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special section

Best Practices for the Treatment of Older Adult Problem Gamblers

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Abstract

Whereas the proportion of older adults who experience gambling problems appears relatively small, factors such as cognitive changes with age, social isolation and maintaining fixed incomes can make older adults particularly susceptible to gambling problems, increasing the severity of the consequences they may experience. Relatively few resources are available that are directed specifically to older adults with gambling problems. This report identifies, based on the knowledge and evidence currently available, Best Practices for treating gambling problems among older adults intended for practitioners, patients, families, policy makers and others concerned with this population. A team of gambling researchers and experienced clinicians first identified overarching conceptual frameworks to guide the work. The researchers then shaped a set of Best Practices that was reviewed by a working group developing Best Practices for preventing gambling problems among older adults. Based on their feedback, the authors created a final set of Best Practices. This process was informed at all stages by a systematic review of the literature, evidence from a recent population survey of gambling among Ontario older adults, and ongoing review by practice experts. These guidelines focus on five areas: (1) person-centred and family-focused care, (2) screening and assessment, (3) secondary prevention and early intervention, (4) tertiary prevention and specialized treatment, and (5) ongoing support and recovery resources. Limitations include the paucity of studies specifically on gambling and older adults. We offer these as the most current clinical guidelines for those clinicians and researchers working with older adults,

in anticipation of evolving Best Practices as new evidence and consequent greater knowledge become available.

Keywords: problem gambling, older persons, treatment, problem gambling, older persons, treatment, older adults, gambling disorders, best practices

Résumé

Bien que la proportion de personnes âgées ayant des problèmes de jeu semble relativement faible, des facteurs tels que les changements cognitifs avec l'âge, l'isolement social et des revenus fixes peuvent rendre les adultes plus vulnérables aux problèmes de jeu, ce qui augmente la gravité des conséquences. Il existe relativement peu de ressources disponibles destinées spécifiquement aux personnes âgées ayant des problèmes de jeu. Selon les connaissances et les données probantes actuellement disponibles, ce rapport fait l'inventaire des meilleures pratiques pour traiter les problèmes de jeu chez les personnes âgées, pratiques qui sont destinées aux praticiens, aux patients, aux familles, aux décideurs et aux autres personnes concernées par cette population. Une équipe de chercheurs sur le jeu et de cliniciens chevronnés a d'abord établi les cadres conceptuels généraux pour guider le travail. Ensuite, un ensemble de pratiques exemplaires a été constitué et examiné par un groupe de travail chargé de mettre au point les meilleures pratiques pour prévenir les problèmes de jeu chez les personnes âgées. Un ensemble de meilleures pratiques a été retenu en tenant compte de leurs commentaires. Toutes les étapes du processus ont été soutenues par une revue systématique de la littérature, des preuves tirées d'une enquête récente sur la population des personnes âgées en Ontario et un examen continu effectué par des experts praticiens. Les directives portent sur cinq domaines: (1) les soins centrés sur la personne et la famille, (2) le dépistage et l'évaluation, (3) la prévention secondaire et l'intervention précoce, (4) la prévention tertiaire et le traitement spécialisé, (5) ainsi que les ressources permanentes pour le soutien et le rétablissement. La rareté des études portant spécifiquement sur le jeu et les personnes plus âgées a limité cette analyse. Nous offrons actuellement les meilleures lignes directrices cliniques aux personnes qui travaillent avec des personnes âgées, en gardant en vue l'évolution des meilleures pratiques au gré de nouvelles preuves et connaissances.

Introduction

Gambling has become common in the Ontario adult population, and older adults are no exception in this regard (Ialomiteanu, Hamilton, Adlaf, & Mann, 2016). Among such adults in Ontario, 69.7% report participating in at least one gambling activity in the past year (van der Maas et al., this issue). Whereas most older adults appear to be able to participate responsibly in gambling, and seem also to derive social and other

benefits from this participation, a measurable proportion nevertheless experiences gambling-related problems that can have devastating economic, social, personal and health consequences on older adult gamblers and their families (McCready, Mann, Zhao, & Eves, 2008). Ialomiteanu et al. (2016) observed that, whereas rates of gambling had declined in the Ontario population between the early 2000s and 2015, the rates of problem gambling nonetheless remained constant.

Among older adults on Ontario, 2.6% fell into the moderate risk-or high-risk gambling categories based on the Problem Gambling Severity Index (PGSI) (Ialomiteanu et al., 2016). More recent data suggest that, while the percentage of adults over 55 gambling in Canada did decline from over 75% to under 70%, among older adults, 1.8% were still experiencing harm (van der Mass, this issue). These changes were not as dramatic as those shifts that are found in other age cohorts, leading van der Mass et al. (this issue) to note that the prevalence of gambling harms is relatively stable in the older adult population (shifting from 2.1% in 2004 to 1.8% in 2016), while prevalence in other age cohorts has shown more measurable decline (from 3.8% to 2.6%).

It is also noteworthy that, among certain subgroups of older adults, the rates of problem gambling may be substantially higher. McCready et al. (2008) observed that older adults who reported gambling on Video Lottery Terminals at casinos were 29 times more likely to report any gambling problem than those who reported never participating in this form of gambling. Similarly, these investigators found that older adults who reported participating in additional types of gambling, and who recorded spending more on gambling, showed significantly higher odds of reporting gambling-related problems. Recently, van der Mass (this issue) determined that, in an intercept sample of older adults gambling in casinos in Ontario, 28.8% fell into the moderate or severe problem gambling categories (based on the PGSI) or about 14 times higher than the rate observed in the general population. As well, in this sample, those participants who reported using bus tours to visit casinos in the past 12 months were 1.71 times more likely to develop severe problem gambling than those respondents who did not patronize bus tours.

Problem gambling among older adults may be a special concern for several reasons. The health, social and financial changes that occur with ageing may create special risks for older adults in comparison with younger adults. For example, cognitive abilities change with age (Franklin and Tate, 2009), and certain of these shifts may as a result impair the ability of an older adult to control his or her gambling behaviour. Older adults may be more likely, because of their respective immediate situations, to be dealing with personal loss (e.g., death of a spouse) or isolation (Oxley, 2009), and as a result be more susceptible to the dissociative products of gambling, effects which actually interfere with healthier processes of grieving. Gambling provides escape functions which allow the person to be drawn into excessive involvement, with psychological, social and financial consequences. Gambling also creates temporary relief and distraction, much like other addictive behaviours. Factors related to stress, loss and vulnerability underline the special therapeutic challenges in working with

older adults. As well, older adults are more likely to be on fixed incomes or be living on savings, and thus less able to deal with large financial losses (Levens, Dyer, Zubritsky, Knott, & Oslin, 2005; McCready et al., 2008).

Recently, the Canadian Centre on Substance Use and Addiction (CCSA) released a document on substance use among older adults in which a number of parallel themes were explored from the perspective of psychoactive drugs (Flint et al., 2018). This document explored the vulnerabilities of ageing, as well as the reality of "healthy ageing," which the authors reported was the more common self-perception of older adults. Yet it is also worth noting that, as much as this new document drew attention to addiction issues of older adult, it also contained no mention of problem gambling either as a distinct addictive disorder or as a comorbidity of substance use disorders.

As the population continues to age and the proportion of older adults continues to increase in Canada and other nations (Oxley, 2009), the number of older adults with gambling problems may be expected to increase as well. In spite of this expected increase, and the special needs that older adults present compared to the general adult population, targeted resources to assist those who deal with gambling problems among older adults remain scarce.

In this paper, we describe Best Practices for the treatment of problem gambling among older adults. We provide an initial consideration of Best Practices, their development, and factors needing to be taken into account in developing Best Practices. Subsequently, we describe the broader considerations in developing the Best Practices, including theoretical considerations and the processes followed in developing the Best Practices. Finally, the Best Practices are described, including a description of the evidence base relevant to such inquiries, and limitations in the current state of knowledge.

Definition of Best Practices

Broadly considered, these Best Practices are clinical guidelines. According to the Institute of Medicine (2011, p.5), "clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefit and harms of alternative care options."

Best practice guidelines are drawn not only from rigorous scientific evidence, such as clinical trials, but also from clinical expertise (Health Canada, 2002). Challenges with relying on rigorous scientific evidence exclusively include (1) reliance on a body of literature that is subject to pervasive publication bias, (2) lack of attention to multicultural issues, (3) limitations on generalizability, and (4) over-reliance on the "gold-standard" of research designs, the randomized control experiment (Health Canada, 2002). Incorporating expert consensus into the process of developing Best Practices addresses these concerns and permits the development of broader, more

encompassing and more useful guidelines (Kahn, Docherty, Carpenter, & Frances, 1997; Lomas, 1991; RNAO, 2015a).

Best Practices for treatment of the older adult problem gambler have not previously been described. Whereas certain literature reviews have focused on older adult problem gamblers (e.g., Tse, Hong, Wang, & Cunningham-Williams, 2012), none have identified Best Practices, while other reviews on problem gambling treatment do not focus on older adults (e.g., Toneatto & Ladoceur, 2003; Westphal, 2008). One manual for treatment of older adults in Ontario (Lemay, Bakich & Fontaine, 2006) did not include evidence-based Best Practices. Existing Best Practice documents address the gambling field more generally and do not focus on older gamblers (e.g., Korn and Shaffer, 2004; Williams, West, & Simpson, 2012). This paper, on the other hand, is designed to provide a Best Practices resource specifically for those dealing with the treatment of older problem gamblers.

Methods

Steps in Developing Best Practices

The development of best practice guidelines for the treatment of older adult problem gamblers involved three important components. First, a systematic literature review was conducted, supplemented by literature known to the research team. Second, practice experts were consulted at all stages of the development process. Third, overarching conceptual frameworks and theories to guide Best Practices were identified. Finally, throughout the process, the research team supplemented these components with practice-based evidence, based on professional practice experience, and normative evidence, based on professional values and principles. Figure 1 summarizes the processes and steps involved in developing the Best Practices.

Literature Review. The first step in identifying, developing and compiling the Best Practices was to conduct a systematic review to identify (1) literature on prevention and treatment of problem gambling among older adults, and (2) research gaps in the existing literature (Matheson et al., this issue). Multiple electronic databases were searched (e.g., Medline) based on pre-defined search terms and eligibility criteria. Grey literature was identified through the Knowledge Repository database maintained by the Gambling Research Exchange Ontario (GREO). Articles were eligible for inclusion if they met the following two criteria: written in English; and conducted between January 1994 and January 2015, with a focus on either prevention or treatment of problem gambling among adult populations.

The initial search retrieved 7,632 articles. After eliminating duplicates, 4,268 were first subjected to title and abstract review, 700 articles received full text review and 247 articles matched the inclusion criteria. Those articles relevant to treating older problem gamblers were supplemented by additional relevant papers known to the authors. The research team included content matter experts (treatment of problem

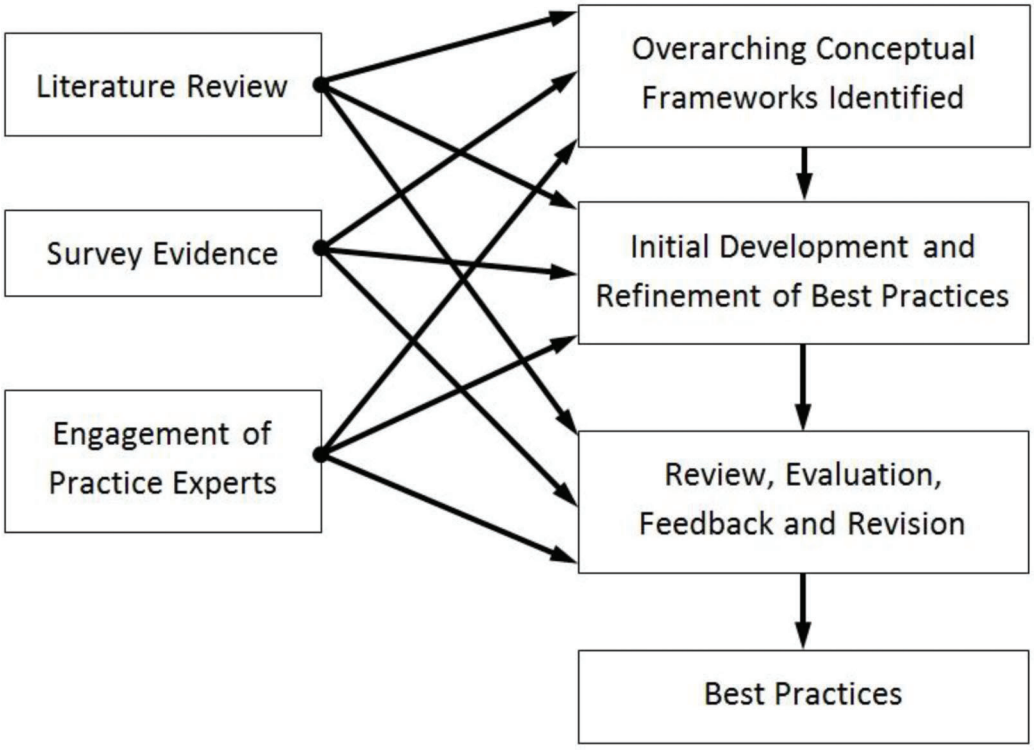

Figure 1. Flowchart for the development of Best Practices.

gamblers and older problem gamblers specifically), experts in gambling Knowledge Translation and Exchange (KTE), and individuals with experience in research and knowledge synthesis. The research team reviewed the results of the systematic review and other relevant literature and developed a list of preliminary Best Practices.

Engagement of Practice Experts. Supplementing the work of the research team, a series of key informant interviews were conducted with knowledge users and service providers. Three sequential interviews were conducted with 10 key informants from the treatment area. The first interview sought to identify the challenges the key informants face in addressing problem gambling among older adults. The second interview solicited feedback on the Preliminary Best Practices for Treatment. The third interview appealed for suggestions for the effective dissemination of the Best Practices to knowledge users and service providers throughout Ontario and beyond. Following each set of key informant interviews, the summary of responses from the prevention and treatment key informants were distributed to all members of the research team. The research team members reviewed, considered and integrated selected aspects of the key informant feedback.

Guiding Principles and Conceptual Frameworks. Best Practices are informed by conceptual and theoretical frameworks, particularly in areas where specific evidence may be lacking (e.g., Health Canada, 2002). Recognizing this fact, the development of these Best Practices incorporated principles and perspectives from the following

frameworks, as well as approaches that are widely recognized and influential in guiding health-related programs, policies and practices.

Public Health Framework. A public health approach to gambling examines the effects of gambling at the individual level, as well as the familial and community levels. Using this method, in which the social determinants of health are addressed, can "help create and apply 'healthy public policy' that seeks to prevent or mitigate problem gambling, promote healthy choices, and protect vulnerable and high risk populatons" (Centre for Addiction and Mental Health, 2011, updated 2014, p. 2). Healthy public policy examines gambling from several perspectives including population health, addiction and human ecology, as well as outlining the major ways gambling can negatively affect the individual, families and communities (Korn & Shaffer, 1999). Additionally, healthy public policy takes into account vulnerable populations, as the risks and harms associated with problem gambling are not evenly distributed through society. Importantly, both individual and population-level factors that can make an individual more likely to develop a problem can be addressed (Centre for Addiction and Mental Health, 2011, updated 2014).

Bio-Psycho-Social Approach. The Bio-Psycho-Social (BPS) model was developed to help medical practitioners frame health and illness not only in biological terms, but also to include psychological and social perspectives as well (Engel, 1977). The model has been widely accepted and has been taken up in a variety of domains beyond health care. A principal component in this approach is that these three dimensions are not separate vectors, but instead interconnected and interdependent. Rather than seeing illness as an event that just occurs in the body of a particular person (Leshner, 1997), the BPS approach is to factor in psychological and social aspects to build a comprehensive approach to understanding illness, recovery, and health. Skinner and Herie (2014) have suggested an expanded view, one which they call BioPsychoSocial Plus (BPS+), and which recognizes that two additional variables, culture and spirituality, have particularly salience in understanding and responding to addictive behaviours, including gambling.

Harm Reduction. Harm reduction has been defined as "any policy or program designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community, or society" (Erickson, Butters, & Walko, 2003, p. 1). The approach was originally designed for drug-related practices, specifically to control the spread of HIV through intravenous drug use (Blaszczynski, 2001; Lowinson, Ruiz, Millman, & Langrod, 2005). In the past, drug policies focused on use reduction; however, a shift has taken place towards finding a balance of use reduction and harm reduction policies. This entails assessing programs and policies to determine their overall impact on reducing harm to the society before accepting or rejecting them (Marlatt, 1996). Given the similarities between substance abuse and gambling, the harm reduction approach is applicable to problem gambling. Harm reduction measures aim to reduce gambling-related problems without requiring that the person abstain from gambling. (Blaszczynski, et al., 1991; Blaszczynski, 2001; Dickerson & Weeks, 1979; Nower & Blaszczynski, 2008).

Cultural Competence. 'Culture' refers to the systems of custom, shared beliefs, values, behaviours, and artifacts, transmitted from generation to generation through learning, that shape the ways we as members of societies understand and manage our worlds, ourselves and the people around us. (Srivastava, 2007). As culture is recognized as a determinant of health by the Public Health Agency of Canada (2011), cultural competence becomes an important consideration to guide Best Practices for prevention and treatment (Agic & Kobus-Matthews, 2004; Betancourt, Green, Carrillo, & Ananeh-Firempong, II, 2003; Ontario Resource Group on Gambling, Ethnicity and Culture, 2010). Cultural competence is a framework that was developed to address the disparities in health and healthcare. Cross (1988, p. 1) has defined cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations." To develop prevention and treatment strategies that are culturally competent, we need to address various sociocultural barriers. Effective strategies include recruiting diverse health professionals, providing translation services, and developing language-appropriate educational material (Betancourt et al., 2003; Ontario Resource Group on Gambling, Ethnicity and Culture, 2010; Svivastava, 2007).

Targeting Special Populations. The prevalence and severity of problem gambling can vary significantly for different sub-populations as they may have unique risk factors that contribute to gambling-related harms. A "one size fits all" approach to prevention and treatment may not address the needs of these special populations; the better practice is to develop approaches that involve the target population. A special population is here defined as group of persons who have specific social determinants of health which increase or reduce their risk for certain conditions, including problem gambling. One such special population is older adults for whom the risk factors include cognitive changes, social isolation or limited entertainment options (e.g., Oxley, 2009). Within the older adult population, sub-groups are operating, groups which may have varying degrees of risk and needs. Certain of these subgroups include ethno-cultural groups, Indigenous populations, female gamblers, and persons with mental health or other addictive disorders (Afifi, Cox, Martens, Sareen, & Enns, 2010; Boughton & Falenchuk, 2007; McKay, 2005; Raylu & Oei, 2004; Shaffer & Korn, 2002; Wardman, el-Guebaly, & Hodgins, 2001).

Development and Refinement of Best Practices

Working from the literature review, the frameworks, the initial key informant interviews, the evidence and their own knowledge, the Work Group identified and generated Best Practices and developed a Summary of Preliminary Best Practices, listing them by category.

Review, Evaluation and Feedback. The Preliminary Best Practices were then distributed to those key informants who were asked for their feedback, including their overall impressions, strengths, weaknesses, needed improvements, and any

missing elements. This feedback was used by the research team to develop the next draft of the Best Practices; the drafts were then reviewed by selected Expert Knowledge Users. These Users were agency professionals who provided support services in mental health and addictions in Ontario. Six Expert Knowledge Users were contacted by telephone and asked about the Best Practices developed by the working groups, their overall impressions, the strengths, weaknesses, areas for improvement and knowledge generation. A summary of responses or feedback was provided to the Work Groups, leading to further revisions.

This penultimate version of the Best Practices was then reviewed by the companion research team working on Prevention Best Practices (Turner et al., this issue).

Best Practices for Treatment of Problem Gambling among Older Adults. The final Best Practices for treatment of problem gambling among older adults, incorporating and addressing the points raised in the previous review, are presented below. The Best Practices are organized according to principal themes: person-centred care, family-focused care, screening and assessment, secondary prevention and early intervention, tertiary prevention and specialized treatment, and ongoing support and recovery resources. In each thematic area, we present a commentary, elaborating on its importance in guiding best treatment practices for older adults with gambling problems. The Best Practices and sources of evidence are summarized in Appendix A.

Person-centred Care (Evidence: Theoretical, Expert Opinion, Practice-based, Normative)

1. Use the principles and practices that constitute person-centred care.

    1.1. Engage the older person using the five principles of person-centred care (NARI, 2006)

        1.1.1. Learn to know the client as a person.

        1.1.2. Share responsibility and power.

        1.1.3. Be flexible and accessible in the provision of services.

        1.1.4. Coordinate and integrate the person's care.

        1.1.5. Provide an environment that supports staff to work in person-centred ways.

Commentary. A long literature that reaches back to Carl Roger's client-centred therapy and the importance of reflective listening has evolved in a robust set of principles that define and operationalize person-centred care (NARI, 2006). At the heart of person-centred care is focus on the relationship between the care receiver and the caregiver as one of partnership, based on respect for the individuality and the autonomy of the care receiver within a comprehensive (or holistic) view of the

person. This approach places the person at the centre of care, while taking into account the needs of family and other significant others who provide care to the person and mobilizing them to support the health goals that have been agreed upon (RNAO 2015b). Person- and family-centred care is operationalized through a set of skillful practices that include effective engagement of the person, sharing decision-making and power, adapting services to the person's circumstances, and providing integrated care that is coordinated (RNAO, 2015a).

The three key dimensions of a patient-centred care health care system are (1) *interpersonal* (communication, knowledge of the client, teamwork), (2) *clinical* (clinical decision support, coordination and continuity, access virtually as well as in-office), and (3) *structural* (physical environment, access to care, and information technology) (Greene, Tuzzio, & Cherkin, 2012). Clients who identify a strong therapeutic alliance typically show better treatment outcomes both on gambling and on general functioning (Dowling & Cosic, 2011). These general principles become exquisitely important when working with older persons who, in addition to problems related to gambling, may be:

- suffering from physical and mental health challenges;
- experiencing social isolation, multiple losses or interpersonal conflict;
- under economic distress; or
- experiencing challenges related to proper nutrition or adequate housing.

It is equally important to remember that ageing and its discontents are not universally felt: many persons exist who are living long years, and who are healthy, resilient, socially supported with access to all the resources to live a eudaimonic life. The concept of "healthy ageing" is one way this point is being made, including the recognition that most older adults give scores of 7 or higher when asked to rate how healthy they are on a 10-point scale (Flint, Merali, & Vaccarino, 2018). Person-centred care seeks to understand older persons within this comprehensive framework to develop care plans that are effective for individual scenarios.

This approach opens up a continuum of circumstances and needs that represents the full range of the human condition as it applies to older adults, understood in its full diversity rather than in the stereotypes that speaking about "the" older adult invokes. Ageing among older adults has at least one inevitability to it that brings an added dimension to therapeutic engagement. It predicts an elevated risk of biopsychological decline in virtually every area of physical and mental health (White-Campbell, 2011). Just as importantly, a larger set of factors related to the social determinants of health and vulnerability to problem gambling and other addictive disorders have been identified as crucial. Working from a holistic perspective can be facilitated through approaches that work to understand the interplay of these biopsychosocial factors (Skinner & Herie, 2014).

Women are present in higher percentages in the older adult population (Barr & Carver, 2014). Treatment approaches need to be informed by feminist principles of holistic

care. The Center for Substance Abuse Treatment observed (CSAT, 2009) that when the specific needs of women are addressed from the beginning, treatment engagement, treatment completion and therapeutic outcomes improve. Gender matters: taking that point seriously continue to challenge (and guide) effective clinical practice as well as societal values and practices in general. (Poole, Harrison, and Ingber, 2014; Zgabor, 2007) This extends to broader issues of diversity when applied to gambling and related issues in older adults (White-Campbell, 2011). The ability to apply evidence-guided principles of care to the circumstantiality of each client is the hallmark of effective practice. Depending on the severity and complexity of issues to be addressed, the client will need access to a health care and social service system that offers a range of services from primary care to specialized and provides continuing support through phases and stages of care, intervention and support (National Treatment Strategy Working Group, 2008).

1.2. Family-focused care:

1.2.1 Use person-centred care principles to identify and involve, as appropriate, those family members and friends who are important in the older person's life. Do so to assess the impacts and precursors of the gambling problem, identify supports for the older person's recovery, and promote recovery practices for the family as a whole.

Commentary. Person- and people-centred care involves a focus that goes beyond the bio-psychological health status of an individual to include family, friends, culture and community (WHO, 2007). Social support may be the most important variable affecting outcomes for persons with addictive behaviours, including older adults with gambling problems (Miller, Forcehimes, & Zweben, 2011). Family relationships are often the primary ones that older adults rely on (Barr & Carver, 2014). Family members and close friends are often already actively engaged in supporting the older client with gambling problems. At the same time, problem gambling can severely affect family functioning (Kourgiantakis, Saint-Jacques, & Tremblay, 2013). Conflict may be pre-existing and, if so, a predisposing factor in the person's gambling and other problems. Family distress also be exacerbated and intensified by the impact of problematic gambling on the family.

Models of intervention can include a family-focused approach to care, working with family members to engage the older person with gambling-related problems in care, treating the family as a whole or in part. Alternately, working with the older person individually—but using the family system perspective—becomes necessary when other members are not available or willing to participate or the older person does not consent to their involvement (Skinner et al., 2014; Skinner, Kourgiantakis, & O'Grady, 2014). It is often the case that the initial request for help will be made by a concerned significant other (CSO). Traditional approaches to addiction treatment that require the identified client to initiate initial contact will exclude the real needs of families where a member is experiencing gambling and related problems but not

able or willing to seek formal help. At the same time, there are evidence-informed approaches, such as CRAFT (Community Reinforcement and Family Training) that offer treatment providers effective ways of working collaboratively with CSOs to successfully engage the identified client in care (Meyers et al., 2013). Nayoski and Hodgins (2016) report a promising finding using a CRAFT based approach with CSOs of treatment-resistant problem gamblers when provided individually rather than in a workbook format. This approach offers a more inclusive and accessible paradigm of care than has traditionally been available in the addiction treatment system in Ontario (National Treatment System Working Group, 2008). Skinner et al. (2014) propose an "all-many-some" approach to family involvement: all addiction treatment programs would require policies and practices that welcome *all* family members seeking help about the gambling problems of another family member to include actively, inform, and involve as many family collaterals as is appropriate (with client consent). Second, provision of psycho-education and counselling supports to as *many* families as possible would be a requirement. Third, and finally, specialized treatment would need to be available to *some* families where need and commitment to participate both exist. A bottom-line message from the literature is that to involve even one collateral in a client's care increases the chances of a positive outcome (Miller et al., 2011). Agencies and their staff must align their respective policies and practices to ensure that the skills, supports and supervision are provided to make this an integral feature in their approach to the treatment of older adults as well as any others with problems related to gambling (Barr & Carver, 2014).

Screening and Assessment (Evidence: empirical, theoretical, expert opinion, practice-based)

2. As part of universal procedures, screen all older adults on a routine basis for problems related to gambling in the broader context of screening for the full range of addiction and mental health issues.

    2.1 Screen older persons for problems related to gambling during initial contacts, and repeat this test minimally on an annual basis, unless more frequent review is indicated. Ideally, this procedure or series of procedures, would be part of universal screening for addictions by health care professionals conducted on an open-ended basis.

    2.2 For older persons with no signs of gambling or related problems, offer positive health messages, and identify and support the healthy alternatives the person is practicing.

    2.3 For older adults whose screening indicates negative effects from gambling behaviours, screen further to determine the severity and complexity of their problems, and whether any resources may be accessible to deal with such specific difficulties.

2.4 For older adults flagged through screening as maintaining mild-to-moderate problems related to gambling or gaming, provide a brief intervention in the community or primary care environment, since a referral to a specialized setting is not indicated.

2.5 Refer older adults who continue to show gambling-related problems after Brief Intervention (BI) for comprehensive assessment by health care providers specialized in addictive behaviours and mental health problems. Availability of and access to these resources for older adults identified by primary and community care providers is essential for an effective system of care.

2.6 Refer older adults who screen as having gambling problems that are moderate or more severe to a specialized addiction treatment setting for a comprehensive assessment.

2.7 Support older adults who are referred for specialized assessment or other services through case management while they are awaiting assessment and treatment planning, and follow-up care afterwards.

Commentary on Screening. Problems related to gambling can occur across the lifespan from adolescence to old age. They can occur as isolated issues or as part of clusters of problems. Older adults may experience elevated risk factors for problem gambling such as loneliness and boredom stemming from the inactivity that often accompanies post-retirement (Kerber, Schlenker, & Hickey, 2011). At the point that a health care professional is asking an older person about issues affecting their health and functioning, gambling behaviours may only be issues of risk or they may already be resulting in measurable harm. In either the case, by screening for these behaviours, the professional gains valuable information which can be put to good use in brief health education, further screening, or perhaps referral for more comprehensive assessment by someone with specialized expertise. In most cases, the focus will be health promotion and risk reduction, since the great majority of older persons do not experience gambling problems (McCready et al., 2008; McCready et al., 2016; Turner et al., this issue; Wiebe, Single, Falkowski-Ham, & Mun, 2004). For the significant minority who do, screening presents the opportunity to identify these issues, provide objective feedback, and to negotiate and plan action steps. Gambling problems are not severe in most instances (McCready et al., 2016), and brief interventions, included self-directed change, are indicated. As gambling problem severity increases, the number of persons affected decreases, but the need for more specialized assessment and treatment grows. Indicators of risk for early withdrawal from treatment include gambling as a strategy to avoid personal issues or dysphoric mood, high levels of guilt and shame and an overall lack of readiness to change (Dunn, Delfabbro, & Harvey, 2012; White-Campbell, 2011). A major obstacle to readiness to change is depression, and a major boon is social and emotional support (Gomes & Pascual-Leone, 2009). In turn, treatment outcome is enhanced by factors such as social support, self-efficacy, motivation, readiness for change, and emotion-focused coping (Ingle, 2007).

Universal screening questions for addictive behaviours in general that can be applied to older persons regarding their gambling behaviours include: "Do you gamble (that is, spend money on activities such as slot machines, bingo, lottery tickets scratch tickets, card games, etc.?" If the answer is "yes," ask "How much do you spend weekly on these activities." Asking these two questions is an effective first-level brief screening approach for health care and social service professionals in any helping environment. In most cases, it leads to a "no problem" outcome. Where the answers are concerning, they are a prompt to explore further and possibly to refer for more comprehensive assessment (Barr & Carver, 2014; Skinner, White-Campbell, Meier, & Kahan, 2011).

Where the answers are concerning, the following three questions complete the brief screening process:

1. Have you ever had any problems related to your gambling behaviour?
2. Has anyone, such as a relative, friend, caregiver, doctor, or other health care provider expressed concern about your gambling behaviour?
3. Have you ever said to another person, "No, I don't have any problems with gambling" when around the same time you questioned yourself and felt, "Maybe I do have a problem." This problem may look like spending too much time buying lottery tickets or at the casino, track, off track betting.

A "yes" answer to any of these questions is sufficient to justify further assessment (Health Canada, 2002). Other indicators that an older person may be experiencing gambling problems are (1) frequent gambling in casinos, (2) repeated taking of bus tours to casinos, and (3) motivations to gamble that involve making money to pay bills or escaping negative affective states (Turner et al., this issue; van der Maas, 2017), while gambling to socialize or for entertainment appear to be protective against gambling problems (van der Maas et al., this issue).

Increasingly, computerized tools that embed questions about gambling in a wider assessment of mental health and addiction issues are available. One such tool, GAIN-SS, is widely used in Canada (Dennis, Chan, & Funk, 2006; Rush & Castel, 2011). In addition, more detailed tools focus on gambling behaviours and are typically used when a more comprehensive assessment is indicated. These include the SOGS (Lesieur & Blume, 1987) and CPGI (Wynne, 2003). Ideally, clear questions that elicit clear answers are the best way to approach screening, especially within the context of person-centred care. To the best of our knowledge, no tools have been found that are explicit validated for use with older adult problem gamblers, but draw on the broader adult population for their validity.

Commentary on Assessment. While screening is done in non-specialized settings on the full population, including older persons, assessment is conducted when there is either evidence, or an expressed concern about whether a gambling problem is present. This tactic may include more extensive screening when an older person

expresses feelings of depression, loneliness and isolation that can mark a higher risk for gambling and or other addictive behaviours (Abeles et al., 1998; Bjelde, Chromy, & Pankow, 2008; Lee et al., 2011; Potenza, 2005; Stea & Hodgins, 2011.) Those concerns can be expressed by the older person him- or herself, a family member or friend, or health care or social service professional.

A formal clinical assessment will first be concerned about the presence of urgent issues that need to be addressed without delay. This includes the risk of immanent harm, either to the client through suicidal or self-harm behaviour, or to others, through intentions and plans to do physical harm (Barr & Carver, 2014). These concerns, even if they are not problematic upon initial assessment, are ones that need to be continuingly reassessed in working with clients with gambling problems, whose rates of suicidal ideation and behaviour are among the highest (Littman-Sharp, Weiser, Pont, Wolfe, & Ballon, 2014). Among older adults who gamble, this risk is further elevated. In addition to a detailed assessment of gambling-related issues, it is an important practice (Rush & Castel, 2011), in the spirit of comprehensive, holistic care, to at least screen for life problems related to:

- other addictive behaviours
- family history of gambling, other addictive behaviours and mental illness
- physical health and medical conditions
- mental health issues
- socio-economic information including education, employment, housing, family circumstances, relationships
- culture and diversity
- spirituality
- circle of care
- strengths and motivation for change

There are assessment protocols that are used in addiction settings in Ontario that provide detailed materials for fully comprehensive assessments (White-Campbell, 2011). The level of severity of gambling and other problems are important factors to explore, and will shape how extensive the assessment will need to be, within a person-centred care paradigm. For example, a person with mild-to-moderate gambling problem who is highly motivated to change that behaviour, has no co-occurring problems, and is accessing social support, would be an ideal candidate for a brief treatment, without the need to be subjected to an extensive clinical assessment. On the other hand, a person with severe, chronic gambling problems, complicated by other addictive behaviours and diagnosed physical and/or mental health problems, needs to ensure that his or her care needs are carefully understood, and a comprehensive plan of collaborative care has been implemented (Dowling, 2009; Miller et al., 2011). When the client is an older person, the risk of confounding factors increases (White-Campbell, 2011), including:

- declining cognitive functioning
- the accumulated effects of long years of diverse problems
- the loss of peers and social support

- diminished motivation in the face of late-life contingencies
- stereotyped assumptions and biases about ageing from family, friends, health care providers, and even oneself
- lack of social and economic capital to access resources that could improve quality of life or at least mitigate their suffering

While this hints at the ways negative factors interconnect, create and sustain suffering among older adults, it is still important to frame these considerations within an adult population that is living longer, functioning at higher levels and enjoying flourishing, vibrant lives to a degree never seen in history. At the same time, with those individuals and families in which complex problems operate can be radically compromised in their quality of life, drawing on health care and other social resources to remarkable degrees, even when the care they receive is not well delivered or effectively coordinated. In that sense, the question is not about the extra drain on resources this will require, but—given the resources being used already—what can be done to more effectively address the needs for care that exist in each particular situation (Jesseman, Brown, & Skinner, 2014).

Certain particularly complex situations will require a more advanced assessment than most specialized addiction treatment settings can provide. An example is where the need for a specialized gerontology consultation is required. Older adults with problems severe enough to merit specialized and comprehensive assessment are more likely to have complex and severe needs and greater health challenges. The importance of person-centred and family-focused care becomes clearer when viewed through this lens (Barr & Carver, 2014; White-Campbell, 2011).

It is crucial to bear in mind that social support is perhaps the single most important element. Petry and Weiss (2009) found low social support to be associated with severity of gambling behavior, problems with family, psychiatric problems, and inferior outcomes after treatment. It is crucial to view recovery as a social issue. For example, among adults in general, employment and education level are each meaningful indicators of willingness to seek treatment (Suurvali, Hodgins, Toneatto, & Cunningham, 2012), and relationship issues are a key motivator for help-seeking (Suurvali, Hodgins, & Cunningham, 2010). Positive social support reduces relapse risk, whereas negative social interactions have been identified as precursors to relapse (Oakes et al., 2012a, 2012b).

Secondary Prevention and Early Intervention (Evidence: empirical, theoretical, expert opinion, practice-based)

3. Offer BI to older adults who have gambling problems that are less than moderate.

    3.1 Use the principles of person-centred care in the provision of BI.

    3.2 Include the core components of BI: client goal setting; education about risks and harms; self-monitoring of gambling and gaming behaviour;

relapse planning; planning of alternate behaviours to support healthy change.

3.3 Assess and re-assess on a regular basis for changes related to addictive behaviours, behavioural health, mental health, physical health, social well-being, and other domains that are germane to healthy life functioning.

3.4 Follow-up older adults who are eligible for or referred to BI regularly in the subsequent year, regardless of whether they completed BI.

3.5 Reassess older adults whose gambling problems are not mitigated by BI and negotiate an action plan which could include referral for comprehensive assessment.

3.6 Involve family members and friends who can offer positive social support when appropriate. Assess briefly for impacts of the gambling behaviour, and provide education and support the family in addressing its own needs as well as the older person's.

3.7 Provide primary and community care providers with ongoing training in BI for gambling-related problems and follow-up access to consultation, and access tools and materials that provide evidence-informed approaches to secondary prevention of problems related to gambling.

Commentary. Strong evidence suggests that many persons with gambling and other addiction problems recover without assistance from formal addiction treatment or even informal addiction resources such as mutual aid (Miller et al., 2011; Petry, 2009; Slutske, 2006; Suurvali et al., 2010). Growing evidence also suggests that the greater number of persons with mild-to-moderate gambling problems may be helped by being screened and identified in primary and community care settings, where they then can be offered a brief intervention (BI). BI can have a variety of forms, including self-guided methods that can be provided in the form of a workbook or accessed on line, a brief education- and advice-oriented session provided by a health care professional, or a series of sessions, usually four or fewer, lasting no more than an hour each. Whereas certain older adults are actively engaged and quite literate in the worldwide web, there are nevertheless likely to be more members of this age cohort that are out of the loop, either by choice or by circumstance, so that the assumptions one might have for younger population would not likely apply here. The goals of BI are to help the older person identify and set goals about gambling behaviours that are at risk of causing or already have caused harms to the person or others. The intervention is most effective when the client recognizes a problem, sets a goal, is committed to work on it, identifies and includes individuals who can provide social support, and takes personal responsibility for carry out the plan, using the BI counsellor as a guide and a coach, and a point of contact, as they carry out the plan (CSAT, 2012; Hodgins, Currie, el-Guebaly, & Peden, 2004; Ladouceur, 2005; Miller et al., 2011).

Primary and community care settings can sponsor BI by having screening processes in place that identify older persons who could benefit from BI, have trained staff who can use BI tools and materials to provide guidance and direction to clients who are willing to make those changes which address risks or harms related to gambling behaviours, provide case management to address practice issues that present barriers and opportunities to care, and maintain standard protocols for tracking and following up on older persons who are eligible for BI because of their mild-to-moderate level of harmful consequences from gambling.

It should be noted that gambling severity level alone may not be sufficient to determine eligibility for BI. Older persons who manage other problems, men and women with high levels of severity, may in fact find it difficult to focus on what may seem a minor problem within the context of more severe and complex issues. On the other hand, when an older person's complex issues are well-addressed by other treatment providers, brief intervention for problem gambling may well be effective, particularly when it is offered in the context of collaborative teamwork among care providers. This work may lead to greater self-efficacy for the client. The principles of person-centered care, particularly the client's right to make decisions and take action based on his or her motivation and readiness, are key to effective secondary intervention with older persons (RNAO, 2015a; Miller & Rollnick, 2013).

Each contact is an opportunity to track progress related to gambling problems and the status of other life domains. Following up all older adult clients, whether or not they start or complete BI, is an important Best Practice principle, as is taking a practical approach to the client's circumstances so that case management around basic issues, from housing to food to access to needed resources, is an active part of the care protocol (Barr & Carver, 2014).

Social support tends to be ignored or under-utilized in secondary prevention and early intervention, but is an important predictor of good outcomes. BI protocols should include information and education materials for concerned significant others (CSOs). Involving even one supportive individual in BI is associated with improved outcomes (Miller et al., 2011). Indeed, Meyers et al. (2013) have shown that working directly with CSOs can lead to the effective engagement of persons with addiction problems who are reluctant to seek help on their own.

As technologies advance, BI intervention resources will be more available through the Internet. This will allow for the expansion of menus of secondary prevention, including self-directed change, coaching support (both ad hoc and planned), therapist-guided BI, and peer support groups that can be accessed through live dialogue or open discussion forums, as well as independent and web-based interactive self-help study guides with linked resources. Certain of these interventive options could also serve as step-down options for persons leaving tertiary-level treatments in specialized gambling and other treatment services. Applications and smart devices can help persons monitor change behaviour and self-manage in high risk situations.

Tertiary Prevention and Specialized Treatment (Evidence: empirical, theoretical, expert opinion, practice-based)

4. Conduct a comprehensive initial assessment of older persons with moderate-to-severe problems related to gambling, involving concerned significant others, taking a trauma-informed approach. An emphasis on reflective listening so that the older adult client feels heard and understood increases the person's motivation to share information and to value the experience of receiving help. Older adults with levels of severity that merit their being seen in a specialized addiction setting may need extensive ongoing assessment for physical ailments and functional issues. Including family collaterals in the assessment process usually helps deepen the helper's understanding of the older person's situation as well as the amount and quality of support that is available to them, a first step engaging the network of significant others whose role in treatment and recovery can be vital.

    4.0.1 Explore gambling and other behaviours that may have addictive aspects, including substance use.

    4.0.2 Explore mental health and physical health status and history. If indicated, refer for gerontology assessment to identify any issues that might affect the client's cognitive functioning and capacities.

    4.0.3 Inquire about other areas of life functioning that may relate to the client's problems and concerns, including housing, income, finances, family relationships (partner, children, extended), other relationships (peers and social connections), legal concerns, leisure and recreational activities, cultural issues (positive connections and areas of deficit or conflict), religious affiliation, and spiritual orientation and values. This approach can be part of a larger discussion on whether personal circumstances or any aspect of life has changed since the previous visit.

    4.0.4 Involve, with client consent, family members and other collaterals who can contribute to an effective understanding of the client and his or her circumstances, engage in recovery work for the family as a whole, and play a supportive role in developing and completing treatment plans that may be negotiated.

    4.0.5 Explore the key concerns and goals that the client has at the current moment in time.

    4.0.6 Discuss and negotiate a plan of action with the older person and his or her support system, focusing on immediate next steps.

    4.0.7 Formulate and document the initial assessment to provide a comprehensive description of the client and his or her circumstances from biological, psychological, social, cultural and spiritual perspectives.

4.1 Clarify and document who is in the case management role to ensure (1) next steps are arranged, (2) referrals are made, and (3) the client and family are aware of who is the person or resource of first resort and how to reach them in timely and effective ways. These considerations are important ones, best addressed proactively because resource issues such as suitable emergency housing and funds for such things as transportation, food and prescriptions can emerge unexpectedly, and be barriers both to effective participation in care and stable everyday functioning.

4.2 Ensure that the older person and others involved in his or her care are aware of that person's respective and specific roles and tasks, and understand the initial treatment plan.

4.2.1 Identify the circle of care, including the older person, concerned significant others, primary and community care providers, providers specialized in gambling disorders and co-occurring problems

4.3 Continue to monitor and assess the older person and communicate both with family members and others who are involved in the circle of care, reviewing and renegotiating the plan to adapt to changing circumstances, needs, opportunities and goals.

4.4 Structure the treatment plan so that clear steps and stages are in place, with explicit process measures and outcomes, and shared understanding of roles, tasks and timelines, so that care is coordinated in ways that fit for the client, the family and the other actors involved in the plan.

4.5 Review goal progress on a regular basis, at least once within the first month and at least every three months thereafter, including all persons who are key to accomplishing the tasks agreed on in the treatment plan.

4.6 Negotiate and plan discharge in a collaborative and timely process involving as appropriate those involved in the circle of care and considering the comprehensive bio-psycho-social plus cultural and spiritual dimensions of care.

4.7 Provide training, supervision, and continuing education to the professionals engaged in specialized treatment to maintain excellence in their skills and performance.

4.8 Ensure that the older person, family members and concerned significant others all receive the education, training, consultation and support they require to function optimally in their respective recovery roles.

4.9 Ensure that older persons with severe problems related to gambling receive the supports and resources they need to achieve the standard of care that exists for those persons receiving the best evidence-based care.

Commentary. Older persons with gambling problems in the moderate-to-severe range are more likely to have problems in other life areas, including substance use and other addictive behaviours, mental health, and physical health. The gamblers are at higher risk of histories that include trauma, and they are vulnerable to elder abuse and exploitation in their current context. Their social relationships are more likely to be problematic, as their peer group becomes reduced by infirmities, diminished resources, and mortality. Their respective family relationships may become distressed and conflicted. Financial resources may not be sufficient to address emerging needs for supportive living. Gambling and other forms of spending may already have compromised financial resources and the social support they need to provide for circumstances that improve functioning and enhance motivation and hope (Barr & Carver, 2014; Skinner et al., 2011; White-Campbell, 2011).

A comprehensive assessment is an important event in developing a plan of care. Attention to engagement of the client and others participating in the process is as vital as the technical tasks of collecting information or forming diagnostic observations. This means that the process of interaction and the pacing of the assessment need to be informed as much by the needs and capacities of the older person and the family as the clinician's need to come to an effective understanding and action plan as soon as possible (Rush & Castel, 2011, White-Campbell, 2011).
Depending on the resources available and the areas of concern that have been identified, a comprehensive initial assessment may require not just a specialist in problem gambling, but expertise in psychiatry, physical medicine, psychogeriatrics and other specialized domains, not to mention the practical expertise required to assess and respond to issues such as finances, housing, nutrition, and other dimensions that need to be considered in understanding and responding to the complex of problems that may be related to serious gambling disorder in older persons. This process may take particular time, during which the need for support and practical case management can be particularly acute. Being able to identify the particular needs of the older person and his or her family, how they are each to be at least temporarily addressed, and who is responsible for carrying out the needed tasks are key elements in an effective initial response as well as a foundation for ongoing care (Crockford et al., 2008; White-Campbell, 2011).

Increasingly, the evidence shows that clients, of whatever age and circumstance, who become engaged in and complete programs of care and can draw on family and other social support have better outcomes (Miller & Carroll, 2006; Miller et al., 2011; Petry & Weiss, 2009; SAMHSA, 2015). For the frail elderly, access to residential care is limited, as relatively few programs are operating that can provide treatment for persons with significant functional limitations. Many older persons cannot afford these facilities, are or not able or willing to travel the required respective distances to attend residential treatment (Barr & Carver, 2014; Flint et al., 2018; White-Campbell, 2011).

The ability to engage clients actively has been shown to be measurably enhanced by focusing on the therapeutic relationship through the use of motivational and client-centred approaches to treatment. Seeing engagement itself as a creditable outcome is

important when working with older clients with complex problems in a broader health care environment that values throughput and discharges in health delivery services (Miller & Rollnick, 2013).

Another principal aspect in working with older persons with complex and severe problems related to gambling is that their needs are greater than those that are narrowly defined as clinical. Having the right diagnosis, the right medications, and the appropriate psychosocial interventions, as essential as they are, may not be sufficient. The more that clinical care is provided in social and environmental contexts that are supportive and adequate, the better the clinical outcomes are likely to be. In their absence, even excellent clinical care can be ineffective. Clinical services achieve their highest levels of effectiveness when the older person and their circle of care are engaged with the other community supports and resources that can address these issues that function beyond a narrowly clinical approach (RNAO, 2015b). Implementing this consequent need may require the clinical service to have a wider view of the case management role they need to play, especially if only inadequate engagement with family and community resources is taking place (Skinner & Herie, 2014).

Ongoing Support and Recovery Resources (Evidence: Empirical, Theoretical, Expert Opinion, Practice-based)

5. Support older persons and their families as they recover from problems related to moderate-to-severe gambling disorders by clarifying needs, goals, tasks and roles among those individuals involved in the circle of care.

    5.1 Negotiate discharge and ongoing care plans as part of the treatment process before discharge, clarifying the case management needs and roles as explicitly as possible.

    5.2 Schedule follow-up contacts regularly, at least once every three months.

    5.3 Identify in dialogue with the older person, his or her family and others, the social supports available to facilitate and enhance change and recovery.

    5.4 Scan to identify gaps and challenges in sustaining progress so that relapse prevention can be enhanced, involving all members of the circle of care.

    5.5 Provide professionals engaged in specialized treatment with the training, supervision, and continuing education necessary to maintain excellence in their skills and performance.

    5.6 Provide the older person, family members and concerned significant others with the education, training, consultation, support and counselling they require to support the family's successful recovery.

    5.7 Ensure that older persons with serious gambling problems receive the supports and resources they need to achieve the standard of care that exists for those receiving the best evidence-based care.

Commentary. As the older person improves and no longer needs to receive tertiary or specialized care for gambling problems, keeping the older person and his or her family at the centre of treatment and planning processes, ensures smooth and effective movement from one level of care to another.

Changes in client status, particularly at discharge, need to be clearly understood by all participants in the helping process, with shared understanding of what steps to take across the range of contingencies that can eventuate. The growing literature on this topic supports the use of proactive approaches to follow-up, such as recovery check-ups (RNAO, 2015a; Scott, Dennis & Ross, 2005).

As a final comment, it is fitting to return to the literature that shows, as important as the methods and techniques that are used in the assessment, treatment and recovery support of older adults with gambling problems, the "how of helping" may be even more important (Miller et al., 2011; Skinner & Herie, 2014). Unless clients and families are effectively engaged in the helping process as every stage, their participation and continued commitment to the goals of treatment will likely be sub-optimal. The ability to forge a strong therapeutic relationship and to kindle the hope of improvement is a more potent predictor of effective outcome than the tools, techniques and methods that the helper may have at his or her disposal. At the heart of the diverse sources of evidence that inform better clinical policies and practices is the ability to embody the core principle of empathic engagement in the provision of client-centred and family-focused care at all stages of the care journey from screening to specialized treatment and recovery (Miller & Rollnick, 2013).

Concluding Comments

Best Practice guidelines for treating problem gambling among older adults presented here are designed to provide practitioners, patients, families, policy makers and others with advice on appropriate care for specific circumstances (Health Canada, 2002). As such, they are drawn from a rigorous review of the available scientific evidence, leading conceptual clinical frameworks, and clinical expertise. They are offered with the goal of improving the standard of care provided to older adults experiencing gambling problems.

However, several limitations of the Best Practices presented here must be noted. First and foremost is the paucity of research dealing specifically with older adults afflicted with gambling problems. The issues and needs of these adults, and the effectiveness of interventions for this population, and other key issues have not been given the scientific study they require. This problem is a result of several factors. One major reason is the relatively small number of older adult problem gamblers in the population and in gambling treatment settings (e.g., McCready et al., 2008), thus creating challenges in identifying these individuals and in obtaining sufficiently large samples for meaningful research. However, more recently researchers have been able to find ways to circumvent these concerns. For example, incorporation of gambling measures in large population health surveys, such as the Canadian Community

Health Survey (e.g., McCready et al., 2008) can enable the identification of larger numbers of older adult problem gamblers for epidemiological research into prevalence and risk and protective factors. As well, research is identifying locations in which relatively large numbers of older adult problem gamblers can be found (e.g., van der Maas, 2017).

A related limitation is that, because of special circumstances faced by certain older adults, generalizations based on gambling research conducted with general adult samples may enjoy only limited applicability for certain subgroups. For example, cognitive abilities are affected by age, and in certain instances quite substantially. The effectiveness of Brief Interventions with individuals suffering from cognitive impairment may be less than that seen among individuals without this impairment (e.g., Borsari, Apodaca, Yurasek, & Monti, 2017). Similarly, the experience of bereavement, loss and social isolation, more common among older adults, may enhance the reinforcing properties of gambling for certain affected individuals and result in individuals who are particularly at risk for gambling problems.

The World Health Organization and others have promoted the concept of active ageing, defined as "the process of optimizing opportunities for health, participation and security to enhance quality of life as people age" (WHO, 2002, p.12) as a response to maximize the quality of life of older adults and their contribution to society. These best practice guidelines are presented in that spirit, seeking ways to optimize health, participation and security for older adults. However, it is clear that much can be done to refine further the Best Practices presented here, by pursuing research targeted to gambling issues facing older adults specifically. Thus, these guidelines, while drawing effectively on the best information and guidance currently available, need nevertheless to evolve progressively as a stronger research and knowledge base develops. A stronger evidence base is operating here, one that points to gambling disorders as a more significant health and social issue for older adults than the general population than there is to provide guidance for the identification and treatment of these problems in older adults. As new insight is gained into the determinants of problem gambling among older adults and how that behavior can be modified, best practice guidelines will continue to evolve meaningfully as well.

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Appendix A

Summary of Best Practices and Sources of Evidence for the Treatment of Older Adult Problem Gamblers

Best Practices	Sources of Evidence
Person-centred care	Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence, Normative Evidence

1. Use the principles and practices that constitute person-centered care.

    1.1 Engage the older person using the five principles of person-centred care (NARI, 2006):

        1.1.1 Get to know the client as a person
        1.1.2 Share responsibility and power
        1.1.3 Be flexible and accessible in the provision of services
        1.1.4 Coordinate and integrate the person's care
        1.1.5 Provide an environment that supports staff to work in person-centered ways

Family-focused care	Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence, Normative Evidence

    1.2 Use person-centred care principles to identify and involve, as appropriate, family members and friends who are important in the older person's life, in order to assess the impacts and precursors of the gambling problem, to identify supports for the older person's recovery, and to promote the recovery of the family as a whole.

Screening and Assessment	Empirical Evidence, Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence

2. As part of universal procedures, screen all older adults on a routine basis for problems related to gambling in the context of screening for addictive behaviours and mental and behavioural health status.

    2.1 Screen older persons for problems related to gambling during initial contacts, and repeat minimally on an annual basis, unless indicated more frequently. Ideally, this would be part of universal screening for addictions from family physicians conducted on an ongoing basis.
    2.2 For older persons with no signs of gambling or related problems, offer positive health messages and identify and support the healthy alternatives the person is practicing.
    2.3 For older adults whose screening indicates negative effects from gambling behaviours, screen further to determine the severity and complexity of their problems and any resources they may have available to address these problems.
    2.4 For older adults flagged through screening as having less than moderate problems related to gambling or gaming, provide a brief intervention in the community or primary care environment, since a referral to a specialized setting is not indicated.
    2.5 Refer older adults who continue to show gambling related problems for comprehensive assessment by health care providers specialized in addictive behaviours and mental health problems. The accessibility of these resources to Primary Health Providers is necessary.
    2.6 Refer older adults who screen as having gambling problems that are moderate or more severe to a specialized addiction treatment setting for a comprehensive assessment.
    2.7 Support older adults who are referred for specialized assessment or other services through case management while they are awaiting assessment and treatment planning, and follow-up care afterwards.

Appendix Continued.

Best Practices	Sources of Evidence
Secondary Prevention and Early Intervention	Empirical Evidence, Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence

3. Offer older adults who have gambling problems that are less than moderate a Brief Intervention (BI).

- 3.1 Use the principles of person-centred care in the provision of BI.
- 3.2 Include the core components of BI: client goal setting; education about risks and harms; self-monitoring of gambling and gaming behaviour; relapse planning; planning of alternate behaviours to support healthy change.
- 3.3 Assess and re-assess on a regular basis for changes related to addictive behaviours, behavioural health, mental health, physical health, social wellbeing, and other domains that are germane to healthy life functioning.
- 3.4 Follow-up older adults who are eligible for or referred to BI regularly in the subsequent year, regardless of whether they completed BI.
- 3.5 Reassess older adults whose gambling problems are not mitigated by BI and negotiate an action plan which could include referral for comprehensive assessment.
- 3.6 Involve family members and friends who can offer positive social support when appropriate. Assess briefly for impacts of the gambling behaviour, provide education and support the family in addressing their own needs as well as the older persons.
- 3.7 Provide primary and community care providers with ongoing training in BI for gambling related problems and follow-up access to consultation, and access tools and materials that provide evidence-informed approaches to secondary prevention of problems related to gambling.

Tertiary Prevention and Specialized Treatment	Empirical Evidence, Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence

4. Conduct a comprehensive initial assessment of older persons with moderate to severe problems related to gambling, involving concerned significant others, taking a trauma-informed approach and using motivational approaches to ensure that care is person-centered and family-focused. Narrative is often the preferred method with an emphasis on reflective listening when interviewing older adults. A trauma-informed approach to care is recommended. Particularly in specialized addiction settings, older adults may need extensive ongoing assessment for physical ailments and functional issues best pursued in open dialogue with the primary care provider.

- 4.0.1 Explore gambling and other behaviour that may have addictive aspects, including substance use.
- 4.0.2 Explore mental health and physical health status and history. If indicated, refer for gerontology assessment to identify any issues that might impact the client's cognitive functioning and capacities.
- 4.0.3 Inquire about other areas of life functioning that may relate to the client's problems and concerns, including housing, income, finances, family relationships (partner, children, extended), other relationships (peers and social connections), legal concerns, leisure and recreational involvements, cultural issues (positive connections and areas of deficit or conflict), religious affiliation, spiritual orientation and values. This can be part of a larger discussion on whether personal circumstances or any aspect of life has changed since the previous visit.
- 4.0.4 Involve, with client consent, family members and other collaterals who can contribute to an effective understanding of the client and their circumstances, engage in recovery work for the family as a whole, and play a supportive role in developing and completing treatment plans that may be negotiated.

Appendix Continued.

Best Practices	Sources of Evidence

4.0.5 Explore the key concerns and goals that the client has at the current moment in time.
4.0.6 Discuss and negotiate a plan of action with client, focusing on immediate next steps.
4.0.7 Formulate and document the initial assessment to provide a comprehensive description of the client and their circumstances from a biological, psychological, social, cultural and spiritual perspective.

4.1 Clarify and document who is in the case management role to ensure next steps are arranged, referrals are made, and the client and family are aware of who is the person or resource of first resort and how to access them in timely and effective ways. These are important considerations best addressed proactively because resource issues such as suitable emergency housing and tertiary funds for such things as transportation, food and prescriptions can emerge unexpectedly and be barriers to effective participation in care and stable everyday functioning.
4.2 Ensure that client and other involved in their care are aware of their roles and tasks, and understand the initial treatment plan.

4.2.1 Identify the circle of care, including the older person client, concerned significant others, primary and community care providers, providers specialized in gambling disorders and co-occurring problems

4.3 Continue to monitor and assess the client and communicate with family members and others who are involved in the circle of care, reviewing and renegotiating the plan to adapt to changing circumstances, needs, opportunities and goals.
4.4 Structure the treatment plan so that there are clear steps and stages, with explicit process measures and outcomes, and shared understanding of roles, tasks and timelines, so that care is coordinated in ways that fit for the client, the family and the other actors involved in the plan.
4.5 Review goal progress on a regular basis, at least once within the first month and at least every three months thereafter, including all who are key to accomplishing the tasks agreed on in the treatment plan.
4.6 Negotiate and plan discharge in a collaborative and timely process involving as appropriate those involved in the circle of care and considering the comprehensive bio-psycho-social plus cultural and spiritual dimensions of care.
4.7 Provide training, supervision, and continuing education to the professionals engaged in specialized treatment to maintain excellence in their skills and performance.
4.8 Ensure that family members and concerned significant others receive the education, training, consultation and support they require to function optimally in their recovery roles.
4.9 Ensure that older persons with severe problems related to gambling receive the supports and resources they need to achieve the standard of care that exists for those receiving the best evidence-based care.

Ongoing Support and Recovery Resources	Empirical Evidence, Theoretical Evidence, Expert Opinion Evidence, Practice-based Evidence

5. Support older persons and their families as they recover from problems related from moderate to severe gambling disorders by clarifying needs, goals, tasks and roles among those involved in the circle of care.

5.1 Negotiate discharge and ongoing care plans as part of the treatment process before discharge, clarifying the case management needs and roles as explicitly as possible.
5.2 Schedule follow-up contacts regularly, at least once every three months.

Appendix Continued.

Best Practices	Sources of Evidence
5.3 Identify in dialogue with the older person, their family and others, the social supports available to facilitate and enhance change and recovery.	
5.4 Scan, involving all members of the circle of care, to identify gaps and challenges in sustaining progress so that relapse prevention can be enhanced.	
5.5 Provide professionals engaged in specialized treatment with the training, supervision, and continuing education necessary to maintain excellence in their skills and performance.	
5.6 Provide family members and concerned significant others with the education, training, consultation, support and counselling they require to support the family's successful recovery.	
5.7 Ensure that older persons with serious gambling problems receive the supports and resources they need to achieve the standard of care that exists for those receiving the best evidence-based care.	