention efforts statewide.

In November 2004, Governor Vilsack declared Iowa a State of Promise and a member of the American's Promise Program founded after the Presidents' Summit for America's future, April 27-29, 1997. At that conference, the president challenged the nation to make youth a national priority. The call to action included a commitment by the nation to fulfill Five Promises. America's Promise created a diverse and growing alliance of more than 400 national organizations called Partners that make large-scale national commitments to fulfill one or more of the Five Promises. These groups span all sectors of society and include higher education, corporations, non-profits, faith-based groups, associations, federal agencies, and arts and cultural organizations.

The SAFE community coalitions will be working with the America's Promises. Substance abuse prevention may be integrated

within each of the Five Promises of 1) Caring Adults, 2) Safe Places, 3) Healthy Start, 4) Marketable Skills, and 5) Opportunities to Serve. Over time, the intention and goal is for individual SAFE community coalitions to blend with larger "community of promise" coalitions.

### **20–8.1 Action Step**

By 2006, establish a sub-group (continue the State Incentive Grant Advisory Subcommittee) of the Office Of Drug Control Policy's Drug Policy Advisory Council to coordinate policy development, planning and resources for increasing and sustaining alcohol, tobacco and other drugs coalitions. (An Office of Drug Control Policy action step.)

### **20–8.2 Action Step**

By 2006, identify and facilitate common initiatives for the Drug Policy Advisory Council's sub-group and the interagency youth-development group. (An Office of Drug Control Policy and Iowa Department of Human Rights/Criminal and Juvenile Justice Planning action step.)

### **20–8.3 Action Step**

By 2006, establish a mechanism for community coalitions to interact with one another at least twice annually on assessment, sustainability and evaluation. (An Office of Drug Control Policy and Iowa Department of Public Health action step.)

**Substance Abuse and Problem Gambling  
Chapter Team**

***Team Leader***

G. Dean Austin  
Iowa Department of Public Health

***Team Facilitators***

G. Dean Austin  
Iowa Department of Public Health

Debbie Synhorst  
Iowa Department of Public Health

Frank Biagioli  
Iowa Department of Public Health

***Team Members***

Reginald Alexander, M.D.  
Veteran Medical Center

Ed Barnes  
Willkie House

Lowell Brandt  
Iowa Department of Corrections

Carlos Macias-Castillo  
Making Connections

Dedric Doolin  
Area Substance Abuse Council

Jay Hansen  
Prairie Ridge

John Hostetler  
Community and Family Resources

Bob Jepperson  
Central Iowa Center for Independent Living

Dave Kuker  
Iowa Department of Human Rights

Vickie Lewis  
Substance Abuse Treatment Unit of Central Iowa

Carol Logan  
Wapello County Central Point of Coordination (CPC)

Peter E. Nathan, Ph.D.  
University of Iowa/College of Public Health

Linda Phillips  
Siouxland Cares

Leslie Schmalzried  
Prevention Concepts, Inc.

Art Schut  
MECCA

Julie Shepard  
Training Resources

Mary Sloan  
Northwest Iowa Alcohol and Drug Treatment Unit

Becky Swift  
Office of Drug Control Policy

Diane Thomas  
Substance Abuse Services Center, Inc.

Tressa Youngbear  
Iowa Substance Abuse Information Center