Proceedings of the Interprovincial Think Tank on Youth and Gambling

OCTOBER
21-22, 1999

WINNIPEG,
MANITOBA

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Foreword

Like the three interprovincial conferences before it, the Interprovincial Think Tank (ITT) was rooted in the need to enhance understanding of gambling and problem gambling as it relates to the day-to-day work and personal experiences of Think Tank participants. From the beginning, our collective mandate has been to address problem gambling, and in doing so we have created opportunities to do two important things: share our knowledge and experiences; and broaden the base of understanding in the wider community. During this process, we have learned from each other as well as from the community at large. This ITT was a continuation of the exchange and the learning.

For this Think Tank, the Planning Committee set its sites on the topic of youth and gambling. The need to explore this topic stems from three key realities. First, there is a public, political and interest-group expectation that the needs of youth be addressed in the context of problem gambling. Second, while prevalence data exist, there is uncertainty among those working in the problem gambling area about the meaning of the data. And third, uncertainty also exists around the importance of problem gambling as an issue for youth and of youth gambling as an issue for society.

The proceedings of this ITT were not developed as a "blueprint for action." Rather, they are intended to provide information that will guide people as they work in their communities and collaboratively develop plans to address youth and problem gambling issues.

As the reader will see, these proceedings accomplish this goal. They reveal the richness and diversity in the details that emerged as participants expressed their views and described their experiences in response to the discussion questions. While several themes around the topic of youth and gambling became defined, it was the diversity of the participants' perspectives that drove the conference towards its conclusion: no single formula can be presented to address the youth gambling issue across

different communities. Instead, communities need to implement the strategies and approaches that make sense for them. The information garnered from this Think Tank will help to guide discussion and action across the country towards this end.

It is evident that this Think Tank and the previous conferences have laid a strong foundation for continuing the country-wide exchange on problem gambling.

The committee expresses its gratitude to the sponsors of this event as well as to all participants. The Think Tank would not have been the success it was without the energy, sense of humour and candidness of all those who took part.

The Planning Committee

Introduction

The Interprovincial Think Tank on Youth and Gambling held at the Hotel Fort Garry in Winnipeg, Manitoba October 21-22, 1999 was a partnership project of the Addictions Foundation of Manitoba (AFM), Saskatchewan Health and the Alberta Alcohol and Drug Abuse Commission (AADAC). The main purpose of the Think Tank was to provide people working with youth and youth gamblers the opportunity to discuss and share thoughts and ideas regarding gambling prevalence, resiliency and perceptions among young people.

The ultimate goal was to promote relevant and effective community responses to youth and gambling issues. The objectives were to:

1. Share research experience and expertise related to youth and gambling.
2. Explore implications for prevention and community intervention.
3. Identify prevention opportunities and appropriate points of intervention.
4. Identify potential roles and responsibilities of community stakeholders.
5. Contribute to the body of knowledge on youth and gambling issues.

The 89 participants who attended the Think Tank included researchers, counsellors, program managers, therapists, consultants, teachers and volunteers. They represented a wide range of service agencies and organizations from across Canada who interact with youth and/or their caregivers.

Three papers were commissioned for the Think Tank. The papers focused on the issues of youth prevalence of problem gambling, risk and resiliency, and perceptions of youth gambling. These papers provided the foundation for participants' discussions. Plenary presentation of each paper was followed by questions and answers. Participants then were

assigned to six small working groups to consider and respond to pre-assigned questions posed by the Think Tank's Planning Committee.

The final working session challenged each group to reflect upon what they had heard and discussed during the conference. They were asked to identify core youth and gambling issues and offer pragmatic intervention strategies that they believed would positively influence their, and their communities', efforts regarding youth and gambling issues.

These proceedings offer a permanent record of the information presented at the Think Tank and the collective thoughts and ideas offered by those who attended. Complete transcripts of the research papers, plenary questions and answers, and small group presentations are provided within the body of this document or in the appendices.

Executive Summary

The Interprovincial Think Tank on Youth and Gambling served as a catalyst for further exploration and action by participants on youth gambling issues. Participants reflected on presented research, considered existing issues, and shared personal observations and experiences. Presentations and small group discussions generated a diversity of thoughts and ideas, many of which were unique or innovative. The presentations and scope of discussion are reflected in these proceedings.

Several central themes emerged from Think Tank discussions that participants felt required much more study and discussion. This executive summary provides a synopsis of these themes.

Reconciling Research with Experience

Experiences shared by participants made it clear that youth prevalence numbers suggested by the limited research done in Canada to date are not reflected in the number of youth seeking treatment for gambling problems. This anecdotal input from participants was supported by statistical results presented at the Think Tank. For example, an Alberta survey of 972 youth conducted in 1995 identified 8% of the sample as "problem gamblers". However, records show that only 32 of the 2,634 people or 1.2% admitted for gambling problems in 1997-98 by the Alberta Alcohol and Drug Abuse Commission (AADAC) were youth (12-17 years old).

Dr. Randy Stinchfield, in his presentation on youth gambling prevalence studies, suggested existing research may be correct but there are unknown barriers preventing youth from seeking treatment. If the estimates are suspect or wrong, then the methodology used to gather and analyze data should be scrutinized and changed, he said.

Participants believed understanding why this gap exists is an important key to preventing and treating problem gambling. They suggested there is some urgency in closing this gap since today's youth are the first

generation to be exposed to widespread gambling activity. Participants pointed out that uncertainty about existing data makes it difficult to plan, develop and implement effective prevention and intervention programs.

Dr. Stinchfield offered several suggestions for future research including a national sample, longitudinal designs, and youth specific methodologies. These approaches would help accurately identify the extent of problem and illegal gambling activity among youth, risk and protective factors, and effective prevention and treatment strategies.

AADAC's youth gambling screen was presented to the Think Tank by Dr. Harvey Smith as an example of an initial screening tool that can help identify youth who may need to be referred for further assessment. It is also a means of collecting additional information about youth gambling that may assist in developing youth gambling program strategies.

Small group discussions emphasized the need for a program of research and information exchange that focuses on clarifying the severity and extent of youth gambling. There was also general support for a common pool of gambling statistics, information and research that can be accessed by a variety of stakeholders who are involved in creating and resourcing gambling prevention and intervention programs.

Understanding the Risks

Think Tank deliberations repeatedly identified a need for all stakeholders to gain a better understanding of the risks associated with youth gambling. While participants acknowledged that normal adolescent development involves experimentation and risk-taking, poor understanding or recognition of risks hampers the ability of youth to deal effectively with gambling's challenges. One working group suggested this could be overcome by developing and implementing a life management program for school-aged children that identifies and discusses gambling as a youth developmental challenge — not unlike what occurs now regarding drugs and alcohol.

Former AADAC Research Officer Heather MacDonald, in her presentation on a 1999 AADAC focus group study on perceptions of youth gambling, echoed the view that understanding is hampered by existing perceptions

concerning gambling behaviour. For example, the study's 18 focus groups (involving teens, parents of teens and other adults) equated gambling with age-restricted, legalized forms of gambling. They made a distinction between this type of gambling and informal 'betting' on contests and games of chance. Also, teens involved in the study felt gambling among youth was not an important issue although most said they participated in gambling activities.

Dr. Miriam Stewart, in her presentation on the relevance of adolescent resiliency to problem gambling, indicated individuals, families, peers, schools and communities share many common risk and protective factors — factors that may be positively influenced by the right combination of supports and resources. However, it is not clear what all of these factors are in relation to youth gambling.

Lack of definition concerning risk and protective factors, and a general lack of consensus regarding the appropriateness of youth gambling (regardless of its form), were seen as major handicaps in efforts to increase stakeholders' level of awareness and understanding. As Dr. Stewart pointed out, common ground is not easy to find when culture, history, societal values, public policy and other factors vary from community to community and from individual to individual.

This diversity was reflected in Think Tank discussions. While participants considered informal forms of betting (school bingos, charity raffle tickets, low value or no value wagers on foot races, card games, etc.) a common activity among teenagers a generation ago and today, there was a wide range of opinion about what degree of gambling puts youth at risk. For example, while some believed any type of gambling represents risk, most believed youth gambling should only be an issue when it starts to affect healthy growth and development.

Similarly, discussions on risk and protective factors led to a myriad of suggested pressures and impacts. These are itemized in Section 2 of these proceedings.

Gambling As Normative Behaviour

Gambling is generally viewed and aggressively promoted as an acceptable, appropriate form of entertainment/recreation in most

provinces. There was consensus among Think Tank participants that widespread social sanction of gambling is a major barrier to public understanding and acceptance regarding gambling's personal, family, community and societal impacts.

The research findings presented at the Think Tank confirmed for participants that not enough is being done to communicate gambling risks or encourage responsible gambling. Existing marketing messages about gambling, which herald entertainment value, availability and the allure of winning, dominate the public domain. This contributes to perceptions about youth and gambling that are inconsistent with statistical and anecdotal evidence. Participants said messages about the potential benefits of gambling — not only to the individual player but to the community — need to be balanced by factual information about potential risks. AIDS and drug awareness campaigns were highlighted as models upon which a gambling awareness project could be built.

As in other areas, youth look to peer or older role models to define appropriateness in gambling behaviour. Participants said it is important for adults, community leaders and others to promote attitudes and behaviours that paint a true picture of gambling's benefits and pitfalls.

Role models were considered to be individuals, and organizations such as governments, business, schools, etc. On an individual level, participants felt more needed to be done to insulate youth from behaviours that would encourage gambling at a young age. One group advocated for specialized treatment services for children exposed to unhealthy gambling behaviours, particularly those who have immediate family members with problem gambling histories.

Systemically, organizations need to clarify policies or direction in dealing with the impacts of gambling. This was seen by many as essential to forming an improved, more holistic approach to youth problem gambling prevention and treatment.

Communicating Risk

Effectively communicating the risks once they are identified is a significant challenge, acknowledged participants, but one that should be a priority for communities. Dr. Stewart told participants a community

empowerment approach that "sees youth as community assets and resources and promotes their participation" can work to increase resiliency and reduce risk.

Her suggestion found considerable support among participants. In Think Tank breakout sessions, it was evident that agencies and communities who tried a collaborative, multi-stakeholder approach in dealing with youth gambling issues enjoyed considerable success. This success was attributed to the sense of ownership teens, supporters and sponsors felt for locally planned and implemented program(s). It also allowed for the uniqueness of the community to be woven into intervention strategies. For example, one participant related that the respect for Elders and the inherently strong sense of culture and tradition within an Aboriginal community was used to anchor a successful program targeting Aboriginal teens.

Participants agreed high-pressure tactics to discourage certain types of behaviour among youth do not work. Rather, knowledge and awareness — and a balanced message — about gambling's impacts were seen as keys to reducing high-risk behaviour among youth. This prevention-focused approach was supported by people who participated in AADAC's 1999 focus group study. Participants in that study also supported educating teens to help them avoid gambling problems in the future.

One group suggested teen education could be self-initiated through a public awareness campaign that appeals to young people's emotions and encourages them to talk about gambling with parents, teachers and peers.

Idea Bank

There was a great deal of interest in communicating more with youth, stakeholders and the public at large on the nature and risks of youth gambling, and prevention and treatment programming. This emphasis on communications is reflected in many of the small group discussions noted elsewhere in these proceedings. Collectively, participants offered a wealth of thoughts and ideas that, given the right circumstances, they believed would have a positive impact. Some of the more creative ideas included:

"Dialogue on Gambling" campaign.

Multi-media awareness campaign focused on youth-frequented businesses and recreational outlets like video arcades.

Messages on video game and computer programs that would appear on screen at log-on.

Internet banner messages attached to gambling-related and youth-frequented web sites.

Speakers Bureau composed of youth who have experienced gambling problems.

Continue the Dialogue

Participants repeatedly offered that not enough dialogue occurs among people who have an ability and responsibility to prevent and treat youth gambling. The diversity of the Think Tank (participants represented all parts of Canada, some U.S. jurisdications, and a wide variety of organizations, services and professions), coupled with new perspectives on gambling issues offered by researchers, gave participants a rare opportunity to meet and share thoughts and ideas with colleagues who face the same day-to-day challenges and opportunities of working with youth.

Most participants saw this kind of interaction as valuable, not only to those who attended the Think Tank, but to the organizations they represented. Collaboration, support, knowledge, counsel and opportunity to identify potential solutions to common obstacles were all cited as reasons the dialogue needs to continue.

section**one**

Youth Gambling Prevalence Issues

ABSTRACT OF PRESENTED PAPER

TITLE:
Youth Gambling Prevalence Studies

PRESENTED BY:
Randy Stinchfield, Ph.D.

WITH THE RAPID growth of gambling throughout North America have also come concerns about youth gambling. Recent youth gambling studies show that most youth gamble infrequently and do not suffer any adverse consequences. However, a minority of youth gamble excessively and are experiencing problems associated with their gambling.

This is the first generation of youth to be exposed to such widespread access to gambling venues, ubiquitous gambling advertising, and general social approval of gambling. The legalization of gambling is about 10 to 20 years old in most areas, so youth who were preschool and grade school children at the onset of gambling legalization are now reaching adolescence and early adulthood. It will be important to measure the effects of exposure to legalized gambling on this cohort.

Gambling advertising permeates society and the effect of this advertising on youth is unknown. Some youth may not understand the inherent risks of gambling and the low probability of winning. Therefore, they may be susceptible to the advertised messages that you will have fun and you will win money if you gamble.

Most studies report that underage youth are playing legalized games — this is illegal, potentially harmful for youth, and must be stopped. This paper addresses a number of questions concerning youth gambling. It also raises a number of questions and identifies gaps in our knowledge about youth gambling that need to be addressed by future research.

Dr. Stinchfield is a licensed clinical psychologist and is the Associate Director of the Center for Adolescent Substance Abuse at the University of Minnesota Medical School.

PRESENTED PAPER

Youth Gambling Prevalence Studies

Introduction

Youth gambling is of great concern to parents, public health officials, and public policy makers. To understand youth gambling, we must first consider the social and cultural context in which youth gambling occurs. Two important social phenomena that have played a role in youth gambling are the growth of legalized gambling and the change in public sentiment toward gambling. The gambling industry has experienced rapid expansion and dramatic growth. In Canada, gambling is legal in all provinces. Gambling is now legal in all but two states in the U.S. (Utah and Hawaii).

All Canadian provinces and most states in the U.S. have a variety of forms of legalized gambling, including casinos, lotteries and instant scratch off games, horse/dog tracks, bingo, video lottery terminals (VLTs), river boat gambling, etc., in addition to informal and illegal betting. Gambling in most states is operated by state government, American Indian tribes, charitable organizations, and private companies. Although there are varying opinions about gambling among the public, in general there has been a shift from a negative sentiment toward gambling to one of tolerance and acceptance. Gambling appears to have experienced a transformed public image from a prohibited vice to an acceptable leisure activity.

With the rapid expansion of legalized gambling have come concerns about youth gambling and problem gambling. Research into youth gambling is in its infancy, however, there is a fairly substantial body of literature to review at this time. For the purpose of this paper, youth are defined by the age range of 12-18. The purpose of this paper is to provide information and to raise questions regarding youth gambling.

This paper will address seven important questions. First, what do the most recent prevalence studies tell us about youth gambling, i.e., what types of games are being played and how often? How many are experiencing problems? Are youth gambling more, less, or about the same? How much money are youth spending? Second, how do we define and

measure "problem gambling"? Third, are there gender and age differences in the types of gambling activities and problem levels? Fourth, are there data indicating whether problems are temporary or predictive of future problems? Fifth, how do youth prevalence rates compare to adult prevalence rates of problem gambling? (i.e. types of problems, gambling activities, frequency of play). Sixth, is problem gambling associated with other risky or problem behaviours? Seventh, what are the gaps in our knowledge about youth gambling and what are the directions for further research? Each of these seven questions will be addressed. Information about what is known will be presented and finally, gaps in our knowledge will be discussed along with suggestions for further research.

FIRST QUESTION

What do the most recent prevalence studies tell us about youth gambling, i.e. what types of games are being played and how often? How many are experiencing problems? Are youth gambling more, less, or about the same? How much money are youth spending?

Youth gambling prevalence research to date has typically been one-time surveys of a single province or state or other population, such as a city or school district. There have been a few studies that have surveyed the same sample or population more than once. These studies on youth gambling have shown some interesting findings.

First, like most behaviours, youth gambling is best represented by a continuum of involvement, from no gambling at one end of the continuum to problem gambling at the other end. Second, most youth have gambled at some time and many underage youth have played a legalized game. Third, rates of youth gambling and problem gambling appear to be fairly stable from the few studies that have monitored gambling rates over time in the same population (Stinchfield, Cassuto, Winters, and Latimer, 1997; Wallisch, 1996; Winters, Stinchfield, and Kim, 1995).

There have been two recent reviews of youth gambling prevalence studies. One was written by Shaffer, Hall, and Vander Bilt (1997) and the other was written by the National Research Council (NRC) (1999) under contract with the National Gambling Impact Study Commission (NGISC) in the United States. These reviews concluded that most youth have gambled and do not experience any adverse consequences or problems; however, there is a small percentage of youth who have serious gambling

problems and show signs of pathological gambling. Shaffer, Hall and Vander Bilt (1997), give an estimate of between 3.2% and 8.4% of youth have a serious gambling problem (in the past year).

The NRC (1999) reported that 52 to 89 percent of youth have gambled in the past year and that the current (i.e., past year) prevalence rate for pathological gambling among adolescents is approximately 6.1 percent (range of 0.3 to 9.5 percent) and for pathological and problem gamblers combined is 20 percent. The NRC report states that adolescent rates of pathological gambling could be more than three times that of adults, while acknowledging that the rates of adolescent pathological gambling may not be directly comparable to adult rates, due to differences in instruments and definitions between these two groups of studies.

Even within youth studies, it is difficult to make direct comparisons between results due to the differences in measurement instruments, definitions, and cut-scores across studies. The NRC report concludes: "There remains considerable question about how pathological and problem gambling should be defined and measured among youth, and no general consensus on these matters seems to be emerging in the research" (NRC, 1999, 3-11).

A few recent studies on youth gambling have been conducted in Canada and the U.S., including one in Oregon (Carlson & Moore, 1998), a U.S. national study conducted by the National Opinion Research Center (NORC, 1999), Manitoba (Wiebe, 1999), Nova Scotia (Omnifacts Research Ltd., 1993), Ontario (Govoni, Rupcich, and Frisch, 1996), and Alberta (Wynne Resources Ltd., 1996).

First, recent Canadian studies will be examined. A sample of 300 adolescents in Nova Scotia was surveyed in 1993 using the SOGS (Omnifacts Research Ltd., 1993). They found that 3% of youth were probable pathological gamblers. A survey was conducted in Ontario with a sample of 400 youth in 1994 and also used the SOGS. They found that 4% of their sample scored five or higher on the SOGS, indicating probable pathological gambling. The most recent Canadian youth study was conducted in 1999 in Manitoba (Addictions Foundation of Manitoba, 1999). This survey of 1,000 Manitoba youth used the SOGS-RA and it was found that 78% of the sample had gambled in the past year and 3% of the sample was classified as having gambling problems (i.e., SOGS-RA score of 4 or more).

The Manitoba study is one of the few surveys of youth that asked about Internet gambling. There is great concern that youth may become involved in Internet gambling and this survey showed that Internet gambling was played the least frequently of all forms of gambling. It was hypothesized that Internet gambling is not played because most youth do not have credit cards, which are required to gamble at Internet gambling sites. It should also be noted that this study used the same instrument as its neighbour to the south, Minnesota, and Minnesota had the same prevalence rate of 3% in 1990, almost ten years prior to the Manitoba study (Winters & Stinchfield, 1993).

Therefore, the prevalence rates of youth problem gambling found in these three Canadian provinces are fairly similar. An Alberta survey of 972 youth was conducted in 1995 and also used the SOGS. But, this study found that 8% of their sample scored five or higher on the SOGS. Therefore, Alberta had a significantly higher rate than Nova Scotia, Ontario, and Manitoba. Because Alberta had such a high rate, it is important to look at this study more closely.

The Alberta study was conducted in 1995 and was a telephone survey of 972 youth between the ages of 12 and 17. This study reported that two-thirds of the sample gamble; 8% were identified as "problem gamblers", using the South Oaks Gambling Screen (SOGS) (Lesieur and Blume, 1987) and a cut-off score of 5 or more; and 15% were "at risk", i.e., SOGS score of 3 or 4.

Problem gamblers were more likely to: (a) be in trouble with the police; (b) feel that they could not confide in parents, teachers, school counsellors, and ministers; (c) feel ignored or rejected by their family; (d) report negative school experience; (e) have started gambling early, often before age 10; (f) report that their family gambles; (g) wager large amounts of money; (h) borrow money for gambling; (I) steal or sell personal property; (j) report feeling anxious, worried, upset or depressed; and (k) smoke cigarettes, frequently drink alcohol and use illicit drugs. This study also suggested that there are "problem gambling social groups", essentially, a group of young males who have gambling as their primary pastime.

This study found one of the highest reported rates of problem gambling among youth. Alberta youth were four times more likely to be "at risk" or "problem gamblers" than Alberta adults (23% of youth versus 5.4%

of adults). The most recent estimate of adult prevalence for Alberta is 4.8% (Wynne Resources, 1998).

While the authors are not sure why the Alberta prevalence rate was higher than most other youth gambling surveys, they offered the following possible explanations: (a) Alberta has more forms of licensed gambling and has had them longer than other Canadian provinces and the United States; (b) gambling vendors do not routinely ask for proof of age; (c) the message from gambling advertising suggests that gambling is harmless amusement; (d) many youth programs are funded by gambling (e.g., bingo and raffles) and the youths sell and purchase tickets; and (e) Alberta society at large does not appear concerned about youth gambling.

Now, let's look at two recent U.S. surveys. Carlson and Moore (1998) surveyed 1,000 youth between the ages of 13-17 in Oregon in 1998 via a telephone interview and found that 66% had gambled for money in the past year. They used the SOGS-RA to measure problem gambling and found that 4.1% obtained a score of four or more and therefore were classified as having a gambling problem.

A U.S. national survey of youth aged 16-17 was conducted by the National Opinion Research Center (NORC) of the University of Chicago under contract with the National Gambling Impact Study Commission (NGISC). NORC interviewed 534 youth via a randomized telephone survey of U.S. households during November and December of 1998. NORC used DSM-IV diagnostic criteria to measure problem gambling (i.e., 3 or 4 endorsed criteria) and pathological gambling (five or more endorsed criteria). NORC found that 67% had gambled and that 3% were classified as problem or pathological gamblers (i.e., three or more DSM-IV criteria endorsed). Unfortunately, NORC did not report a separate number for pathological gamblers only and explained that the sample size was too small to report this number alone.

This study has two methodological considerations that need to be acknowledged in interpreting the results. First, this study employed an improved measurement instrument and criteria for categories. Namely, the study used DSM-IV diagnostic criteria, rather than the typical set of screening items. Second, this study was intended to be a national survey, however, the sample size of 500 youth is much smaller than most state and provincial surveys. Therefore, the generalizability of these results is less than ideal, and certainly, no breakdown of state data is available.

In summary, most recent surveys of youth gambling behaviour in both Canada and the U.S. have yielded relatively similar estimates of gambling and problem gambling, with the exception of the Alberta study.

Is youth gambling increasing?

One of the most important questions for public health officials is that with the legalization of gambling and growth of the gambling industry, whether youth gambling is increasing. This may be stated both in terms of whether youth are gambling more frequently and whether more youth are becoming gamblers. There have been three studies that provide information about youth gambling over time.

The first study was a longitudinal design that surveyed 702 Minnesota adolescents by telephone in 1990 and 532 participants from the original sample (76% response rate) were resurveyed a little over one year later in 1991 and 1992 (Winters, Stinchfield, and Kim 1995). The investigators reported that rates of gambling and problem gambling did not change in this sample. There was a change in that gamblers' preferences shifted away from informal games to legalized games, particularly among those youth who reached the legal age for gambling during the course of the follow-up interval (i.e., 18 year olds).

The second study was conducted in Texas and involved the re-administration of a telephone survey to two different youth samples from the same general population in 1992 and 1995. Wallisch (1993; 1996) administered a youth gambling survey to 924 adolescents in 1992 and re-administered the survey to a new sample of 3,079 youth in 1995. She found that gambling remained relatively stable from 1992 to 1995 with gambling in the past year remaining at 67% and weekly gambling dropping slightly from 14% in 1992 to 11% in 1995. Problem gambling also declined from 5% in 1992 to 2.3% in 1995.

The third study examines three waves of survey data from the Minnesota Student Survey, conducted in 1992, 1995, and 1998 (Minnesota Department of Education 1992; Minnesota Department of Children, Families and Learning 1995). The 1992 sample included a total of 122, 700 6th, 9th, and 12th grade public school students. Gambling items were

not administered to the 6th graders in the 1995 and 1998 Minnesota Student Survey due to the need for a brief survey for 6th grade students. The 1995 sample included a total of 75,900 9th and 12th grade students. The 1998 sample included a total of 78,582 9th and 12th grade students. There were five gambling activities items and two gambling problem items.

This study did not measure prevalence rates of pathological gambling. Stinchfield, Cassuto, Winters, and Latimer (1997) and Stinchfield (1999b) report that gambling rates were fairly stable between 1992 and 1995, however, there was an increase in percentage of weekly/daily gamblers in 1998 for 12th grade boys and girls and 9th grade boys (See Figure 1). This study also allows the examination of the same class of youth as they mature, because the 6th graders in 1992 became the 9th graders in 1995 who then became the 12th graders in 1998. The percentage of weekly/daily gamblers for boys and girls is shown in Figure 2.

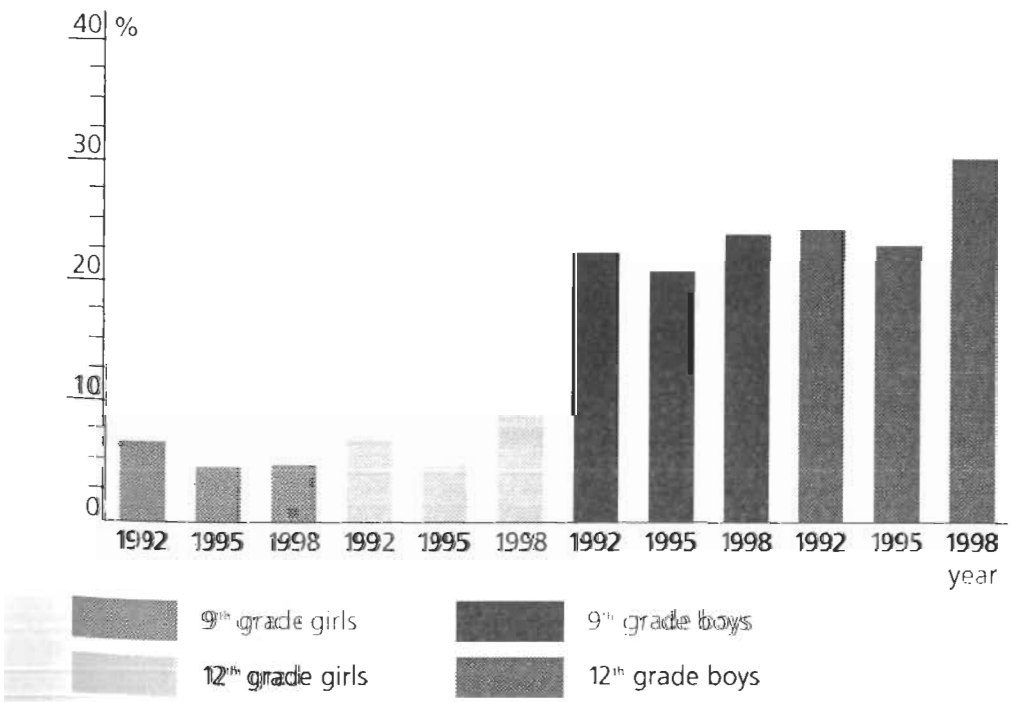
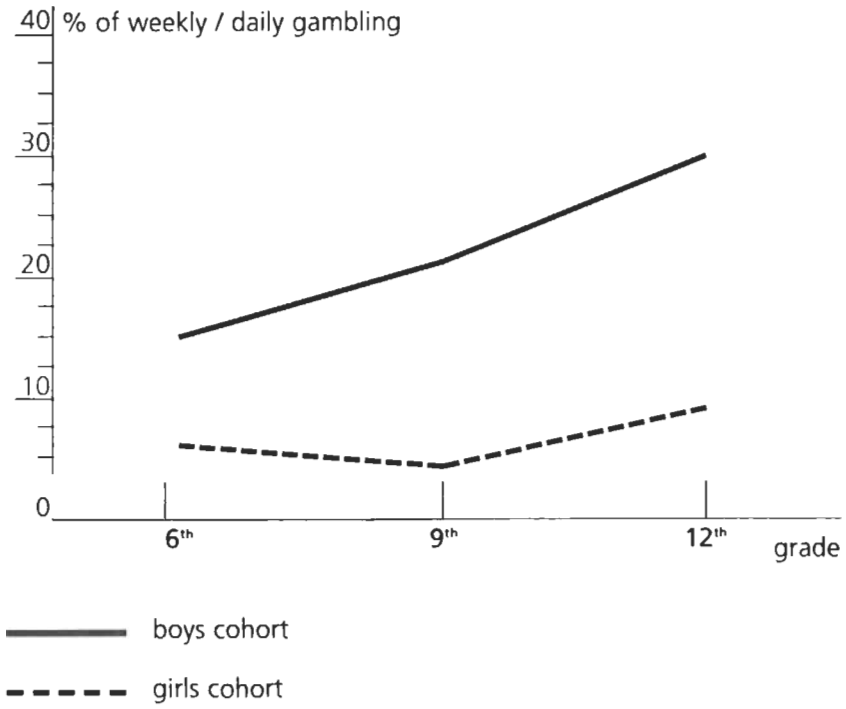


FIGURE 1:
Comparison of 1992, 1995 and 1998 percent of weekly/daily gambling of four grade-by-gender groups.

FIGURE 2:
Comparison of 1992, 1995, and 1998 percent of weekly/daily gambling of boys and girls cohort groups.



In summary, it appears that youth gambling has remained fairly stable in the general population, however, there does appear to be an increase in play of legalized games for youth who turn 18 years old; and an increase in the number of youth, particularly males, who are gambling at a weekly or daily rate (Stinchfield et al., 1997; Stinchfield, 1999b). Therefore, the answer to the question "Are youth gambling more, less, or about the same?" is that for most youth it is about the same and for a small minority it is more.

Although the finding that gambling frequency appears to be relatively stable is encouraging, there is concern about the increase in youth gambling in 1998. These 12th grade students were in the 5th and 6th grades when gambling was legalized in Minnesota, so they have grown up during the period of legalization and expansion of gambling. It will be important to continue to monitor youth gambling behaviour to see if there are changes over time.

What games do youth play?

Youth tend to play informal games, such as betting on games of personal skill, sports teams, and cards, at least until they come of legal age, at which time their preferences shift to legalized forms of gambling. Boys and girls have different game preferences. Boys tend to bet on games of personal skill such as golf or billiards, play lottery games, play cards, and bet on sports teams. Whereas, girls, if they gamble at all, tend to play lottery games and bet on sports teams (Winters, Stinchfield, & Fulkerson, 1990).

It has also been reported that where legalized games are accessible to youth or where the legal age is not enforced, youth will play legalized games (Wynne Resources Ltd., 1996). On average, youth tend to play games on a monthly to weekly rate, however, some youth gamble on a daily basis. For example, in the Minnesota study (Stinchfield et al, 1997; Stinchfield, 1999b) most kids were gambling about once a month or less.

How much money are youth spending?

A few studies have reported the amount of money spent gambling. Winters, Stinchfield, and Fulkerson (1990) found that most youth spent less than $100 on gambling in the past year. In the Nova Scotia study, the median expenditure was $10/week. The recent Manitoba and Oregon surveys indicated most youth spend less than $10/month on gambling. Most of the studies found that youth do not spend a lot of money gambling.

SECOND QUESTION

How do we measure and define "problem gambling"?

Although there are various ways to define and measure problem gambling, the increasingly accepted standard is the definition and diagnostic criteria from the Diagnostic and Statistical Manual of the American Psychiatric Association, now in its fourth edition (DSM-IV) (APA, 1994). These criteria are commonly measured by screening or diagnostic instruments, including questionnaires, surveys, and interviews. For example, the SOGS was originally based upon DSM-III (APA, 1980) diagnostic criteria for pathological gambling (Lesieur & Blume, 1987).

Since then, other instruments have been developed which more closely reflect each specific diagnostic criterion, such as the Gambling Client Intake Questionnaire (Stinchfield & Winters, 1996) and the NORC DSM

Screen for Gambling Problems (NODS) (NORC, 1999). Problem gambling is measured by this set of criteria, which is oftentimes converted into a set of questions. Then, a cut score is determined, which is the number of questions from the list, which maximizes classification accuracy and minimizes classification errors. For example, the cut score for the DSM-IV diagnostic criteria is five out of the ten criteria must be present to be diagnosed with pathological gambling (APA, 1994).

For measuring problem gambling among youth, the research community has tended to be more lenient with diagnostic criteria and cut scores than they are with adults. For example, Winters, Stinchfield, and Fulkerson (1993) used a cut score of four with the SOGS-RA, rather than the standard SOGS cut score of five used with adults. Also, Fisher lowered the DSM-IV cut score from 5 to 4 on her instrument, DSM-IV-J. This practice of lowering the cut score for youth has the effect of casting a wider net and is likely to account in part for the higher prevalence rates reported for youth problem gambling.

The fact that youth problem gambling has been measured by different definitions, different instruments, different timeframes, and different cut-scores, raises the question of whether these prevalence rates can be compared. For example, in the Shaffer et al (1997) meta analysis, a number of studies are used to compute an overall prevalence rate of 5.8%, with a 95% confidence interval of 3.2% to 8.4%; however, many of the studies used in the meta-analysis used quite divergent methodologies for classifying problem gamblers.

These studies used different instruments, including the SOGS, SOGS-RA, MAGS, and DSM criteria; furthermore, some studies that used the same instrument used different cut scores and different timeframes (e.g., past year versus lifetime). See Table 1 for a presentation of the different instruments and scoring methodologies that have been used in youth gambling prevalence surveys.

Youth Problem Gambling Instruments and Scoring Criteria | Table 1

INSTRUMENT	NUMBER OF ITEMS	SCORING CRITERIA
SOGS	20	5+ indicates Probable Pathological Gambling
SOGS-RA	12	Narrow criteria: 4+ indicates Problem Gambling Broad criteria: Weekly gambling and score of 2+ indicates Problem Gambling
MAGS	7	2+ indicates pathological gambling
DSM-IV-MR-J	9	Score of 4+ indicates Problem Gambling
NODS	17 (10 criteria)	Score of 3 or 4 indicates Problem Gambling Score of 5+ indicates Pathological Gambling
PGSI (DSM-III)	7 criteria	Score of 3+ indicates Pathological Gambling
Multifactor Method	SOGS, gambling frequency, money spent	SOGS behavioural dimension (4+); or SOGS borrowing dimension (4+); and gambled weekly; or spent $10/month or more
GA-20	20	Score of 7+ indicates Compulsive Gambling

MAGS = Massachusetts Gambling Screen
SOGS = South Oaks Gambling Screen
SOGS-RA = South Oaks Gambling Screen-Revised for Adolescents
NODS = NORC (National Opinion Research Center) DSM-IV (Diagnostic and Statistical Manual, fourth edition) Screen for Gambling Problems
GA-20 = Gamblers Anonymous 20 Questions
PGSI = Pathological Gambling Signs Index

The SOGS is the most commonly used screening instrument for pathological gambling, and is has been shown to be highly correlated with DSM diagnostic criteria for pathological gambling (Lesieur & Blume, 1987), however, the SOGS and DSM criteria are not identical. Table 2 compares the content between the SOGS and DSM-IV criteria. There is some content overlap, but there are even more differences. There are three important differences between the SOGS and DSM-IV criteria.

First, the SOGS includes subjective items, whereas the DSM-IV criteria are strictly behavioural. Second, about half of the SOGS is devoted to sources of borrowed money, whereas the DSM-IV has only two criteria that include sources of money to gamble. Finally, the DSM-IV criteria include content regarding tolerance and withdrawal that are absent from the SOGS. Therefore, in terms of content, the SOGS is not equivalent to the DSM-IV diagnostic criteria.

Table 2 | Content Overlap Between SOGS and DSM-IV Diagnostic Criteria

SOGS ITEM	DSM-IV CRITERIA
	1. Is preoccupied with gambling
	2. Needs to gamble with increasing amounts of money in order to achieve the desired excitement (tolerance)
	3. Repeated unsuccessful attempts to control, cut back, or stop gambling
	4. Is restless or irritable when attempting to cut down or stop gambling (withdrawal)
4. Go back another day to win back mone of relieving a dysphoric mood	**5.** Gambles as a way of escaping from problems or
5. Claimed to be winning but weren't really	**6.** After losing money, often returns (chasing)
6. Feel you have a problem	**7.** Lies to conceal the extent of involvement
7. Gamble more than you intended to theft, or embezzlement to finance gambling	**8.** Has committed illegal acts such as forgery, fraud,
8. People criticized your gambling career opportunity1	**9.** Jeopardized or lost significant relationship, job or
9. Felt guilty a desperate financial situation (bailout) [1]	**10.** Relies on others to provide money to relieve
10. Felt like you would like to stop gambling but	
11. Hidden betting slips didn't think you could	
13. Money arguments centred on gambling	
14. Borrowed money and not paid them back	
15. Lost time from work	
16a. Borrowed household money	
16b. Borrowed from spouse	
16c. Borrowed from relatives or in-laws	
16d. Borrowed from banks	
16e. Borrowed from credit cards	
16f. Borrowed from loan sharks	
16g. Cashed in stocks	
16h. Sold personal or family property	
16i. Borrowed from checking account	

Note 1: Similar but not identical

In terms of other definitions of problem gambling, Stinchfield et al (1997) suggested looking at population norms and using these norms to define what is abnormal or out of the norm for youth gambling frequency. From a statistical standpoint (i.e., beyond the 97.7 percentile), it may be considered uncommon for girls to play two or more games at a weekly/daily rate, and for boys to play four or more games at a weekly/daily rate.

The statistical approach to identifying common and uncommon gambling behaviour is but one method to demarcate normal from abnormal, functional from dysfunctional, etc. (Jacobson and Truax, 1991). Instead of selecting the criteria for what is abnormal "a priori" and then applying it to the sample, this method allows the population itself to show us what is common and uncommon gambling behaviour.

Because of the lack of consensus over what levels of gambling may be considered normal and abnormal (Dickerson and Volberg 1996), particularly among youth, these findings provide a reference point to be used to help draw the line between normal and abnormal. This information may be helpful in prevention efforts, in order to teach youth what levels of gambling frequency may be considered outside the range of common gambling behaviour for youth, and it could be used to identify youth for prevention efforts.

THIRD QUESTION

Are there gender differences and age differences in the types of gambling activities, problem levels, etc.

The most consistent finding across youth gambling studies is that boys are more involved in gambling than girls. More boys gamble than girls. Boys gamble more frequently than girls. Boys spend more money and more time gambling than girls. Boys gamble at a greater variety of games than girls. This gender effect is considered an established fact in youth gambling research, however, it will be important to continue to monitor this gender effect, because girls may "catch up" to boys in gambling, as they have shown to do in tobacco, alcohol and drug use.

Another fairly consistent finding across studies is that older youth gamble more often than younger youth (e.g., Arcuri, Lester, & Smith, 1985). Again, we will need to monitor this phenomenon since we are finding that youth may begin gambling at earlier ages. A race/ethnic effect has been reported in some studies on youth gambling, with some ethnic

minorities showing higher rates of gambling than whites (Stinchfield, Cassuto, Winters, & Latimer, 1997; Wallisch, 1993). This finding may not be reported as often because most studies have such small numbers of minority group members to make such comparisons.

FOURTH QUESTION

Are there data indicating whether problems are temporary or predictive of future problems?

There is less information in the literature regarding this question. Volberg has conducted the majority of gambling surveys to date and she has concluded that early involvement in gambling is predictive of later gambling problems. We do know that youth start gambling at an early age, oftentimes in grade school (Ladouceur, Dube, and Bujold, 1994). We also know that treatment studies have indicated that pathological gamblers who are in treatment report that they began gambling at an early age. As with most addictions, symptoms seem to ebb and flow and make the individual vulnerable for the development of problems associated with their addiction, such as family discord, financial problems, legal entanglements, etc.

FIFTH QUESTION

How do youth prevalence rates compare to adult prevalence rates of problem gambling, i.e., types of problems, gambling activities, frequency of play?

Prevalence rates of pathological gambling are reportedly higher among youth than adults (e.g., Jacobs 1993; Shaffer & Hall, 1996; Shaffer, Hall, & Vander Bilt, 1997). Shaffer, Hall, and Vander Bilt (1997) give an estimate of between 3.2% and 8.4% of youth have a serious gambling problem in the past year. In comparison, adults have prevalence rates of pathological gambling between 1% and 3% (APA, 1994).

Therefore, prevalence rates of problem gambling for adolescents are estimated to be significantly higher than rates of pathological gambling among adults. What are the possible explanations for this disparity? If we use the recent reviews by Shaffer et al (1997) and the NRC (1999) we find that reported youth rates are about three times that of adult rates. Is it accurate that there are three times as many youth with pathological gambling than adults?

There is evidence that suggests that these high youth rates may not be accurate. For most other addictions, such as alcohol and drug abuse, youth do not have higher rates than adults. Furthermore, there has not been two to three times as many calls to gambling helplines/hotlines by youth, nor are there two to three times as many youth than adults coming for treatment. In fact it is quite the opposite. There are few youth calling gambling helplines and even fewer coming for treatment. This does not mean they are not out there, it is evidence that does not support reported youth prevalence rates. All of this raises the question of whether these rates are "real".

There are at least four possible explanations. First, the rates are real and there are two or even three times as many adolescent pathological gamblers as there are adult pathological gamblers. This is the conclusion of the Shaffer, Hall, and Vander Bilt (1997) report. Second, the rates are not real and are due to a lack of consistency in methodology, definitions, measurement, cut scores, and diagnostic criteria across studies and particularly, the use of lenient diagnostic criteria for youth in some studies.

For example, some studies use the SOGS but lower the cut score and some studies use DSM criteria, but lower the cut score, all of which tend to inflate the rate of pathological gamblers. Third, the rates are not real and are due to youth exaggerating their involvement in gambling. Fourth, the rates are not real and are due to the use of adult instruments being administered to youth and they endorse items they should not, but do so because they do not understand the item (e.g., Ladouceur, 1999) and therefore these elevated rates are due to measurement error.

We know that the SOGS, the most commonly used measure of problem gambling, tends to overestimate the number of pathological gamblers in adult general population samples (Stinchfield, 1999c). That is, it tends to err on the side of false positives. This type of error is acceptable for a screening instrument, but the users of the instrument need to keep this measurement error in mind when reporting results. It may be that this measurement error of false positives is even higher in youth samples than in adult samples.

Often times research methods and clinical tools developed for adults have been adapted for adolescents. For example, it is common to use the adult SOGS in adolescent surveys. This practice of adapting adult tools and methods for adolescents may not be appropriate. Adolescents have some

similarities with adults, but they also are quite different in many developmental respects. We need to understand these differences and develop tools and methods specifically for adolescents that take their developmental differences from adults into consideration.

Should there be a separate or different set of diagnostic criteria for adolescents? No, I do not think so, because pathological gambling is not a strictly adolescent disorder nor does there appear to be a unique adolescent version of pathological gambling. It has the same characteristics of preoccupation, loss of control, continued gambling despite adverse consequences, and failed attempts to stop or cut down.

The recent NORC (1999) survey is the only study that used the same instrument/criteria with both an adult and a youth sample. The reported prevalence rates of problem and pathological gambling for the adult and youth sample are essentially identical (NORC, 1999). Therefore, the NORC study suggests, that when the same survey methodology, instrument, and criteria are applied, the rates for youth and adults are similar.

SIXTH QUESTION

Is problem gambling associated with other risky or problem behaviours?

Gupta and Derevensky (1998) examined correlates of adolescent problem gambling and found that tobacco, alcohol and drug use were related to gambling problem severity. In two consecutive telephone surveys of Texas youth in 1992 and 1995, Wallisch (1996) found problem gamblers were more likely to be male, younger, from a minority racial/ethnic group, work 10 or more hours per week, have a weekly income of $10 or more, have favourable attitudes towards gambling, expect to make money at gambling, and have parents who gamble.

The youth study in Alberta found that youth with a gambling problem were more likely to (a) be in trouble with the police; (b) feel that they could not confide in parents, teachers, school counsellors, and ministers; (c) feel ignored or rejected by their family; (d) report negative school experience; (e) have started gambling early, often before age 10; (f) report that their family gambles; (g) wager large amounts of money; (h) borrow money for gambling; (i) steal or sell personal property; (j) report feeling anxious, worried, upset or depressed; and (k) smoke cigarettes, frequently drink alcohol and use illicit drugs.

This study shows that the problem gambler began gambling early in life, gambling is part of their family norm, they have not had success in school, they feel alienated from their family and community, they use tobacco, alcohol and other drugs, they have a negative affect, and they act out with antisocial behaviours. This shows that the youthful problem gambler is a fairly troubled youth and that excessive gambling is but a part of a larger picture of maladjustment (Wynne Resources, 1995).

In a telephone survey of gambling among 702 general population Minnesota youth, Winters, Stinchfield, and Fulkerson (1993) examined the relationship of demographic and psychosocial variables to problem gambling severity. Those youth with greater gambling involvement were more likely to be male, regular drug users, have parents who gamble, have a history of delinquency, and have poor academic grades.

In the Minnesota Student Survey, variables associated with gambling frequency included antisocial behaviour, being a male, alcohol use, tobacco use, age, feeling bad about the amount of money they bet, a desire to stop gambling, and sexual behaviour (Stinchfield, 1999b). Volberg (1993) conducted a telephone survey of 1,054 Washington State adolescents and found that tobacco, alcohol, and drug use were associated with gambling frequency and problem gambling.

The studies reviewed above exhibit a number of risky behaviours associated with youth gambling and problem gambling including tobacco, alcohol and drug use, and antisocial behaviour. Therefore, these risky behaviours associated with gambling may play a role in the development and/or maintenance of gambling behaviour and problem gambling.

These studies may also indicate that gambling may be part of a constellation of deviant behaviours that are mainly exhibited by some males, including frequent alcohol use, tobacco use, drug use, physical violence, vandalism, shoplifting, and truancy, to name a few. Another explanation is that gambling is part of the normal adolescent experimentation with adult behaviours.

SEVENTH QUESTION

What are the gaps in our knowledge and what are the directions for further research?

Since the field of youth gambling research is in its infancy, there are a number of gaps in our knowledge about youth gambling that need to be addressed by future research. Most of the research to date has focused on the basic questions of the extent of underage gambling and the prevalence of problem or pathological gambling among youth. It will be important to continue to monitor these issues, yet the field also needs to address more specific and more difficult questions.

A pressing research question is whether youth gambling will increase over time? The trend from longitudinal studies conducted so far indicate that most youth gambling has remained fairly stable, however there are only a couple of studies in specific locales that measure change over time and it will be important to continue to monitor youth gambling in other locales and over longer periods of time.

A second question for future research is: Why do youth gamble? We know very little about how youth problem gambling begins, about what variables maintain problem gambling, about how and why youth move from social/recreational gambling to compulsive gambling, and about which youth are most likely to become problem gamblers. Youth gamble for different reasons and it will be important to develop prevention programs with specific determinants in mind. Also, if we can predict which youth are most likely to become problem gamblers, we can then design prevention/intervention efforts to such individuals.

Researchers have begun to look at what variables are associated with youth problem gambling. A number of correlates of youth problem gambling have been identified, including antisocial behaviour, and tobacco, alcohol and drug use, to name a few, however, we don't know if these variables have a causal relationship to gambling or not. Answers to these questions will be critical in that they have immediate application for the development of theoretical models for the development of prevention programs.

This is the first generation of youth to be exposed to such widespread and easy access to a variety of gambling venues, gambling advertising, and general social approval for an inherently risky activity that was once

prohibited. The legalization of gambling is about ten to twenty years old in most areas, so youth who were preschool and grade school children at the onset of gambling legalization are now reaching adolescence and early adulthood and it will be important to measure the effects of exposure to legalized gambling on this cohort.

Along with legalization, has come gambling advertisement. The public is inundated with gambling advertising in all forms of media. The question arises: What effect does the gambling advertising have on youth? It is known that tobacco advertising influenced the decisions of youth about tobacco use and has been outlawed in some forms of media in the U.S.

Gambling advertisements entice the public with the message that gambling is a quick and easy way to get rich. Newspaper ads show pictures of winners with the by-line, "this could be you!" Of course, advertisements do not show the masses of people who lose their money gambling. It is unknown what effect this exposure will have on youth. Youth may not understand the inherent risks of gambling and the low probability of winning, and therefore may be susceptible to this type of promotion.

Most studies of youth gambling have found that the majority of youth have gambled, but do so infrequently and do not suffer any adverse consequences. However, a minority of youth appear to be over-involved in gambling and are experiencing problems associated with their gambling and this group may be most susceptible to gambling advertising.

A new form of gambling that may pose a particular risk for youth is Internet gambling on the World Wide Web. The Internet has gambling sites which provide online casino-style gambling, including such games as blackjack, poker, slots, and roulette. These sites require the user to pay for gambling with a credit card. Because a computer or Internet site cannot tell who is operating the computer, youth can readily access Internet gambling.

Internet gambling is likely more accessible to youth than casinos or other legalized games that are operated by adults who are responsible for preventing underage gambling. Internet gambling may also pose a greater risk for youth, because youth are more adept and facile with computers and the Internet than adults, and therefore, Internet gambling may be more attractive to youth. Internet gambling by youth is virtually unexplored and it is imperative that the investigation of youth Internet gambling be a high research priority.

Recommendations and Future Research Directions

Since this is the first generation of youth to be exposed to widespread access to gambling and advertising, it will be important to monitor youth gambling behaviours and problem gambling. Ideally, this would include a Canadian and U.S. national sample that is assessed on a consistent basis, as is done in the U.S. with the Monitoring the Future study of alcohol and drug use (Johnston, O'Malley, and Bachman 1995).

In order to examine questions about the development of problem gambling and to test developmental theories, the next generation of research needs to include longitudinal designs, as has been suggested by Lesieur (1989). Such designs have greater promise for identifying factors that put youth at risk for developing problem gambling; and conversely that protect youth from developing problem gambling.

In order to make direct comparisons between youth prevalence surveys, there needs to be consistency across studies in the areas of definitions of problem/pathological gambling, methodologies, survey instruments, and cut-scores. Relatedly, the finding that youth have a significantly higher rate of problem or pathological gambling than adults demands immediate attention. We need to verify whether this finding reflects a true rate of adolescent pathological gambling or if it is a measurement artifact. It will be important to develop screening and assessment instruments and methodologies specifically for youth that take developmental issues into consideration.

Current trend data suggests that prevention efforts aimed at a general adolescent population can be primarily an awareness and educational message. However, given that some youth are increasing their involvement suggests tailored prevention and intervention approaches will be needed.

One of the robust findings from youth gambling research is that males are much more involved in gambling than females. Because of this difference between boys and girls it is recommended that researchers report their results separately for boys and girls. This practice will also help us monitor if girls show a tendency to "catch up" to boys in terms of gambling behaviour, as they have in tobacco, alcohol, and drug use. In some circles of youth, gambling may be considered a new "rite of passage" into adulthood.

It is recommended that prevalence studies that use screening items to measure pathological gambling use a two-stage methodology (Dickerson, 1993). A screening instrument is administered in the first stage. Respondents who have a positive screen are then administered a clinical or diagnostic interview to confirm the presence of pathological gambling. This second stage should not be too much of a burden, given that a relatively small number of respondents obtain a positive screen (e.g., 3% of a sample of 1,000 respondents is 30 interviews).

And it is important to confirm our prevalence estimates, given the current doubts about the accuracy of youth prevalence rates (Ladouceur, 1999). This is not to say that there are not youth with serious gambling problems. The purpose of this effort is not to minimize the concern about youth gambling but rather to improve our current measurement technologies so that we can be confident of the reported results.

Most studies report that youth are playing legalized games. This is illegal and potentially harmful for youth. The extent of underage gambling needs to be confirmed and an investigation of how underage youth access legalized games needs to be conducted. Next, plans need to be developed and implemented to prevent youth from accessing legalized gambling, targeting both the vendor and youth.

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Small Group Discussion Questions on Youth Gambling Prevalence

DISCUSSION QUESTION 1

How does your experience working with youth compare with the youth gambling prevalence data presented in the main session?

ThinkTank participants agreed that people working in the field were not seeing the prevalence of gambling addiction or problem gambling suggested in the statistics presented within Dr. Stinchfield's paper. In fact, most participants felt the gap between the research and reality was significant, given the low number of youth presenting for treatment.

There were many suggestions on why more youth were not coming forward for treatment:

Access to legal, sanctioned games has increased.

Gambling is not seen by typical youth referral groups (e.g. schools, justice, families, community workers) as a problem in the same vein as alcohol or drugs

Society has normalized its attitude towards gambling; it is seen and promoted as a healthy recreational pursuit.

Youth do not see gambling as a high-risk activity.

Governments, agencies and communities are more focused on dealing with improper youth behaviours involving alcohol, drugs, sexual activity, etc.

Under reporting of intervention occurrences, particularly when gambling is only one of several presented problems in a case.

Youth do not normally seek treatment on their own and often grow into adulthood before circumstances (bankruptcy, criminal conviction) force a treatment alternative.

Many of the reasons offered were based on personal experience and observations. Existing research, particularly in Canada, was too thin to reliably identify key factors, said participants. More research, as suggested by Dr. Stinchfield, needs to be done to confirm existing estimates and isolate the reasons why few youth access problem gambling treatment.

DISCUSSION QUESTION 2

Youth gambling prevalence studies were not a common occurrence prior to the 1990s, which makes it difficult to compare today's youth behaviour with the behaviour of previous generations. Thinking back to when you were a teen, how does the type of gambling youth are involved in today compare to what you and your friends did?

Participants described gambling in their teen years as low risk, informal, occasional and, for the most part, contained within one's social circle. Card games with family and friends, small community bingos, side wagers at sporting events and carnival wheels of fortune were the most often recalled forms of gambling or betting.

Betting was considered commonplace in the past and all participants acknowledged it continues today. Few participants saw informal betting as a high-risk youth behaviour. However, participants were unsure how the prevalence of more formal types of gambling in today's society has impacted the frequency and/or intensity of previously innocuous, informal forms of betting.

It was conceded that legislative changes and new forms of gaming have revolutionized gambling. Gambling has become a legal, accepted entertainment and recreational pursuit (e.g. permanent casinos, bingo palaces) in most provinces. Visually, economically and socially, it has become a common aspect of everyday life. Participants believe teens today face much greater challenges in resisting high risk gambling activity because:

There is a proliferation of gambling promotion and advertising.

Teens have more access to formal games (e.g. lottery tickets, sports pools, Internet).

They are more likely to be exposed to poor adult role models.

They are more likely to engage in high stake games.

Gambling is seen as normative behaviour in society.

It is not known to what extent the changed face of gambling has affected today's youth or what it may mean for young people in the future. Participants said such questions require more research and a common set of parameters for defining the type and nature of the problem.

DISCUSSION QUESTION 3

When is gambling a normal developmental activity for youth, and when does it become a problem?

Most participants found it difficult to define what is "normal" gambling behaviour for teenagers. As one group noted, "normal" is often defined by a person, organization or community that has its own unique set of values, beliefs and attitudes. This can lead to wide variations between groups about what "normal" is. This was borne out at the Think Tank, where small groups developed a list of things thought to influence attitudes towards gambling acceptability. Some of these included culture, location, religious affiliation, education, ethnicity, household income, school environment, among many others.

Despite this, it was generally agreed that individuals face and react to risk opportunities in different ways. Gambling as experimentation or stimulation for teenagers who were developing coping and other life skills was not seen as negative behaviour.

Participants felt problem gambling in youth occurs when gambling becomes a preoccupation or priority for the individual. Symptoms that indicate gambling has become a problem include lack of self-control, wagering more often, placing larger bets, and taking actions that the individual knows may or will negatively impact school, work and family relationships. It was pointed out by many that problem gamblers have multiple problems and that gambling is often a symptom of other, more deeply rooted concerns.

The small groups had more questions than answers on issues like providing services to youth who may have a problem but are not seeking help, or dealing with the higher incidences of problem gambling among males. However, there was consensus that finding common ground regarding what's "normal developmental activity" regarding youth gambling versus unhealthy gambling behaviour would be a step in the right direction.

Gambling Affected Youth and Resiliency

ABSTRACT OF PRESENTED PAPER

TITLE:

Relevance of Resilience to Adolescent Gambling: Implications for Intervention

PRESENTED BY:

Miriam Stewart, Ph.D.

RESILIENCE IS defined as an ability to succeed, mature and gain competence in a context of adverse circumstances or obstacles. The effects of earlier risk factors, as well as the buffering effects of protective factors, are most readily seen during adolescence. Protective factors and risk factors for adolescents at five levels — individual, family, peer, school and community — are reviewed in the paper.

Resilient adolescents are more socially and academically competent individuals. Self-esteem, social competence, resistance skills, and locus of control also function as individual protective factors. Family strengths that can act as protective factors are parental involvement, decision-making and rules, loyalty, unity, values, religious orientation, emotional closeness and support, communication, family cohesion, and a good relationship with at least one parent. Furthermore, parental interaction with schools contributes positively to the resilience of youth.

The social influence of the peer group, including learning refusal behaviour from peers through modeling and reinforcement, have clear protective effects. Schools in which high responsive roles are provided, high academic standards are maintained, opportunities for extra-curricular achievement are offered, and environments are conflict-free, can foster resilience of youth. At the community level, protective factors include involvement with a significant adult figure outside the family.

Youth who feel alienated from school, family or neighbourhood, or who believe they are not successful in school or relationships may be prone to risk behaviours such as gambling. Other risk factors include the correlation between parents who gamble and children adopting the same

behaviour, and between family members with gambling problems and youth with gambling problems.

Intervention strategies should address individual behaviours and living conditions. Individual interventions (e.g. mentoring) and group interventions should be designed to introduce support early in the stress process for youth. Intervention should be multi-faceted. Prevention and intervention strategies should match the development stage of adolescents, focus on the present not the future, and foster parent-youth communication.

Ecological models for prevention programs use a comprehensive approach to address risk and protective processes at several levels. Twenty-nine intervention programs are summarized in the paper, and success stories are used to illustrate varied levels of programs — individual, peer, family, school, community and multi-level.

Individual level interventions include resistance training and cognitive behavioural relapse prevention. School level interventions such as a core curriculum focused on social, life and coping skills can prevent a variety of problems facing adolescents. Programs should also consider the community context. Instead of viewing youth as community problems, the community empowerment approach assesses youth as community assets and resources, and promotes their participation in the socio-economic and public affairs of the community.

Comprehensive multi-level programs emphasize early intervention, resistance skills training, individualized attention, parent involvement, peer involvement, healthy school climate, social and life skills training, support and advocacy by an adult, and community-wide, multi-agency, multi-component interventions.

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PRESENTED PAPER

Relevance of Resilience to Adolescent Gambling: Implications for Intervention

Introduction to Resilience

The National Forum on Health proclaimed the importance of resilience for health throughout the life space (children, youth, adults, seniors) and across varied settings (families, communities). The final report said: "Resilience is fundamental to the future health of Canadians."

Definition

In developing a definition of resilience, my colleagues and I consulted 60 experts in resilience and 42 experts in health promotion. Commonalties in definitions include: (1) competence and coping in face of significant adversity/risk; (2) development and growth over time; (3) match between characteristics of individual and environment; (4) important role of protective factors; and, (5) impact of social, economic, political, and cultural factors.

Resilience is the capability of individuals, families, groups, and communities to cope successfully in the face of significant adversity and risk. This capability develops over time, is enhanced by protective factors within the individual, group or community and the environment, and contributes to the maintenance or enhancement of health. (Reid, Stewart, Mangham & McGrath, 1997).

Components of Resilience

Risk factors. Risk factors stem from multiple stressful life events, a single traumatic event, or cumulative stress from a variety of personal and environmental factors. They are events/experiences (e.g., low SES) that create vulnerability and link to later maladjustment.

Protective factors. Protective factors ameliorate or decrease the negative influences of being at risk, but may also operate independent of risk. They are events/experiences (e.g., higher education level) that alter adverse effects and decrease negative influences of risk (Rutter, 1993). Recent literature refers to the power of chronic and cumulative risk factors and to change in risk and protective factors over time.

Outcomes. These are indicators of adjustment such as competence, physical and psychological health.

Levels of Resilience

INDIVIDUAL RESILIENCE

Risk factors. Risk factors arising from the individual include male gender, minority racial status, difficult temperament, and chronic illness/condition. Risk factors derived from the family include family income, parental pathology/mental illness, separation from parent, exposure to violence, large family size, chronic conflict, family abuse, marital breakdown, inconsistent parenting, and homelessness.

Community-level risk factors include low socioeconomic status/poverty, deviant peer group, and violent neighborhood (Garmezy, 1996, Gore & Eckenrode, 1996).

Protective factors. *Individual*—level protective factors are: self-esteem, self-efficacy, easy temperament, good genetics, intelligence/cognitive ability, internal locus of control, and planning for the future.

Family protective factors influencing the individual encompass maternal advanced education, maternal employment, quality parenting, household structure and rules, positive parent-child interactions, and parental involvement. Other family-level protective factors include goodness of fit between child and parent, capacities of parents to support optimal child development, and, caring and supportive partner.

Community protective factors include positive relationship with non-custodial adult, participation in extracurricular/community activities, high but achievable expectations in school, and positive school experiences. Other community-level protective factors encompass church involvement, opportunities to contribute, and a civic society (Gore & Eckenrode, 1996; Stewart et al, 1996).

According to a paper in the National Forum on Health Report, the strongest single protective factor associated with resilience in the child's early years is social attachment to a primary caregiver. In addition, the availability and supportiveness of another adult beyond the family is frequently found in children and youth who are resilient despite disadvantage (Steinhauer, 1998).

FAMILY RESILIENCE

Risk factors. Risk factors for families include: isolation, exposure to violence, illness, changes in family structure, social adversities, economic disparities, unemployment or underemployment, and unsafe or unhealthy physical environments.

Protective factors. Family protective factors involve trust, integration, responsiveness, and routines. They also include stability, cohesiveness, sense of coherence, adaptability and flexibility, collective coping skills, communication, family beliefs and spirituality, and strong internal and external support networks (McCubbin et al., 1998; Mangham, Reid & Stewart, 1996).

COMMUNITY RESILIENCE

Risk factors For communities are economic disadvantage, unemployment, cultural barriers, social/geographical isolation, low literacy, low education levels, and communal apathy and anger.

Protective factors. Encompass community connectedness, community social support, communal coping, community involvement and participation, and quality education and retraining services (Stewart et al., 1997).

RELEVANCE TO HEALTH AND HEALTH BEHAVIOURS

Resilience shifts the focus from pathology, problem behaviours and ill health toward protective factors, reduced risk, and health enhancement/maintenance. All aspects of an individual's well-being should be examined including behavioural competence, social relationships, emotional stability, academic and vocational achievement, and physical health. Although health behaviours may serve as protective factors in relation to physical and psychological well-being, they are rarely examined from a resilience perspective (Reid et al, 1997).

RESILIENCE IN ADOLESCENTS

Adolescence is a major transition time with inevitable stresses of life span changes, however, normal adolescents do not experience major turmoil and serious symptomology. The effects of earlier risk factors, as well as the buffering effects of protective factors, are most readily seen during adolescence (Grossman et al., 1991).

The 1999 report "*Manitoba Youth Gambling Prevalence Study*" concluded that a follow-up study is needed to gain a better understanding of protective and risk factors associated with problem gambling (Wiebe, 1999). National surveys document changes in prevalence rates, but typically do not systematically examine risk and protective factors for risky behaviour such as gambling. Only a few studies of risk and resilience have focused on adolescence.

PROTECTIVE FACTORS FOR ADOLESCENTS

Individual protective factors. Resilience is defined as an ability to succeed, mature and gain competence in a context of adverse circumstances or obstacles. Resilient adolescents are more socially and academically competent. In one study, resilient youth were less likely to initiate new health-endangering behaviours (e.g., alcohol, marijuana, other drugs) than their non-resilient peers (Rouse et al., 1998). Their resistance to risky behaviours is a reflection of behavioural competence.

Studies of resilience have focused on social competence in ninth-grade inner city youth (Luther, 1991), adolescent coping styles and family coping strategies (McCubbin et al, 1998). Resilient youth are more sensitive, social, and cooperative than nonresilient youth; they also demonstrate more inner control, cognitive superiority, and higher self-esteem (Rouse et al., 1998). Self-esteem, social competence, resistance skills, and locus of control function as protective factors against substance use (Dusenbury, 1994). In particular, the protective effect of sense of competence in daily tasks is important (Wild, 1999).

Family protective factors. Child attachment with parents is associated with decreased adolescent drug use. Specific protective effects of attachment include identification, positive affect, and positive involvement with parents (Spoth et al., 1996). Quality of parenting and family expressivity, assignment of chores, and firm spirituality increase the likelihood of resilience in aversive situations.

Family strengths that can act as protective factors against substance abuse are time and involvement, decision-making and rules, loyalty and unity, values and religious orientation, emotional closeness and support, and communication (Lee & Goddard, 1989). Familial factors also include absence of marital discord, family cohesion, and a good relationship with at least one parent. Furthermore, the degree to which parents interact with schools contributes positively to resilience of youth (Jessor et al, 1998).

Most youth (82%) in the Manitoba gambling prevalence study reported having a parent or other adult that they could talk to about problems; however, adolescents with gambling problems were least likely to have someone to talk to (Wiebe, 1999).

Peer protective factors. The social influence of the peer group includes learning refusal behaviour from peers through their modeling and reinforcement.There are clear protective effects of association with peers having prosocial norms (Spoth et al., 1996).

School protective factors. Contextual factors that appear to foster resilience include school personnel and other significant adults who express care for youth. Schools in which responsible roles are provided, high academic standards are maintained, opportunities for extra-curricular achievement are offered, and environments are conflict-free, can foster resilience of youth.

Community protective factors. In the social environment, protective factors include involvement with a significant adult figure outside the family. The majority (63%) of youth in the Manitoba gambling study indicated that an adult was available to provide help "some of the time" or "most of the time".

RISK FACTORS FOR ADOLESCENTS

Dryfoos (1996) identifies six risk factors for high-risk behaviours in youth. These pertain to quality of parenting, quality of schooling, peer influence, mental health, poverty, and race/ethnicity.

Individual risk factors. Youth who feel alienated from school, family or neighborhood, or who believe they are not successful in school or relationships, may be prone to risk behaviours. At risk youth have positive attitudes toward using substances, place a low value on

academic achievement, are socially critical, rebellious, sensation-seeking and alienated, and seek independence from conventional society.

Early precocious social skills have been linked with deviant behaviours and substance use (Scheier & Botvin, 1998). Personality traits such as distractibility, impulsivity, and novelty seeking are correlates of gambling in adults (Vitaro et al., 1996). Low harm avoidance predicted adolescent gambling, whereas aggressiveness/ antisociality was predictive of delinquency and substance use. Underlying characteristics (e.g., risk-taking, rebelliousness) or motivation (e.g. escape) may be related to gambling problems (Wiebe et al., 1999).

Gambling can be linked to delinquency and substance use. Gambling youth report more fighting, alcohol/drug use, cigarette use, vandalism, and theft than non-gamblers. This has been labeled a "constellation" of risky behaviours (Lesieur et al, 1986; Buchta, 1995; Vitaro, 1996)

Family risk factors. Many youths, in one study, had suffered the loss of family members or friends. Among at-risk/problem gamblers, 44 percent had at least one friend die in the previous year or two and 77 percent had at least one family member die (significantly higher than for non-gamblers or non-problem gamblers) (National Council of Welfare, 1996).

A review of adolescent risk factors led to the conclusion that the one risk factor consistently evident is the family (Thomas & Schandler, 1996). Jacob's theory of addiction refers to a childhood or adolescence marked by deep feelings of inadequacy or inferiority and perceived rejection by parents and significant others. Only parental smoking and family conflict predicted the transition from experimental to regular smoking. Parental smoking and family conflict predicted regular smoking for girls but not boys (Flay et al., 1998).

In Manitoba, youth with gambling problems were most likely to report that their parents gambled too much, and that they learned such behaviours at home. Gambling was used as a mechanism to cope with stress in the home (Wiebe, 1999). The three most common sources of support for gambling activities among youth in Alberta came from parents/guardians, relatives and friends (Adebayo, 1998). Many parents purchase lottery tickets for their youngsters, take children to bingo, or engage in small-time wagering.

There is a clear correlation between parents who gamble and children adopting the same behavior (Pursley, 1991), and between family members with problem gambling and youth with problem gambling (Proimos, Durant, Dwyer et al, 1998). Similarly, in a UK study, there was a strong link between parental and child participation in lotteries and scratch cards (Wood & Griffiths, 1998).

Peer risk factors. Experimental substance use is more common among youth who identify more with their peers than with their parents. Friends' use and approval of substance is regarded as a key proximal influence on substance use. Best friends who smoke, offers from best friends to try smoking, perception of high smoking prevalence among peers, direct pressure to smoke by best friends, and cigarette offers by friends were strong risk factors for adolescent smoking (Chassin et al., 1990).

School risk factors. Chassin et al., (1990) suggest that risk of smoking onset is highest at transition points that are potential threats to self-concept (e.g., transitions to junior high or high school). Predictors of escalation to regular smoking include stressful interactions with larger social environments (e.g., school). Compared to other youth, youth with gambling problems experience more difficulties in school.

Community risk factors. Almost half (49%) of Aboriginal youth in Alberta communities were either problem gamblers or were at risk of becoming problem gamblers (National Council of Welfare, 1996). Community recreational sports, and social and cultural programs for young people are often funded by gambling dollars. Alberta had more forms of licensed gambling than most other jurisdictions.

Interventions Fostering Resilience and Diminishing Risk Behaviours of Adolescents

PRINCIPLES FOR INTERVENTIONS

Health promotion programs could be designed with varying levels of intervention — the greater the risk, the more intensive the intervention. Moreover, multiple levels of intervention could be focused on family, group, and community resilience (Reid et al, 1997). Individual interventions (e.g., mentoring) and group interventions should be designed to introduce support early in the stress process for youth and interventions should be multi-faceted (e.g., role modeling, media, personal contacts, environment modification). Indeed, interventions have the best chance for success when they are multi-factorial and target protective factors at all levels (Gottlieb, 1998).

Intervention strategies should address individual behaviour ("personal resources") and living conditions ("social resources"). Four types of intervention measures are individual competency training (preventive), systematic behavior modification (corrective), improving social living conditions (preventive), and constructing support networks (corrective) (Hurrelman, 1990). Common components of successful programs are: (1) emphasis on early intervention, (2) focus on educational achievement, (3) effective parental involvement, (4) effective peer involvement, (5) connections to the world of work, (6) emphasis on social and life skills training, (7) attention to staff training, (8) *attention to cultural sensitivity*, (9) *presence of dedicated people*, and (10) *attention to policy issues* (Dryfoos, 1996).

Considerable care must be taken in identifying at-risk individuals or groups to avoid stigmatization or "blaming the victim". Resiliency can inform preventive innovations designed to enhance protective factors in those most at risk for adjustment problems (e.g., substance use, gambling) (Reid et al, 1997). Prevention efforts have shifted from a focus solely on individuals to the individual in the context of community. New directions in programs emphasize protective factors and harm reduction (Brown & Horowitz, 1993). Intervention strategies can emphasize risks, resources, and processes (Masten & Coatsworth, 1998). Prevention and intervention strategies should match the developmental stage of adolescents; focus on the present not the future; and, foster parent-youth communication (Thomas & Schandler, 1996).

Empowerment of youth is a more helpful intervention than compliance-oriented programs.The mechanisms for building empowerment for youth includes individualized goals and skills (Fox, 1994), adequate family support, caring and supportive adults; high expectations placed on youth by significant others in social network; opportunities to learn life skills that have vocational implications; meaningful opportunities to assume responsibilities; opportunities to contribute to the social, cultural, economic, or public affairs of the school, community or government; opportunities to demonstrate their abilities and successes, and, having achievements reinforced by adults in schools, home, and community (Kim et al, 1993).

Ecological risk/protective models for prevention programs include the following strategies.

(1) Identify real issues/problems facing local youth (e.g., gambling)

(2) Establish well-defined goals that target risk and protective factors associated with issue.

(3) Comprehensive approach to addressing risk and protective processes at several levels.

(4) Collaborate with stakeholders in community/neighborhood.

(5) Tailor plan to community, reducing local risks and building protective processes.

(6) Involve youth in program design, planning and implementation.

(7) Be sensitive to cultural, ethnic, and other diversity in community.

(8) Intervene early and continuously.

(9) Select developmentally appropriate prevention strategies.

(10) Anticipate how changes in one system/sector may affect changes in others.

(11) Evaluate effectiveness by monitoring changes in risk and protective processes (Bogenschneider, 1996).

INDIVIDUAL-LEVEL INTERVENTIONS

Resistance training includes (1) information on social influences such as peers and mass media, (2) rehearsals, and (3) reinforcement to resist situational pressures (Kim et al, 1998).

Treatment using a **cognitive behavioural relapse prevention** model seems suited for adolescent addictive experience because it addresses developmental needs, engages the whole system (e.g., school, clergy, social services), empowers parents, and facilitates adolescents' autonomy. The adolescent becomes empowered by learning alternative coping strategies and social skills.The treatment of choice is peer group therapy (Purslay, 1991). Success story "Cognitive-behavioural treatment for adolescent pathological gamblers" (Ladouceur et al, 1994).

FAMILY-LEVEL INTERVENTIONS

Many family life skills programs and some *parenting* programs are directed at prevention of youth substance use. However, most follow structured curricula and include didactic materials, role-playing, discussion, and homework; strategies which are not appropriate for low-income parents (St. Pierre & Kaltreider, 1997). Success story "Family Advocacy Network" (St. Pierre & Kaltreider).

PEER-LEVEL INTERVENTIONS

The use of modeling in prevention interventions may counteract negative modeling. Social learning theory points to the importance of peer models, role-play, contrast modeling of positive and negative behaviours, attention-directing narratives, feedback, and rehearsal of memory aids. Success story "Teams-Games-Tournaments" (Wodarski & Smyth, 1994).

SCHOOL-LEVEL INTERVENTIONS

Intense *multi-component programs* are needed to change behaviours. A core curriculum focused on social, life and coping skills (e.g., problem solving, relaxation, self regulation, assertiveness training) can prevent a variety of problems facing adolescents such as STD, pregnancy, school drop-out, (Cleaveland, 1994) and gambling. Success story "Adolescent Transitions Project" (Andrews et al, 1995), Cities in Schools (Steinhauer, 1998).

COMMUNITY-LEVEL INTERVENTIONS

Public education about the negative effects of drug use and campaigns arousing fear have some effect on drug knowledge levels, but essentially no effect on drug use and abuse. Social policies and programs should aim at prevention of risk behaviour, empower youth, and consider the community context (Lerner, Entwistle & Hauser, 1994). Instead of viewing youth as community problems, the ***community empowerment approach*** sees youths as community assets and resources and promotes their participation in the socioeconomic and public affairs of the community (Kim et al., 1998). The following strategies can be implemented:

- Build community support by forming a task force, which represents a variety of youth-serving agencies and organizations and young people themselves.
- Initial training of youth team leaders and adult advisors. The youth/adult dyads are trained together in team-building communication, listening, problem solving, decision-making, and interpersonal social skills.
- Train youth in same skills.
- Service oriented/career development skills workshop

  Service/career project implementation. Youth apply their skills to address social concerns in the school, neighborhood, or community. For example, youth may conduct public awareness campaigns, peer-counseling programs, individual or group peer-tutoring, vocational exploration and career development programs, or community service projects.

This empowerment process encourages youth to develop positive relationships with adults and peers, participate in social/public affairs, and demonstrate their success in solving community problems and issues (Kim et al., 1998). Success story "Wisconsin Youth Futures Program" (Bogenschneider, 1996).

MULTI-LEVEL PROGRAMS

Interventions that focus their positive influence on only one specific context or element (e.g., school context) will likely fail if the combined effects of other negative influences (e.g., family, peers, organizations,

groups, mass media, nonschool community) are greater. A focus on knowledge and attitude change is typically insufficient to change behaviour. Accordingly, comprehensive programs should emphasize early intervention, resistance skills training, parent involvement, peer involvement, healthy school climate, social and life skills training, and community-wide intervention (Wodarski & Smith, 1994).

Multi-modal prevention and intervention strategies are needed to address the personality, biological, genetic, cognitive, attitudinal, social, and environmental factors in adolescent substance use (Thomas & Schandler, 1996), and other risky behaviours (e.g., gambling). Dryfoos (1996) emphasizes the need for individualized attention, support and advocacy by an adult, and community-wide, multi-agency, multi-component interventions in school settings. Success story "Social Competence Promotion Program for Young Adolescents" (Gottlieb, 1998).

FACTORS INFLUENCING PROGRAM USE BY YOUTH

The most common source of assistance, accessed by youth in Manitoba wanting help with gambling was friends (37%), followed by school counselor or teacher (36%) and family (24%). Other supports not accessed included the Addictions Foundation, social workers, psychologists, psychiatrists, family physicians, and religious sources (i.e. professional sources). The majority (71%) of youth who wanted help with their gambling did not try to get help. Six percent indicated that they didn't know where to go for help, and 8% that they were afraid to get help. Others described such reasons as: ability to quit gambling on their own, not feeling that the problem was serious, "didn't have time", "didn't think anyone would help me", "my friends didn't want me to stop gambling", "no one helps you around here. It's a small community" (Wiebe, 1999).

Implications for Programs and Policies

NATIONAL FORUM ON HEALTH RECOMMENDATIONS

Policies and programs should encourage early leavers to return to school (Anisef, 1998).

Design culturally relevant and language-appropriate interventions.

- Provide rewards and enticements to youth participants who play a key role in program success (Godin & Michaud, 1998)

- Multiyear, coordinated, comprehensive health education and social competence programs are needed in schools.

  Offer incentives to communities to create after-school youth development organizations, with governing structures that include parents, educators, and youth-serving agencies.

- Ask education authorities and national community service and health organizations about options for community service internships, including those that earn academic credit (e.g., in-school tutoring, practicum with elderly, wildlife and conservation programs, recreation, and childcare) (Gottlieb, 1998).

- Provide programs involving positive role models and mentors (Fralick & Hyndman, 1998). Grants to foster mentoring programs particularly for at-risk youth. Secondary school co-op programs are ideal for recruiting and deploying adult mentors. Public and private sector employers and labour unions should encourage retirees to become youth mentors (Gottlieb, 1998).

- A range of services should be available to young people including prevention, crisis intervention, maintenance, and transition services.

- Interagency initiatives maximize limited resources (Caputo & Kelly, 1998). Foster intersectoral collaboration among key community institutions (e.g., schools, recreation centres) to promote healthy, nurturing social environment for youth.

- Facilitate multidisciplinary collaboration by various levels of government when interventions fall within the jurisdiction of more than one department (Godin & Michaud, 1998).

- Test strategies for fostering positive, healthy home environments (e.g., parent training).

- Decrease socioeconomic inequities among young people by providing income-generating opportunities for disadvantaged youth (e.g., summer job training programs).

Provide learning experiences and opportunities for social interaction that enhances life skills.

Promote community-level adoption of policies aimed at preventing the use of tobacco, alcohol, other drugs, (and gambling) by young people (Fralick & Hyndman, 1998).

Train parents and key players in the natural support system for preventive interventions (Godin & Michaud, 1998)

Table 1 | Protective Factors for Adolescents

(Grossman et al, 1992; Kaplan et al, 1996; Rouse, Ingersoll & Orr, 1998; Thomas & Schandler, 1996; Spoth et al, 1996).

INDIVIDUAL	• More internal locus of control
	• Higher self-esteem than non-resilient peers
	• Self-efficacy
	• Sense of direction
	• Realistic appraisal of environment
	• Socially competent and social problem-solving skills
	• Adaptive distancing
	• Religious commitment
	• Academically competent and intellectual capabilities
PEER	• Close friend
	• Peer with pro-social norms
FAMILY	• Family cohesion
	• Family modeling, accessibility, sanctions against use
	• Good communication with parents
	• Parent-child attachment
	• Good marital relationship of parents
	• Consistent, warm, positive relationship with a caring adult
	• Positive family environment and bonding
	• High but realistic parental expectations
	• Family responsibilities and household tasks
	• Positive parental modeling of resilience and coping skills
	• Extended support networks
SCHOOL	• Opportunities for school decision-making
	• High but realistic expectations
	• Caring, supportive atmosphere
WORK	• Required helpfulness
COMMUNITY	• Positive community norms, cultural norms and media influence
	• Community resources for youth and families
	• Relationship to significant non-parent adult

Risk Factors for Adolescents | Table 2

(Buchta, 1995; Lesieur et al, 1991; Resnid & Burns, 1996; Wodarski & Smyth, 1994).

INDIVIDUAL	• Gender (males)
	• Gambling prior to age 20
	• Use gambling as an alternative means of coping
	• Antisocial behaviour
	Alienation or rebelliousness
	Link between gambling and other risk-taking or addictive behaviour
	• Students with non-traffic arrests, delinquent behaviour
	Personality problems, anger, depression
PEER	• Association with peers engaged in risk behaviours
	• Associating with delinquent peers
FAMILY	• Parental gambling and alcohol and drug use
	• Gambling by siblings
	• Alcoholism in father
	Family dysfunction, disruption and marital conflict
	• Lack of familial support
	Poor parental involvement; distant or hostile relationship with parent
	• Unclear family rules, expectations, and rewards
	• Involved with child protective services or out-of-home placement as a result of abuse or neglect
SCHOOL	• School transitions
	• Academic failure
	Low commitment to school
WORK	• Long work hours
COMMUNITY	• Living in poor neighbourhood
	‣ Poverty
	‣ Neighbourhood safety and quality of life problems
	‣ Communities with dearth of social resources and social institutions
	• High-stress communities
	• Negative media influences
	Complacent or permissive community laws and norms
	Low neighbourhood attachment, community disorganization, and high mobility
	• No meaningful roles in community

Table 3 | Adolescent Risk-Behaviour Interventions

REFERENCE	SUMMARY OF PROGRAM
Individual-level Programs	
Ladouceur, Robert, Boisvert, Jean-Marie, and Dumont, Jilda. (1994). Cognitive-behavioral treatment for adolescent pathological gamblers.	TREATMENT: Development and evaluation of a treatment program for four male pathological gamblers which includes cognitive restructuring, problem-solving training, social skills training (communicating with peers, parents, and superiors), and relapse prevention. Treatment continued until perception of control reached a level of 8/10 or more for 2 consecutive weeks. EVALUATION: Measurement of perception of control over gambling and perception of severity of the gambling problem taken over course of treatment until levels reached target, then follow-up at 1, 3, and 6 months. OUTCOME: Significant improvements for both variables in all subjects, with all reporting complete abstinence after 6 months, thereby supporting the clinical efficacy of the treatment program.
Berger, Roni, and Shechter, Yuta. (1996). Guidelines for choosing an "intervention package" for working with adolescent girls in distress.	TREATMENT: Recommendations for tailoring treatment plans to specific needs, based on level of personality and socialization for adolescent girls. Treatment varies by frequency of contact, focus, nature of relationship between worker and girl, position of worker in the therapeutic milieu, target system, and main strategy. EVALUATION: None OUTCOME: No examples given
Peer-level Programs	
Wodarski, John S. and Smyth, Nancy J. (1994). Adolescent substance abuse: A comprehensive approach to prevention intervention.	TEAMS-GAMES-TOURNAMENTS (TGT) is a program to teach adolescents about alcohol to prevent its misuse. It uses games as teaching devices, small groups as classroom work units, and emphasizes task-and-reward structures. The structures emphasize group, rather than individual, achievement and utilize peers as teachers and supporters of pro-social norms. The method capitalizes on peer influence, increases social attachment to peers, and influences the acquisition and subsequent maintenance of knowledge and behaviour change. EVALUATION: Students in a four-week program were compared to those in traditional education and those not receiving any instruction. OUTCOMES: The TGT method was superior in self-report measures of alcohol knowledge, reduction in drinking behaviour, and positive changes concerning drinking and driving. A one and two year follow up showed that these attitudes were maintained.
Family-level Programs	
St. Pierre, Tena L., and Kaltreider, Lynne, D. (1997). Strategies for involving parents of high-risk youth in drug prevention: A three-year longitudinal study in Boys and Girls Clubs.	PREVENTION: The Family Advocacy Network (FAN) Club strengthens high-risk families by creating a bond between program youth in early adolescence and their parents, reducing maternal isolation, providing opportunities for families to participate in pleasurable activities together, assisting parents to influence their children to lead drug-free lives, and providing social and instrumental support. The program focuses on families' strengths rather than deficits, to inspire parental confidence and competence, to respond to family cultural preferences and values, to take a developmental view of parents, to be flexible and responsive to parental needs, to encourage voluntary participation by parents, and to include parents as partners in the planning and implementation of the program. The program consists of basic support activities (supporting parents with social services, problems at children's schools, problems with the justice system, transportation, etc.), parent support activities (group social activities to reduce social isolation), educational program activities (speakers, discussion, culturally appropriate events), and leadership activities (planning and implementation of activities). OUTCOMES: Gradually participants took over more of the lead in organizing and coordinating activities. Increases in sense of self-confidence and competence resulted from program activities. Direct effects of a 3 year implementation included increasing ability to refuse alcohol, marijuana, and cigarettes, and increasing negative attitudes toward using marijuana.

PREVENTION: PROJECT FAMILY, a series of studies of preventive interventions focusing on family-skills training. Evaluation Preparing for the Drug (Free) Years, which targeted families residing in economically-stressed rural areas. Based on the social development model, the primary objective is to reduce adolescent substance abuse by enhancing positive parent-child interactions. Parents are encouraged to provide their children with opportunities for positive family involvement, teach their children positive-involvement skills, and reward them for such involvement, while providing appropriate consequences for rule-violating behaviour. It is a five-session, multimedia program, with each session lasting two hours. Four of the sessions for parents only include (1) identifying risk factors for adolescent substance abuse, (2) enhancing parent-child bonding, (3) developing effective child-management practices, (4) managing family conflict, (5) enhancing positive child involvement in day-to-day family tasks, and (6) utilizing family meetings as a vehicle for improving child management and positive child involvement. The last session involves both parents and children in instruction regarding peer resistance skills, utilizing a five step refusal skill procedure. Parents and children practice the skills with feedback from group leaders.

Spoth, Richard, Yoo, Seongmo, Kahn, Jeffrey H, and Redmond, Cleve. (1996) A model of the effects of protective parent and peer factors on young adolescent alcohol refusal skills

FAMILY TGT PREVENTION STRATEGY: parents participate in a five-week program in which they meet in groups of 10 families, two hours each week. Initial focus is on learning drug concepts through handouts and discussions. The second session covers basic knowledge about drug consumption and usage, with elaboration on the effect of parental drinking on their children. The third and fourth sessions are devoted to teaching problem-solving skills and communication skills for conflict resolution. Ideas are presented in lecture form, then discussed in the group and then role plays. Communication training and role-play problem solving reinforce conflict resolution skills. In these sessions, information is shared on use of positive and negative control with adolescents. The fifth session integrates new skills and applies them to drug and alcohol prevention.

Wodarski, John S. and Smyth, Nancy J. (1994) Adolescent substance abuse: A comprehensive approach to prevention intervention.

PREVENTION: Family Connections is a program aimed at developing family strengths through education and individualized enrichment and skills training. The program is a family enrichment model designed to be used by families themselves or with a trained volunteer facilitator. First, family strengths are assessed using a Family Profile Questionnaire. Second, each family member completes a Diary of Daily Events where they identify areas of strength and concern. Using this information, the family selects which of the seven key areas they want to work on and in what order. They can identify either a targeted prevention approach if they have a high-risk adolescent, or a primary prevention approach if they have pre or early adolescent children.

Lee, Thomas R., and Goddard, H. Wallace (1989). Developing family relationship skills to prevent substance abuse among high-risk youth.

School-level Programs

PREVENTION: Adolescent Transitions Project is a prevention program designed to work with parents to reduce problem behavior in high-risk early teens (83 boys, 75 girls). Focus is on teaching skills and reducing conflict to target problem precursors, rather than on symptoms associated with the problem. Program components include (1) recruitment by letter with telephone and home visit follow-up, (2) Teen Consultant and Parent Consultant who help with skill development and practice assignments and act as advocates for students and liaisons for parents, (3) behavioural consultation available to students and teachers focused on academic or social behaviour, and (4) a peer enhancement media project with anti-problem behaviour messages that integrate teens into pro-social groups, reinforce skills during the 12 skill building sessions, and provide information on substance abuse and other problem behaviours.

Andrews, David W., Soberman, Lawrence H., and Dishion, Thomas J. (1995). The adolescent transitions program for high-risk teens and their parents: Toward a school-based intervention.

EVALUATION: Families selected to participate in the program based on risk-factor screening instrument were assigned to one of four intervention conditions: Parent Focus only, Teen Focus only, Parent and Teen Focus, and Self-Directed Change. Intervention duration was 34 months. Program effectiveness was measured by level of intervention engagement, skill acquisition, and changes in adolescent behaviour.

OUTCOMES: Sixty-four percent of parents claimed the program was helpful, regardless of intervention condition, 48% of teens reported it helpful with parent interactions, and 41% with peer interactions. Higher social learning scores occurred for those involved in the Teen Focus condition. Parents involved in the Parent Focus scored higher on social learning scores. Negative engagement between mothers and children was significantly reduced in both parent and teen focused conditions. Family conflict was reduced for

those in both parent and teen focused conditions. Youth aggression was decreased only for those in the parent focused condition.

Gottlieb, Benjamin H. (1998). Strategies to promote the optimal development of Canada's youth.

PREVENTION: The Social Decision Making and Problem Solving (SDM-PS) Program is a 3-phase primary prevention program targeted at young children to develop their social problem solving skills. First, students learn self-control skills like listening, concentrating, following directions, remembering, resisting provocation by others, resisting the urge to provoke others, and self-calming. Students then learn group and social awareness skills such as giving and receiving help and praise, showing caring, selecting friends, and playing roles. Second, core problem solving skills are presented and integrated into specific situations. Third, skills are applied in everyday life (i.e. classroom behaviour). Students record their experiences through personal diaries and are given opportunities to reflect in groups on their experiences in the classroom.

EVALUATION: Children receiving the curriculum improved their social decision-making and problem-solving skills, and used them both inside and outside the classroom. The curriculum also fostered pro-social skills, immediately and after the program terminated and on entrance to high school.

Anisef, Paul. (1998). Making the transition from school to employment.

CHANGE YOUR FUTURE PROGRAM: Targets visible minority students at the secondary school level at risk of dropping out of school, providing individual and group counselling sessions to help students complete their studies. The program is run by guidance counsellors who provide mentoring and alternative schooling regarding personal, school-related, and employment problems in a supportive environment.

OUTCOMES: Moderate success has been documented as measured by a decrease in dropout rates from 19% to 9% among participating youth.

Hicks, Gail F., Hicks, Barry C., and Bodle, Virginia. (1992). Natural helpers needs assessment and self-esteem: Pro-social foundation for adolescent substance abuse prevention and early intervention.

PREVENTION: Natural Helpers is a program that uses a needs assessment process that identifies problems for which students in grades 9 to 12 want help and obtains student consensus to identify students and staff to be trained as "natural helpers". Actual program implementation varies with the school, depending on results of the needs assessment.

Cleaveland, Bonnie L. (1994). Social cognitive theory recommendations for improving modeling in adolescent substance abuse prevention programs.

PREVENTION: Project ALERT: Students discuss both positive and negative drug expectancies in the classroom, and several films present the pros and cons of drug use. Based on Bandura's argument that resistance to messages can be an important source of learning rather than an obstacle. To facilitate retention, both the rules or steps for a behaviour along with various strategies are provided (e.g. teaching general assertiveness skills in a variety of situations, such as refusal of various drugs, asking for help in stores, and asking for a date). Categories of ways to say no are outlined on a poster, and examples are discussed with the class.

Bain, Alan. (1992). An evaluation of the application of interactive video for teaching social problem-solving to early adolescents.

PREVENTION/INTERACTIVE VIDEO: Evaluates a six-lesson intervention designed to teach students (11 to 12 years old) social problem solving in three component elements: Setups, Actions, and Outcomes. Video narrators delivered instructional content with animation and screen prompts to the entire class. Students were selected at random to use a computer mouse to interact with the video.

EVALUATION: Effects of instruction were measured by achievement and attitude, whereas instructional processes were measured by duration, teacher and student questioning, student attention, and teacher encouragement.

OUTCOMES: Results showed that interactive video had a significant positive effect on student achievement. Students maintained higher levels of attention when video based models were used over non-video instruction. Duration was shorter in video versus non-video instruction. Attitudes were generally positive in all three groups.

PREVENTION: Process evaluation of **Project Towards No Drug Abuse** for high school students. Schools are assigned to one of three conditions: Control, Classroom only, and Classroom plus School as Community. Hypothesis is that community involvement may enhance school-based efforts through facilitating an alternative channel to promote pro-social attitude shifts, subjective "ownership" of the program ideals, successful experiences for high-risk youth in the community, and networks with more conventional social groups. The program identifies popular community events through a survey of students and staff. The events include job training, field trips, sports competition, other competitions, fundraising, recreational events at school, and environmental concerns. Students organize into groups under a staff adviser and engage in weekly meetings up to 8 months where they plan and compete in at least 6 events.

Sussman, Steve, Galaif, Elisha R., Newman, Traci, et al. (1997). Implementation and process evaluation of a student "School-As-Community" group: A component of a school-based drug abuse prevention program.

EVALUATION: Part 1: Tabulation of program implementation, rating of event receptivity across schools, and meeting and event process ratings. Part 2: School activity assessment measuring existence of drug abuse prevention activities, use of classroom courses or self-instruction packets, engagement in community-related activities at the school, and existence of ethnic-specific events.

OUTCOMES: Part 1: Favourable ratings given for productivity and enjoyment of meetings, productivity/and enjoyment of drug abuse focus, and anti-drug abuse helpfulness of events. Part 2: More project activities were reported in the school-as-community group than the control and classroom-only groups.

PREVENTION: Cities in Schools develops community partnerships that bring teams of caring adults from business, social agencies, foundations, and volunteer organizations into schools to serve young people at risk of dropping out of high school. They provide highly supportive learning experiences and lower the stress of social and emotional problems through academic guidance and social support measures.

Steinhauer, Paul D. (1998). Developing resiliency in children from disadvantaged populations.

OUTCOMES: Based on a 30-year old American model, the program claims it can lower dropout rates, increase graduation rates, and provide students with skills needed after graduation.

COMMUNITIES IN SCHOOLS (TEXAS): Stemming from the U.S. "Cities in Schools", this program is modelled on strong interagency collaboration and a multidisciplinary approach toward helping youth at risk. Services are tailored to each school site, but usually involve community youth services, state drug and alcohol prevention office, juvenile justice, city parks and recreation, state employment office, Big Brother/Big Sister, child guidance and crisis counselling agencies, tutoring and mentoring activities by local college and high school students, parenting enrichment and advocacy services, and information and referral.

Resnick, Gary., and Burt, Martha R. (1996). Youth at risk: Definitions and implications for service delivery.

Community-level Programs

WISCONSIN YOUTH FUTURES PROGRAM: The purpose of this program for 10 to 17 year olds is to build community capacity to support youth and families through the formation of coalitions comprising community leaders, and through the development of action plans for the prevention of specific youth problems. First, a community youth survey is conducted to identify risks and opportunities. Second, a series of five or six meetings are held to focus on the most critical issues and learn about the latest research in those areas. Third, a community resource assessment determines what gaps need to be filled, based on the identified issues. Finally, a comprehensive, multidimensional action plan is developed and implemented.

Bogenschneider, Karen. (1996). Family related prevention programs: An ecological risk/protective theory for building prevention programs, policies, and community capacity to support youth.

Outcomes: Resultant community actions include persuading city officials to deny liquor licenses to convenience stores; making community events alcohol free; securing parental involvement by having them commit to chaperoned alcohol-free parties; a parent teen drinking education program; creating county plans for more consistent consequences for underage drinking; older teen mentoring program; and first-time offender alternative measures program.

Gottlieb, Benjamin H. (1998). Strategies to promote the optimal development of Canada's youth.

Resnick, Gary., and Burt, Martha R. (1996). Youth at risk: Definitions and implications for service delivery.
Wallerstein, Nina. (1993). Empowerment and health: The theory and practice of community change.

PARTICIPATE AND LEARN SKILLS (PALS): A community based skills development program that initiated 40 sports and recreation programs for children in a public housing project in Ottawa. The program recognized that economically disadvantaged children and youth are not served or poorly served by mainstream recreational programs.Learned skills allowed youth to participate on equal footing in mainstream community programs in the larger community.

GARFIELD YOUTH SERVICES (Colorado): This program focuses on drug and alcohol prevention work by taking an inclusive and cooperative approach toward all youth, not just those "at risk". Stresses importance of developing a sense of community responsibility for "our" children and youth and encouraging citizen participation. Acts as a resource agency for schools, courts, and social services to approach for services.

PREVENTION: This substance abuse prevention program is based on Frierian community empowerment philosophy and methodology. Youths in middle/high school are recruited into the Alcohol and Substance Abuse Prevention (ASAP) program that uses an inductive questioning acronym, SHOWED (what do we See, what's really Happening, how does this relate to Our lives, Why is there a problem, how can we feel Empowered to change, what can we Do) to facilitate dialogue and action in their neighbourhoods.

Multi-level Programs

Gottlieb, Benjamin H. (1998). Strategies to promote the optimal development of Canada's youth.

The **Social Competence Promotion Program for Young Adolescents (SCPP-YA)** concentrates on skills for emotional and behavioural self-control, stress management, problem solving, decision making, and communication. The long-term goal is prevention of adolescent pregnancy, conduct disorders, aggressiveness, and juvenile delinquency. Teachers deliver the program through didactic instruction, class discussions, role playing, daily diaries, videotapes, worksheets, and homework assignments. Additional school and community activities are introduced to reinforce classroom teaching, and parents are enlisted as advocates and agents of reinforcement.

OUTCOMES: Youths receiving the program improved their problem-solving skills, developed more positive attitudes toward conflict resolution, and rated better on impulse control and sociability.

Positive Adolescent Choices Training (PACT) teaches social competence and communication skills, but with focus on violence prevention, particularly among African American youth. Serves youths 12 to 15 at high risk of violence by teaching social skills such as giving positive feedback, learning to receive negative feedback, and resisting peer pressure. Students partake in groups by role playing, behavioural practice, and observation of peer models. A parent training module has been developed that concentrates on anger management and provocation and is used in a group format.

EVALUATION: Target skills were learned correctly and fewer incidents of violence were reported among youths partaking in the program. Suspensions and expulsions were eliminated.

MAKING A DIFFERENCE (MAD): **for Youth: Adolescent Health Project** was launched by local mothers in response to difficulties facing teens in the community, especially suicide rates. An advisory committee made up of youths aged 14 to 19 surveyed 400 teens and helped to design and carry out an assessment of adolescent health needs. A report and video identified problems faced by teens, which were addressed through health promotion events, community forums, workshops, media presentations, a peer health education program, and several cooperative projects. A storefront was opened promoting the well-being of youth in the community, and plans for a café and health centre were underway.

Ontario Coalition for Children and Youth is a youth-led group that includes individual youth, youth-serving organizations, and youth coalitions. In one initiative, the management of a Toronto shopping mall addressed gang and drug problems by adapting the physical environment to discourage large groups from congregating and by employing youth workers to handle problems. A youth services bureau in the mall uses youth, parents, police, schools, and youth agencies. It offers culturally sensitive counselling, community support, and referral services, as well as alternative educational programs for youth.

PREVENTION: **Super II Early Intervention Demonstration Program** (Alabama) targets African-American inner city youth. Involves seven meetings with youth and their parents that focus on family communication, parenting skills, AOD use prevention, dealing with peer pressure, and refusal skills. Participation incentives include transportation, field trips, dinners and tickets to local basketball games.

Wodarski, John S. and Smyth, Nancy J. Adolescent substance abuse: A comprehensive approach to prevention intervention.

EVALUATION: Reduction in AOD use and related behaviour problems and increase in adolescent-parent communication.

Project STAR (Students Taught Awareness and Resistance) (Kansas): A community-based program using a school-based curriculum focusing on teaching resistance skills was extended to include parents, media, and community organizations.

ONTARIO YOUTH APPRENTICESHIP PROGRAM: Coordinates the transition to work with out-of-school cooperative job placements for the 60% of 16 year olds (grade 11) who do not plan on attending university. Apprenticeships begin with a 90 day unpaid cooperative education experience after which the employer decides whether to retain the student as a paid employee. Upon acceptance, the apprentice is committed to three or four years with the employer.

Anisef, Paul. (1998). Making the transition from school to employment.

EDUCATION AND WORK CONNECTIONS PROJECT: Through community-based partnerships, students are provided with cooperative education programs. Included in the program are eight two-year demonstration projects representing a variety of activities, a tabloid on careers distributed to students, service sessions, workshops, four-day training sessions for teachers and community partners, and an internet newsgroup to keep people connected.

A research project undertaken by Latino youths (7th to 8th grade) and professionals to investigate local youths' perceptions about drug and alcohol abuse in the context of their own lives.

Malekoff, Andrew. (1994). Action research: An approach to preventing substance abuse and promoting social competency.

A group of youths, in partnership with professionals, gathered information by surveying their contemporaries with a questionnaire they created. Based on the results, a community meeting was held to stimulate consciousness development among the adult and youth participants. First, a large group provided participants with an anonymous and non-threatening structure. Brief formal presentations were given to summarize the project and research findings. Second, small group discussions for both adults and youths were conducted. Third, the small groups reported their progress at a closing group session. Finally, open discussion within the large group led to consensus on the need to address issues of cultural pluralism and intergroup conflict.

OUTCOMES: The interaction and challenge to think critically improved social competency. Both short and long term outcomes occurred as a result of the action research and community meeting process. For example, a group of students formed the YOUTH OF CULTURE Drug-Free Club (Young, Original, Understanding, Truthful, Heritage, Open, Faithful, Caring, Useful, Loving, Trustworthy, Unique, Respectful, Educated).

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Small Group Discussion Questions on Gambling Affected Youth and Resiliency

DISCUSSION QUESTION 1

What do you see as the key risk factors for youth gambling in your community? (Consider five levels of risk factors: individual, family, peers, school, and community)

Risk Factors

INDIVIDUALS

The person has low self-esteem and a propensity to take risks.

The individual was exposed to gambling early in life.

There is a lack of self-control and addictive behaviour in areas other than gambling.

There is a lack of alternatives to gambling.

There is ready access to gambling.

- There is a lack of knowledge about gambling's risks and their impact.

The person has limited social, decision-making, financial and other coping skills.

The person has not experienced success in relationships, school, sports, etc.

The individual has a mental disorder(s).

There is cultural or peer pressure to gamble.

The person is male.

Personal beliefs and values view gambling as appropriate.

FAMILY

The family models inappropriate behaviour regarding gambling.

There is approval/support/non-interference of the youth's gambling activity.

- Gambling is seen by family members as an important recreational activity.
- The family has zero tolerance for any form of gambling (formal or informal).
- The youth's gambling difficulties are quickly resolved by the family.
- There is a lack of awareness among family members that gambling may be problematic for teens.
- Family members have low self-esteem.

  Parents are unemployed or underemployed.
- There is abuse and neglect by the parents in all facets of child-rearing.

PEERS

- The individual associates with peers who gamble.
- There is reinforcement from peers that gambling is "okay".
- A youth's need to belong encourages joining, or makes it difficult to break away from, a group with gambling patterns.
- Sports team membership or an interest in sports encourages competition, which in turn encourages betting.
- Gambling is seen by the individual as a tool to gain or hold within a peer group a certain status, special bond, or personal reputation.

SCHOOL

- There is a lack of school policies concerning gambling.
- Administrators/teachers lack the time or have little interest in dealing with youth gambling issues.
- The school culture sees or promotes gambling as a source of revenue.
- Administrators/teachers lack knowledge concerning the potential risks of youth and gambling.

  There is a lack of training and intervention skills among administrators/teachers.

There are mixed messages from teachers and students about the value and acceptance of gambling among young people.

- Teachers are not trained to recognize problem gambler symptoms.

COMMUNITY

There is active community promotion and endorsement of gambling as a legitimate activity.

- There is a lack of alternative activities in the community for youth.

The community has inconsistent regulations/laws or doesn't enforce regulations/laws.

- There is a lack of recognition that gambling may be problematic for teens.
- The community's economy depends on gambling revenue.
- Youth have easy access to many gambling opportunities within the community.

There is a lack of intervention services for youth problem gamblers.

The community is economically depressed or conversely, very affluent.

- The community supports gambling as a fundraising tool.

DISCUSSION QUESTION 2

What do you see as the key protective factors for youth gambling in your community? (Consider five levels of protective factors: individual, family, peer, school, and community)

Protective Factors

INDIVIDUALS

Traditional or religious values/attitudes held by the individual views gambling or excessive gambling as inappropriate.

The individual is mature, mentally healthy, has good social skills, is self-assured, and exhibits self-control over behaviour.

- The individual gets support from peers, family and others for their healthy behaviour towards gambling.
- The person has successful relationships and interests outside of gambling.
- The individual understands and is aware of gambling's risks.
- The person is female.
- The individual lacks access to gambling opportunities or has recreational alternatives.
- The person had an early, negative gambling experience.

FAMILY

- There is good communication between youth and parents.
- The family is close and has a healthy attitude towards gambling.
- The family is knowledgeable regarding gambling's risks.
- The family makes healthy lifestyle and financial management decisions.
- Family members are employed, are financially secure, and have strong morals, ethics, and values.
- There are defined rules and expectations for members of the household.
- There is adequate supervision of the children and their activities.

PEERS

- There is healthy role modeling by respected friends or classmates.
- Peers provide support for an individual's positive attitudes toward gambling.
- The individual's peer group is involved in alternative activities.

SCHOOL

- Administrators/teachers support healthy lifestyle choices among students.

Students have access to counsellors who can help them deal with gambling issues.

Teachers provide students with factual information about gambling and risks.

There is positive role modeling by teachers.

Administrators/teachers are aware of the risks of gambling to youth.

There are school policies concerning youth and gambling.

The school has links with community services regarding gambling.

The school has prevention and identification programs.

The school is considered a safe environment for discussing/ resolving gambling issues of concerning to youth.

COMMUNITY

There is a positive community attitude concerning youth and gambling.

There are regulations/laws regarding youth and gambling opportunities/access and these regulations/laws are strictly enforced.

The community recognizes and accepts it has a role to protect teens from gambling risks.

There is community involvement in resolving youth and problem gambling issues.

Multi-level partnerships exist in preventing and treating youth gambling problems.

The community is economically and socially stable.

Adequate and accessible community resources/alternative activities exist for youth.

section**three**

Perceptions of Youth Gambling

ABSTRACT OF PRESENTED PAPER

TITLE:

AADAC Youth Gambling Screen Description and Results of a Pilot Study

PRESENTED BY:

Harvey Smith, Ph.D. & Heather MacDonald, M.Sc.

A 1996 GAMBLING prevalence study suggested a high prevalence of at-risk and problem gambling among Alberta adolescents, yet admission statistics at the Alberta Alcohol and Drug Abuse Commission (AADAC) revealed that only a handful of youth sought gambling treatment that year and in subsequent years.

Two of AADAC's youth gambling initiatives are described that may explain this discrepancy: (a) a focus group study and (b) clinical experiences with youth gamblers. Participants in the focus group study include 11 groups of teens from the general population, "at-risk" teens, and teens in treatment for substance abuse, five groups of parents of these teens and two groups of key influencers.

The vast majority of participants did not perceive gambling to be an important issue among youth, yet most teens did report participating in gambling activities. Teens distinguished between age-restricted "gambling", such as video lottery terminals and bingo, and more common "betting" which included wagering on sports games and other events with unknown outcomes. Overall, participants felt that any programming efforts for youth gambling should be directed at prevention as opposed to treatment. The results of a pilot implementation of the AADAC Youth Gambling Screen to samples from school and treatment populations are also described.

Dr. Smith is Clinical Supervisor of AADAC Youth Services and Ms. MacDonald was the Research Officer with AADAC Service Monitoring & Research.

PRESENTED PAPER

AADAC Youth Gambling Screen Description and Results of a Pilot Study

Introduction

PART 1:
Results of focus group study of teens, parents, and other key influencers

AADAC commissioned a prevalence study of gambling and problem gambling among Alberta adolescents (Wynne et al., 1996). The results, based on a modified version of the SOGS-R, indicated that adolescents in Alberta are four times as likely as adults to develop gambling problems: 15% were classified as at-risk gamblers and 8% as problem gamblers.

The results of this study point to the need for gambling programming for adolescents. However, this need is not apparent in AADAC treatment centre statistics. Although 2,634 total client admissions for gambling problems in the 1997-98 fiscal year, only 32 of these were youth gambling admissions. In other words, although the prevalence study statistics suggest a much higher prevalence of gambling problems among youth than adults,AADAC is actually seeing a much higher number of adults than adolescents for gambling problems. (And in the same fiscal year, AADAC saw almost 3,000 total youth client admissions for all addictions, so it's not the case that AADAC isn't attracting youth clients overall.)

The small number of youth clients showing up for gambling treatment is troublesome, not only because there may be many youth gamblers who are not getting the help they need, but also because it hinders the development of programming for these youth. It's difficult to develop appropriate treatment or intervention plans without having a solid knowledge base of the clientele. Obviously, the development of treatment, prevention and intervention measures would be greatly facilitated by a better understanding of gambling issues as they relate to youth.

One possible explanation for the rather high prevalence rates of adolescent gambling is that the revised South Oaks Gambling Screen (SOGS-R; Abbott & Volberg, 1991), used in the 1996 prevalence study, may be overestimating the true prevalence of adolescent problem gambling

(Culleton, 1989; Dickerson, 1993).[1] As Randy stated yesterday, there is reason to believe that the SOGS tends to overestimate the number of pathological gamblers in adult general population samples, so the same could certainly be true of adolescent samples. If the 1996 prevalence estimates are inflated, this would help to explain why so few adolescents are seeking treatment for gambling problems. However, the extent of this supposed inflation is unknown.

[1] However, it has also been suggested that the prevalence rates measured by the SOGS (and other instruments) are underestimated, since the usual survey method, telephone interviewing, does not tend to capture treatment populations (Lesieur, 1994).

Meanwhile, we cannot discount the possibility that there are young problem gamblers out there who aren't getting the treatment and supports that they need.Therefore, it is important to identify the relevant issues such as who these kids are, how we can reach them, how we can make our services more accessible and relevant to them, and how we can prevent or reduce the likelihood of these problems from developing in the first place.

Today, Harvey and I will talk about two projects that AADAC has initiated to address concerns about youth gambling:

1. I will talk about a focus group study of teens, parents, and other key influencers, and this will make up the majority of the presentation today; and
2. Harvey will talk briefly about the development and pilot implementation of the AADAC Youth Gambling Screen.

Focus group study of perceptions of youth gambling

The major research questions addressed in the study were the following:

1. Why are youth with gambling problems not presenting for treatment?
2. How can treatment services be made more accessible to youth with gambling problems? Accessibility includes not only physical accessibility, such as knowledge of the treatment services and how and where to seek such services, but also social accessibility, that is, the sense that it is appropriate or acceptable or safe to seek treatment.
3. What gambling prevention and intervention measures would be most effective with youth?

Methodology

A total of 18 focus groups were conducted as follows:

	TEENS (12-17 YEARS OLD)	PARENTS	KEY INFLUENCERS	TOTAL
General Population	4 groups	2 groups	—	6 groups
At-risk	5 groups	2 groups	—	7 groups
Treatment	2 groups	1 group	—	3 groups
Youth service		—	2 groups	2 groups
TOTAL	**11 groups**	**5 groups**	**2 groups**	**18 groups**

We included a diverse selection of groups in our focus testing. This was done in hopes of capturing a broad range of opinions and perspectives. For instance, we made an effort to include segments of the population that we expected might have been exposed to considerable levels of gambling, such as the at-risk and substance abuse treatment segments. We also included groups of parents and other key influencers in addition to the teen groups. Finally, we chose three geographical locations for the focus groups. Calgary and Edmonton were chosen as the southern and central urban locations, respectively. Grande Prairie was selected to represent a northern location as well as a rural location, defined for the purposes of this study as a community with less than 35,000 residents.

For the general population category, participants were recruited by the contractor using a random digit dialling procedure. For the at-risk category, participants were recruited with the assistance of AADAC representatives. These AADAC representatives consulted with individuals who work with teens they identified as "at-risk" for social or behavioural problems. The names and telephone numbers of at-risk teens and their parents who agreed to participate were provided to the contractor for recruitment purposes.

AADAC representatives recruited the teen treatment and parent treatment sessions in consultation with the contractor. AADAC also provided the contractor with a recruitment list for the key influencer groups. Key influencers were defined as adults who work closely with youth, who can

influence the attitudes and behaviours of youth, and who potentially could refer youth for help with a gambling problem or other addictions problem. These include teachers, school counselors, youth workers at Social Services, and others. The lists of these individuals were prepared based on AADAC's knowledge of their interaction with teens and teen programs.

All teen participants were asked to complete both the AADAC Youth Gambling Screen and selected items from the SOGS-R Gambling Questionnaire upon completion of the discussion session.

Results

Before I discuss what we learned from the focus testing, I would like to point out that most of the findings presented here are qualitative in nature: they reflect the opinions that were expressed only by selected participants who attended the focus groups, and those that were selected and described by the contractor, who prepared the report. So please keep in mind that although consistencies and logic lend confidence to the analysis and interpretations, there is no way of determining how representative the reported findings are of the study population at large.

Also, I will be reporting some quantitative results from teens' responses to the AYGS and selected SOGS-R items, but they will be reported only when they specifically relate to the qualitative results. Because of the small size and unrepresentative nature of the focus groups, these quantitative results also cannot be generalized to the population at large.

RESEARCH QUESTION 1

Why are youth with gambling problems not presenting for treatment?

We first wanted to examine why we are not seeing many youth problem gamblers. We conceptualized our specific research questions as follows:

(a) How are gambling and problem gambling perceived and defined by youth and their key influencers? Is gambling perceived to be a social problem? Is problem gambling or even gambling perceived to be a reality among youth? Is gambling perceived to be socially acceptable?

(b) How do perceptions of gambling differ from those of alcohol use and other drug use?

(c) How do perceptions of youth gambling differ from those of adult gambling?

(d) How aware are youth and their key influencers of the available resources for obtaining help with gambling problems? Who would they turn to for help if they thought they had a gambling problem?

(e) What supports do parents, teachers, and other key influencers need in order to identify gambling problems in youth or connect youth to treatment?

PERCEPTION OF TEEN GAMBLING AS A SOCIAL PROBLEM

Participants' first task in the focus testing was to describe what issues teens currently face. Some common themes emerged, such as the importance of image, peer acceptance, school, and plans for the future, but none of the participants spontaneously mentioned gambling. When specifically asked about gambling, virtually all participants commented that gambling is not an issue or a problem among teens.

For teens, this was true of both their verbal feedback during the focus group discussions and their questionnaire responses regarding their own gambling. Parents and key influencers also did not perceive gambling to be a teen issue, with the exception of two key influencers who reported problematic levels of gambling among certain youth they knew.

DEFINITIONS OF GAMBLING

All focus group participants were asked to describe in their own words what they perceived "gambling" to be, including what they considered gambling activities to entail. Their definitions of gambling included the following characteristics:

- Risk-taking.
- Risking money on an unknown outcome.

  Uncertainty.
- Trying to get more money.
- Wasting money.

  Something for nothing.
- Taking chances.

When asked to describe what gambling activities are, many participants first mentioned gambling activities that are clearly age-restricted, such as playing VLTs (video lottery terminals), casino games, bingo and purchasing lottery tickets such as scratch-and-win tickets. Scratch tickets, however, were considered much more acceptable and much less harmful than the other forms of age-sanctioned gambling activities.

- Betting
- Bingo
- Black Jack
- Cards
- Casinos
- Craps
- Horse races
- Internet
- Keno
- Lottery tickets, 6/49
- Nevada
- Poker
- Pool / snooker / billiards
- Raffles / 50/50 tickets
- Roulette
- Scratch and win tickets
- Slot machines
- Sports pools
- VLTs
- Cards against the wall

Upon further reflection, participants, especially teens, also perceived a second type of gambling: betting activities. The term "betting" was commonly used to describe gambling activities that are not age-restricted; specifically, participants described betting as wagers on events of unknown outcome, such as card games, sports games, sports pools, or impromptu events. Another perceived characteristic of betting was that the gambling participants themselves decide upon the nature of the wager (the amount, and whether to bet money or material goods).

Adult participants (parents and key influencers) made the same distinction between the two types of gambling as did teens. However, parents and key influencers did not spontaneously describe "betting" behaviours to as great an extent as did teen participants.

Teen Participation in Gambling Activities

Most participants commented that youth rarely think about or participate in gambling activities. Some teen participants, particularly those within the at-risk or treatment categories, did report gambling but considered this to be atypical teen behaviour. Parents and, to a lesser extent, key influencers were less likely than teens to perceive that youth come face to face with gambling activities.

Nonetheless, other comments revealed that teen gambling might not be as uncommon as originally claimed. For example, many adults reported that it is not uncommon for teens to buy lottery tickets or to bet. Similarly, many teens who stated that they didn't gamble did report buying scratch tickets or betting on certain things. In addition, teens' responses to the short gambling questionnaires revealed that more than 80% of teen participants reported doing at least one of the listed gambling activities in the previous 6 months.

The questionnaire results also indicated that 70% of teen participants gambled once a week or less, whereas 25% reported gambling twice or more per week. So although for most participants, gambling does appear to be an infrequent activity, one in four participants bet or gambled at least a couple of times per week.

What can account for these contradictory findings-that participants reported that gambling is not a common teen activity, yet also reported that many teens buy scratch tickets or bet? One possibility is that when participants initially noted that gambling isn't an important issue or even a common activity among teens, they were considering age-restricted gambling activities, but not "betting activities," in their characterizations. This distinction between betting and other forms of gambling also underscores the importance of using terminology that is understandable or relevant to youth when developing treatment or prevention materials.

SOCIAL ACCEPTABILITY OF TEEN GAMBLING

When asked about the social acceptability of gambling, both teen and adult participants stated that gambling activity "done in moderation" is socially acceptable. Participants mentioned the following as factors determining the acceptability of gambling:

The amount of money spent (how much you spend)

What you're betting on.

Where the money is coming from.

How often you gamble.

Whether you set and abide by money limits or time limits.

Whether it is interfering with basic needs or responsibilities.

Whether it is affecting your life or the lives of others around you.

Some teen participants, particularly those in the at-risk category, did not feel that any form of gambling is socially acceptable, due to their direct or indirect contact with others' problem gambling activities.

In terms of the social acceptability of teen gambling specifically, some teens and adults stated that even for teens, gambling done in moderation is acceptable and even "part of growing up." On the other hand, some teens and most adults did not feel that teens should be introduced to gambling activities during what they referred to as their developmental stage in life. Both teens and adults believed that it is unacceptable for teens to gamble in age-restricted locations.

COMPARISON OF GAMBLING TO ALCOHOL/DRUG USE

In contrast to gambling, alcohol and other drug use were spontaneously mentioned as issues currently facing teens in almost all focus group sessions. Alcohol and other drug use were clearly perceived by participants to be common and even mainstream among some teens. Almost all teen participants stated that they have either personally used, or know of other teens using, alcohol or other drugs. Similarly, parents and key influencers perceived this type of activity to be common among teens.

Both teen and adult participants noted the following differences between gambling and alcohol and other drug use:

Impact of gambling psychological, not physical.

Gambling not as visible.

Differ in level of social acceptability (although, as you'll see in a moment, there was not consensus in exactly how they differ).

Enforcement of legal restrictions for gambling appears to be stronger than the enforcement for alcohol.

- Gambling (unlike alcohol or other drug use) can be done anywhere, anytime on anything.
- Can gamble on the Internet.
- Awareness of problem gambling symptoms is less prominent in society.
- Easier to conceal when someone has been gambling (than when someone has been using alcohol or other drugs), i.e., you can't "smell" gambling.

  Can possibly benefit others via charitable gambling activities.
- Gambling more glamorous.
- Consequences not as serious for gambling.

With regard to similarities between gambling and alcohol and other drug use, teens and adults again provided similar descriptions, which tended to focus on the potential consequences of these behaviours. Noted similarities included:

- All can lead to addictions.
- All include a loss of money.

  All can lead to loss of family, friends and material items.
- All offer treatment for problems or addictions associated with the behaviours.
- All become routine.
- All can lead to crime.

  All are illegal for teens to do.
- Individuals are not in control of outcomes when participating in these activities.
- All include taking risks.
- All can be an escape from reality.

When asked about the social acceptability of teen gambling compared to alcohol or drug use, participants' responses were mixed. Gambling was perceived by many participants to be less socially acceptable than alcohol

use, but more acceptable than other drug use. Commonly, teen and adult participants acknowledged that most teens will experiment with alcohol at some point before reaching the legal age of 18 years. In this light, most teens and adults accepted that this is typical and thus, somewhat acceptable teen behaviour, regardless of the legalities surrounding the behaviour.

With regard to gambling, most teen and adult participants did not perceive this type of teen behaviour to be prevalent and, therefore, not as "typical" as teens who may experiment with alcohol. To this end, teen gambling was perceived by many participants to be less acceptable than teen alcohol use based on what they observe to be common and less common practice.

However, certain teen and adult participants believed that teen gambling is in fact more socially acceptable than teen alcohol or other drug use because they feel that the physical effects of teen gambling are much less harmful than the effects of alcohol or other drug use. Further, certain participants felt that teen gambling is fairly acceptable because certain teen gambling activities are part of family activities.

Teen drug use was clearly noted by all participants to be the least acceptable teen behaviour in comparison to gambling or alcohol use. Participants noted that drug use is illegal, regardless of the age of the individual.

TEEN VS. ADULT PARTICIPATION IN GAMBLING/ COMPARISON OF TEEN TO ADULT GAMBLING

We also asked participants about differences between teen and adult gambling. The most commonly reported differences were legal access, the amount of disposable income, and the potential consequences following a gambling loss.

All participants reported that teens could not legally access gambling activities taking place in age-restricted locations such as casinos, bars and bingo halls. Further, teen and adult participants indicated that teens could not legally purchase lottery and scratch tickets until the age of 18, although many teens still manage to gain access to this form of gambling either on their own or with the help of an adult.

Both teen and adult participants explained that teens do not have the same amount of disposable income as do adults. Both teens and adults mentioned that adults could potentially lose their life savings, home, vehicle or job as a result of a gambling loss. As teens generally have not built the same level of assets as have adults, participants felt that the consequences can be much greater for an adult than for a teen. In fact, although most participants believed that the majority of adults gamble moderately and infrequently, several participants also perceived that certain adults in their respective communities gamble much more frequently, some at a problematic level. This observation of problem gambling in adults was not noted in teens (with the exception of the two key influencers mentioned earlier).

PERCEPTIONS OF TEEN RESOURCES FOR PROBLEM GAMBLING

Most teens told us that if they had a gambling problem, they would first turn to a trusted friend. Very few teen participants indicated that they would first discuss this issue with their parents. Many parent and key influencer participants, on the other hand, believed that teens would first turn to trusted adults. Mentions of individuals associated with organizations treating problem gambling did not spontaneously surface at this point in the discussion.

After additional probing, participants mentioned that school counsellors, parents, parents of friends, clergy, or organizations such as AADAC or Gamblers Anonymous could also help with a gambling problem. Telephone help lines for teens were also mentioned by a few participants.

These results suggest that if there are a number of teen problem gamblers in Alberta who are not getting treatment, it is not because of a lack of knowledge about available resources. However, it would appear that the first point of contact is likely to be another teen. Perhaps, then, efforts to implement peer education programs or school curriculum on youth gambling would be a useful strategy for treatment as well as for prevention and intervention.

SUPPORTS THAT KEY INFLUENCERS NEED TO IDENTIFY TEEN GAMBLING PROBLEMS OR CONNECT THEM TO TREATMENT

We asked parents and key influencers to indicate what they felt they needed in order to identify problem gambling in teens and connect teens to treatment.

Parent participants felt informed about teen alcohol and other drug use but not about teen problem gambling. They stated that they would first and foremost need to know what "problem gambling" is, including the signs or symptoms to look for in identifying this problem in teens. To this end, some parents believed that a screening test would be useful in evaluating the degree of gambling behaviour taking place with a teen in question for problem gambling. In addition, parents mentioned that knowing where a teen can go to seek treatment for gambling problems would be useful, along with some educational materials regarding the problem and treatment options.

Key influencer participants noted that school or workplace resources would be useful for connecting a teen to treatment for problem gambling. These could include videos, posters, brochures or curriculum packages. Most key influencers have not received any formal training on the prevalence of teen gambling or how to deal with the issue.

Therefore, key influencer participants also wanted to know how to identify problem gambling among teens, such as through a screening tool, and where to refer teens for help. Key influencers were more concerned than parents in being able to explain to a teen what will take place at a treatment centre for problem gambling.

RESEARCH QUESTION 2

How can treatment services be made more accessible to youth with gambling problems?

Some of the more specific research questions we addressed were:

(a) What barriers to treatment exist for youth with gambling problems?

(b) What measures can be taken to increase treatment-seeking behaviour among gambling youth? What would make treatment more appealing or acceptable to youth with gambling problems?

(c) What would an appropriate service point look like? (What would an ideal treatment centre look like?)

Participants were asked to identify barriers to seeking gambling treatment as well as ways of making treatment more accessible. Because their responses to both questions are closely related, I'll discuss barriers to treatment in the context of their suggestions for making treatment services more accessible.

Participants noted that organizations that offer gambling treatment services for youth need to (1) raise awareness about teen problem gambling and their treatment services. Many participants mentioned the issue of social acceptance as one potential barrier to seeking treatment for gambling problems. Most participants held the view that very few teens are prone to or have a problem with gambling. Given this belief that teen problem gambling is not perceived to be prevalent, participants (especially adults) felt that it also is not commonly accepted as a teen problem behaviour. Raising public awareness of the issue might help to reduce this barrier.

One suggested method of raising awareness was to advertise in popular teen settings such as subways, movie theatres, arcades and rock concerts. Another was to provide educational resources that describe signs and symptoms of problem gambling or the treatment services themselves. (And you'll recall that this was also identified by parents and key influencers as a means of helping them connect appropriate teens to treatment.) Some suggested including information pamphlets on youth gambling in the mail-outs sent by schools throughout the year.

Participants emphasized that (2) treatment strategies should appeal directly to teens. In particular, participants felt that teen treatment should be separate from any programs or services for adults. They also felt that communications must be directed at teens, not adults, and should be memorable (salient), trendy and non-threatening.

Participants felt that it is essential to (3) explain the treatment that may occur when seeking help for a gambling problem. They noted that explanations of treatment, including confidentiality policies and fee structures, could eliminate potential fears in seeking treatment.

Finally, participants noted the importance of (4) making treatment services physically accessible to teens. For example, they noted that a discreet location, location on direct bus routes, appropriate hours of operation, and short or no waiting lists would facilitate treatment attendance. Some even felt that the organizations offering treatment should provide free transportation to those who cannot easily access the treatment facility or afford transportation.

IDEAL TREATMENT CENTRE FOR TEEN PROBLEM GAMBLING

Teen and adult participants provided similar descriptions of what they felt would be the ideal treatment centre for teens having gambling problems. The suggested characteristics included:

> Many activities and resources geared to teens, a characteristic that was particularly important to teen participants who reported that they would need to have their time filled with productive activities during treatment. Resources could include a gymnasium, board games, a music room (i.e. instruments provided for "jam" sessions) or reading lounges.

- The facility should be designated for teens only, separated from any adult facility.

> Spacious, colourful, comfortable, and alive with music, as opposed to "hospital quiet".

> Young counsellors who are perceived to be able to better relate to a teen audience, noted more often among teen participants. Some parent participants mentioned that they would not place a high level of trust in a facility staffed only by young counsellors, noting

that they felt that young people do not have the experience necessary to assist youth with problems.

Counselling staff or regularly scheduled speakers who have had gambling problems in the past to provide testimonials. Some parent participants disagreed with this approach, noting that they could never be assured that the individual has reached full recovery.

- Confidential, non-judgemental treatment approach, noted most commonly by teen participants.
- Options for one-on-one or group counselling.
- Accessibility to public transportation.

Discreet location (not obvious to others in the community as to who is walking in and out of the facility's doors).

Open to teens for treatment and non-treatment purposes (i.e., recreation and/or counselling). One participant noted that the reason a drug and alcohol education program she coordinates is successful might be because teens are not required to state that they have a problem. Some participants believed that teens may be unaware that they have a problem, have a fear of admitting that they have a problem, or may fear how others would react knowing they had a problem, thus creating a barrier to seeking treatment. By making treatment centres open to all teens, there might be a greater likelihood of capturing pre-contemplaters and contemplaters.

RESEARCH QUESTION 3

What gambling prevention and intervention measures would be most effective with youth?

Participants were asked indirectly about prevention and intervention strategies through the following research questions:

(a) Why do youth gamble?

(b) What distinguishes those youth who gamble or develop gambling problems from those who do not?

(c) How do the gambling attitudes and behaviours of people around youth affect youth themselves?

MOTIVATIONS BEHIND GAMBLING BEHAVIOURS

All participants were asked to express their perceptions of why teens gamble. Participants thought that teens gamble for the following reasons:

- For fun/as a recreational activity

  Curiosity

- Rush or thrill

- To gain more money (perhaps to support other behaviours such as alcohol or other drug use)

  Peer/collateral influence

  Societal influence-it's glamourous, cool

All participants were also asked why they thought adults gamble. Reasons they offered were somewhat different from those offered for teens, and included:

Social interaction

To escape from reality/as a diversion

Dream of being rich

Because many participants perceived gambling problems to exist in adults (but not in teens), participants were also asked what they thought adult problem gamblers were like as teens. A few, particularly key influencers, felt that adult problem gamblers likely did not have a strong support network when they were teens, and likely were not involved in many extracurricular activities. Some felt that they were probably loners or social outcasts.A couple of participants also noted that many adults did not develop gambling problems until VLTs were introduced.

IMAGES OF NON-RECREATIONAL AND PROBLEM GAMBLER

As an exercise to better understand what distinguishes those gamblers who develop problems from those who do not, all participants were presented with an array of 200 descriptive words and phrases that were spread out in the focus group working rooms in clear view. Each participant was asked to choose words or phrases that best depicted their perceptions of a teen problem gambler and a teen recreational gambler. Participants were also informed that they could use their own descriptive

words or phrases apart from those displayed in the room. Participants generated their own words and phrases in describing a teen non-gambler.

Teen and adult participants shared the image that a teen problem gambler has an "obsession," is "damaging" or "destroying" himself/herself or others, or is "hurting" from the gambling or other problem in their life. Teen participants were more likely to view a teen problem gambler as a "victim" who is "about to explode", or as someone who views gambling as a "challenge" that teen participants believe will "run you" in the end. Adult participants are more likely to view a teen problem gambler as someone who is "blinded" by their actions and perhaps "disguising" their "fear" through their gambling activities.

TEENS	ADULTS
■ Obsession — 11 mentions	■ Confused — 4 mentions
■ Damaged/damaging — 10 mentions	■ Run you — 4 mentions
■ Hurting — 8 mentions	■ Destruction/destroy — 7 mentions
■ Victim — 7 mentions	Obsession — 6 mentions
■ Destruction/destroy — 6 mentions	Damaged/damaging — 5 mentions
■ About to explode — 5 mentions	■ Hurting — 4 mentions
■ Challenge — 5 mentions	■ Blinded — 3 mentions
■ Distress — 4 mentions	■ Fear — 3 mentions
■ Ignores — 4 mentions	■ Disguising — 3 mentions
Dummy — 4 mentions	■ Confused — 3 mentions

Teen and adult participants alike described a teen recreational gambler as someone who is "fun" or "social." Participants believed that a recreational gambler is "safe" from gambling addiction and is "responsible" enough to know when to stop.

Teen participants were more likely to believe that a teen recreational gambler is "stable" in their behaviours, "worry-free" from any problems in their life, has a "healthy" mindset and outlook towards gambling activities and is "aware" of the potential consequences of gambling and of when to stop.

Adult participants were more likely to depict a teen recreational gambler as someone who is participating in gambling activities out of "interest" or for "interaction" with others and who is "strong" enough to stop gambling.

TEENS	ADULTS
■ Fun — 9 mentions	Social — 7 mentions
■ Safe — 7 mentions	■ Fun — 7 mentions
Stable — 6 mentions	■ Interesting/interest — 6 mentions
■ Social — 6 mentions	Responsible — 5 mentions
Worry-free — 6 mentions	Strength/strong — 4 mentions
Responsible — 5 mentions	Interactive — 4 mentions
■ Aware — 5 mentions	Safe — 4 mentions
Healthy — 5 mentions	

In describing the image of a teen non-gambler, participants' responses were mixed. Participants were most likely to use words or phrases denoting a positive image; however, some, particularly the adult participants, also used descriptions that were meant in a more neutral and even negative sense. The most common image presented by both teen and adult participants was that a teen non-gambler is smart or smarter than other teens. The table below portrays the most common positive, neutral and negative descriptions provided by all participants.

POSITIVE CONNOTATIONS	NEUTRAL CONNOTATIONS	NEGATIVE CONNOTATIONS
Smart/smarter	■ Anti-gambling	Frugal, cheap, broke
■ Happy	■ Recovered	■ Religious
Responsible, reliable	■ Middle-class	■ Boring
Balanced, worry-free, stable	■ Not willing to suffer potential consequences	■ Anti-social
Safe	Doesn't have money	Sheltered, naive
■ Healthy, strong	Doesn't like it	■ Nerd
Good, nice, pleasant	Non risk-taker	■ Pathetic
Aware	Never had the opportunity	■ No fun
Better things to do with money	Doesn't care what others say	■ Stuffy
In control, secure, confident		Biased
Conservative		Fearful of losing
Has a solid belief system		Straight, square
■ Tough/clear-minded		Scared
Success		■ Loner
■ Has higher priorities		No one to gamble with
Has positive influences		
■ Empathetic to others		
Problem-solver		
Independent, free		
Family-oriented		
Not interested		

PERCEPTIONS OF THE INFLUENCE OF OTHERS' ATTITUDES AND BEHAVIOURS ON TEENS

Adult participants tended to be more vocal on this discussion topic than teens. Most adult participants commented that family gambling are the greatest influence upon teens' gambling attitudes and behaviours, by making the activities acceptable. Most teens concurred with this, although others mentioned family members or family friends who have found themselves in dire financial circumstances due to gambling losses, and as a result these teens had very negative views toward gambling.

Participants from the rural site perceived family bingo activities to have a substantial impact on teens' gambling attitudes and behaviours, as family bingo participation in this area is very prevalent, acceptable, and typical.

SPONTANEOUS FEEDBACK REGARDING PREVENTION AND INTERVENTION STRATEGIES

In addition to responding to these questions, several common themes relevant to prevention and intervention strategies evolved in the focus groups on an unprompted basis.

Throughout the focus group discussions, participants stated that problem gambling among teens is a non-issue. However, in the majority of groups, it was noted that problem gambling among adults is very real, and in light of this the potential for teens to develop gambling problems exists.

Participants (particularly adults) in several focus groups suggested educating youth as early as elementary school age about gambling and its potential effects. These years are seen as formative years during which youth are still very impressionable and malleable in their values, attitudes and behaviour patterns.

Several participants felt that this prevention or intervention focus should be repeated on teens approaching the age of 18, as this marks a time when youth suddenly have access to another tier of gambling not previously available (or not easily available) to them.

Finally, participants noted that prevention efforts should not be limited to teens themselves. To be effective, they must focus on parents, other key influencers and the general public as well.

SUMMARY

By and large, participants did not perceive problem gambling to be a reality among youth. Problem gambling was viewed as an adult concern, not a teen concern, partly because adults have easier access to gambling, more disposable income, and greater potential for serious negative consequences. Most participants were able to come up with potential sources of help if a teen had a gambling problem. However, several factors may preclude youth and their key influencers from recognizing potential gambling problems or from seeking information or treatment services, including:

- The social acceptance of gambling

  The distinction between betting and gambling

  Teens' and key influencers' lack of in-depth knowledge about gambling and gambling services, and

- Physical access barriers.

Furthermore, participants noted that the potential for youth to develop the gambling problems observed in some adults underscores the value of prevention and education efforts, particularly at elementary school age and at legal gambling age. In conclusion, the results of this study suggest several areas of research that would further our understanding of and ability to help youth gamblers, including:

  Validation of existing prevalence instruments for youth problem gambling or development of new instruments

- Research comparing betting activities to other gambling activities: characteristics, preferences, problem potential, developmental trends

  Developmental research that examines, for example, the transition that youth undergo when they gain legal access to regulated gambling activities; and

  The development and validation of youth gambling screening tools for clinical use. Although a few such screening instruments have been developed, such as the MAGS and the SOGS-RA, AADAC has also developed a screening tool, called the AADAC Youth Gambling Screen or AYGS, and will now be described by Harvey Smith.

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PART 2:
AADAC Youth Gambling Screen

Background

The Alberta Alcohol and Drug Abuse Commission (AADAC) completed a study of gambling behaviour and problem gambling among Alberta adolescents aged 12 to 17 in June 1996. (Adolescent Gambling and Problem Gambling in Alberta, Wynne Resources Ltd.). This province-wide study found that among adolescents surveyed, 33% did not gamble, and 67% were gamblers. Among adolescents surveyed, 44% scored as non-gamblers, 15% as at-risk gamblers, and 8% as problem gamblers. Compared with adult Albertans, adolescents in the study were four times more likely to be at risk and experience problems with their gambling. These findings are consistent with other studies where it has been found that adolescent problem gambling rates tend to be one and one half to four times higher than adult rates. While this research indicates that adolescents are experiencing problems related to their gambling behaviours, very few adolescents are presenting for treatment, or are being identified in the community as needing intervention. Therefore, this research raised several questions requiring further exploration.

Youth gambling continues to draw attention from educators and other youth professionals in Alberta and elsewhere. There is clearly a need to learn more about the dynamics of adolescent gambling behaviour and problem gambling behaviour so that effective prevention and intervention strategies can be developed. In order to address the anticipated demand for prevention and treatment services in this area, several investigative projects have been initiated by the AADAC Internal Advisory Committee. One of these projects was the development of a gambling screen for youth. The development of a youth gambling screen was initiated to help professionals to identify young people who were likely to have gambling problems, in both clinical and community settings.

The Youth Gambling screen is not meant to be a comprehensive assessment or diagnostic tool, or to form the sole basis for treatment planning. It is intended to be an initial screening tool to help identify youth who may need to be referred for further assessment. It is also a means of collecting additional information about youth gambling that would assist in developing program strategies to address gambling problems among youth.

The content and design of the Youth Gambling Screen was developed by an AADAC committee, with input from field services, research services,

and focus groups of youth. An initial version of the Gambling Screen was evaluated by a pilot project completed in 1998. With revisions, it was approved for implementation and further evaluation commencing early 1999. Concurrent with this period of implementation, AADAC service Monitoring and Research is conducting a statistical validation study of the Gambling Screen.

This report includes a description of the AADAC Youth Gambling Screen, and a report on the results of the pilot study. The pilot study included a review of the adolescents' responses to the items on the instrument, a summary of counsellors' experience administering it, and recommendations regarding its use and further evaluation.

The AADAC youth gambling screen

The purpose of screening is to determine whether sufficient evidence of a problem exists to warrant further assessment, or to warrant referral to a more specialized service for further assessment. Compared to screening, assessment gathers a greater amount of information, in order to understand the client's situation more fully, and to make treatment recommendations.

Screening for problem gambling generally examines two aspects of gambling behaviour. One aspect is whether the frequency of the gambling can be considered excessive. The second aspect is whether there are significant negative consequences of gambling, either evident to the client, or evident to others who are closely associated with the client. These two aspects of gambling behaviour are incorporated into the AADAC Youth Gambling Screen.

Screening instruments are generally designed to ensure that almost all the cases that have the problem in question are identified, even if some "questionable" cases that may not have the problem are also identified. In these "questionable" cases, the need for further intervention may be ruled out after additional, more detailed information is gathered (for example, during a subsequent interview or other assessment method). These cases which are later ruled out are called "false positives" in the screening decision.

In the process of screening, the desire not to miss any true cases ("false negatives") must always be balanced by the potential inefficiency of

identifying too many "false positives". A statistical validation study of a screening instrument is usually performed in order to determine what level of confidence we can have that decisions made using the instrument will be accurate or valid.

Important decisions will be made based on the information reported on the Gambling Screen. In order for the Gambling Screen to be a valid decision-making and information gathering instrument, care should always be taken to ensure that it is administered in a consistent, standardized manner, and under circumstances which will encourage honesty. A user's guide was provided with the implementation version of the Gambling Screen, which gave instructions relating to client comfort and engagement, and instructions for a standardized administration procedure and scoring.

Items for the gambling Screen were drafted by an AADAC Internal Advisory Committee, with input from adolescent service delivery units, research services, and youth focus groups. The intent was to have content and wording which reflected the experience and context of adolescence, rather than being overly tied to adult diagnostic criteria for pathological gambling (e.g. DSM IV). For this reason, it was also decided to ask the youth to respond according to their experience of the previous six months, rather than the typical 12 months found in adult instruments.

The latest version of the Youth Gambling Screen consists of 10 items, and is included at the end of this report. Item 1 asks the youth to indicate what gambling activities they have engaged in, from a list of eight activities. Item 2 inquires about the overall frequency of gambling activities. This item was added after the pilot, and therefore no results on this questions are available from the pilot study. Items 3 to 8 are indicators of negative consequences and expressed concern. Items 9 and 10 ask about exposure to peer and family gambling, as potential environmental risk indicators.

The pilot study

PROCEDURE

From October to December, 1997, AADAC Youth Services in Calgary conducted a pilot study of the initial version of the Youth Gambling Screen. A copy of current Gambling Screen, which has minor revisions from the pilot version, is included with this paper. During the pilot study,

52 Gambling Screens were administered to youth referred for substance abuse problems (approximately 60% male, 40% female).

This at-risk sample was composed of 41 AADAC clients and 11 Sr. High students who had been referred to a "Futures" group, which is an in-school intervention group for youth identified with substance abuse issues. In addition, 62 Gambling Screens were administered to an unselected sample of Junior High School students (approximately 30 % male, 70 % female).

The gambling screen was administered to the AADAC clients either individually on their first appointment, or in small groups to those attending an information series. It was administered in a small group setting to the "Futures" group, and in a large group setting to the Junior High students.

PREVALENCE OF GAMBLING AND BETTING ACTIVITIES

Table 1 displays the distribution of different types of gambling activities reported by the overall sample, that is, the total number of activities endorsed in item 1, out of a possible eight different activities. There were no statistical difference in responses between the "at-risk" (referred) youth, and the general school sample.

Table 1 | Number of different gambling items endorsed by youth in the study

NUMBER OF ACTIVITIES ENDORSED, (OUT OF POSSIBLE 8)	PERCENT OF YOUTH (N = 114)	CUMULATIVE PERCENT
6	3 %	3 %
5	6 %	9 %
4	8 %	17 %
3	11 %	28 %
2	21 %	49 %
1	27 %	75 %
0	25 %	100 %

The data suggested that a greater percentage of the school youth (81 %), compared to those identified with substance abuse issues (69%), report one or more gambling activities, however this was not a statistically significant difference, given the small sample, the variability of responses within each group, and the relatively low overall number of adolescents

reporting multiple activities. Overall, 75 % of the youth reported engaging in one or more gambling activity in the previous six months. The third column of the table displays cumulative percent, and indicates that 49 % reported two or more different activities, 28 % reported three or more different activities, and so on.

Table 2 displays the overall reported prevalence of the different gambling activities listed in question 1. The highest rates (30 % — 37 %) are for activities which are associated with peer social interaction, and "scratch tickets". Other activities cluster at about 20 %, with the exception of slot machines (8 %), which may reflect limited access due to age.

Table 2 | Overall endorsements of each gambling activity in Question 1 (n = 114)

ACTIVITY	PERCENT ENDORSED
Played cards for money	31 %
Played other games of skill for money	36 %
Bet on sporting events	19 %
Bought lottery tickets	19 %
Played slot machines	8 %
Played "pull-tab" or "scratch" tickets	29 %
Played bingo for money	18 %
Played arcade or video games for money, or other	18 %

PROBLEMS AND CONCERNS RELATED TO GAMBLING

There were no statistically significant differences in the responses patterns between the "at-risk" sample and the general school sample. Item 3 inquires about money and time lost to gambling, and item 4 asks about gambling as a main entertainment activity. These items were endorsed by 12 % and 11 % of the youth, respectively. Nine percent of the youth acknowledged that gambling or betting created some degree of problem for them, while six percent endorsed being concerned about their gambling in the past six months. Four percent acknowledged missing school or other important activities to gamble. Table 3 presents the distribution of responses to questions 3 through 10, for the combined sample of 114 youth.

Responses to items related to negative consequences of gambling or expressions of concern about gambling are of particular importance in

making decisions about screening a youth for further assessment. Table 4 displays the number of youth who responded positively to one or more of items 3 through 8. Twenty-three percent of youth endorsed one or more of these items. Therefore, if a criterion for screening were set at one or more endorsed items, then 23 % would have been screened positive for further assessment. If the criterion were set at two or more positive endorsements, then 13 % would have been screened positive. A criteria of three or more positive items would screen 4.5 %.

EXPOSURE TO PEER AND FAMILY GAMBLING

Items 9 and 10 relate to prevalence of gambling activities in the youth's peer and family systems. In the version of the Gambling Screen used in the pilot study, these questions merely asked whether peers or family gambled "a lot". These items were later revised to the current form, which is included at the end of this paper. In the revised version, the youth is asked to assess whether friends or family members gamble "less than" they do, "more than" they do, or "about the same" as they do. Again, there was no evidence for a difference between the two populations, regarding either of these items. About 20 % reported having friends who gambled "a lot", while a slightly higher percentage (25 %) reported having family members who gamble "at lot".

Distribution of responses to questions 3 to 10, for the combined sample (n = 114)* | **Table 3**

QUESTION NUMBER	PERCENT ENDORSED
3 (money and time lost)	12 %
4 (main entertainment activity)	11 %
5 (problem recognition)	9 %
6 (missing school to gamble)	4 %
7 (concern expressed by self)	6 %
8 (concern expressed by others)*	
9 (peers gamble "a lot")**	20 %
10 (family members gamble "a lot")**	25 %

* *pilot version of the gambling screen did not ask about overall frequency of gambling, or concern by others. Items 2 and 8 were added later.*

** *pilot version of the gambling screen asked only whether friends or family gambled "a lot". Comparative options in items 9 and 10 were added later.*

Table 4 | Number of positive endorsements of items 3 through 8

NUMBER OF ENDORSEMENTS	PERCENT OF SAMPLE (N = 114)
None	77 %
1	10 %
2	9 %
3	3 %
4	2 %

COMMENTS ON THE EXPERIENCE OF ADMINISTERING THE GAMBLING SCREEN

Adolescents did not experience difficulties in completing the screen, but a few questioned what "a lot" meant in items 9 and 10. They were reassured that we were interested in their own subjective judgement, i.e. whatever "a lot" meant to them. However, the wording of these questions was changed as indicated above. If a counsellor had any uncertainty regarding a client's ability to read and understand the items, then the screen as administered verbally.

Time to administer the screen varied from less than one minute to about five minutes, but was generally about two minutes (not including time spent discussing or counselling any results of the screen).

Feedback from counsellors was that it was better to administer the screen individually, or in a small group, rather than in a large group, so that the person administering the screen can check for obvious errors, inattentive responding, or confusion on the part of the adolescent. For example, one adolescent answered yes to item 4, but did not check any activities under item 1.

A small number of adolescents put other games of skill (e.g. golf and paintball) under the last item ("other"), rather than checking the second item under item 1. Several adolescents commented that they had not thought of their "betting" as being gambling. It may be useful when administering the screen, or when discussing gambling in general with youth, to include the terms "gambling and betting" together to indicate that they are considered synonymous.

The last two items, dealing with exposure to peer and family gambling, are quite open to different interpretation. "Family members" in question 8 does not distinguish between adult family members and teenage siblings. Two adolescents felt the need to clarify this by writing "brother" in the margin. Also, two adolescents could not decide between yes or no for item 8, because they had a large number of friends, and some gambled "a lot", while most did not.

CONCLUSIONS AND RECOMMENDATIONS

Results of the pilot study suggest that the AADAC Adolescent Gambling Screen, with the noted revisions, has potential value in gathering information about the prevalence of gambling activities, the negative consequences experienced, the level of individual concern, and the exposure to peer and family gambling. It appears to generate useful information when administered individually and in groups. The screen therefore, may be useful as a resource for teachers and other community professionals, for both screening referral, and as an educational tool to facilitate discussion with students and clients.

The results of the pilot study also suggest that the prevalence gambling activity in the general school population is similar to (or perhaps slightly higher than) youth referred for alcohol and drug problems. However, in this pilot study we had no information about substance use among the school sample. During the validation study, subjects will also be screened for substance abuse, to provide more information about the co-occurrence of substance abuse and problem gambling in youth. Reports of time and money lost to gambling, gambling as a main entertainment activity, school absenteeism due to gambling and personal concern about gambling in school populations also appear to be similar to at-risk adolescents referred for alcohol and drug use. These findings support the use of the Gambling Screen for early intervention in schools and other community settings.

Since the pilot study, the Youth Gambling Screen has been revised to include a frequency item, an item on expression of concern by significant others, and a range of options for the youth to compare his or her gambling to that of peers and family members. Administration procedures have been written, and training in the use of the Gambling Screen has been provided to AADAC adolescent counsellors across the province.

POTENTIAL SCREENING DECISIONS BASED ON THE YOUTH GAMBLING SCREEN

Tentative scoring criteria have been set for determining if a youth should be referred for assessment, however these criteria are currently being evaluated as part of a validation study. At this time, the responses to the Gambling Screen are scored against two criteria. Criterion 1 determines if the youth's frequency of the gambling activity is potentially excessive, based on the response to item 2. Gambling two or more times per week is deemed an indication of sufficient potential for concern to warrant further assessment. Criterion 2 determines whether there are significant negative consequences of gambling, either evident to the client, or evident to others who are closely associated with the client. Items 3 through 8 relate to this criterion.

At this time, one or more positive responses to items 3 through 8 is deemed an indication of sufficient potential for concern to warrant further assessment. Meeting either one or both of Criterion 1 or Criterion 2 indicates sufficient concern to screen the youth "positive", and recommend further assessment. Items 1, 9, and 10 on the gambling screen are for information only, and are not scored as part of screening criteria.

The version of the Gambling Screen used for the pilot study did not inquire about frequency of gambling, therefore, no initial testing of the proposed scoring criterion 1 could be done. However, based on the results of the pilot study, the proposed criterion 2 could be expected to result in approximately 20 to 25 percent of youth being screened positive for further assessment about their gambling and betting activities. A higher criteria of two or more, or three or more, items endorsed would result in correspondingly fewer youth being screened positive for further assessment (Table 4).

At this time, it is important to note that we do not have any substantiated criteria to make judgements or recommendations about the severity of an individual's gambling problem based on their responses to the Youth Gambling Screen. The Gambling Screen provides useful qualitative and descriptive information which can be used by counsellors to further question and explore the issues, however, any proposed cut-off between normal responses on the Screen (no reason for concern) and problem responses is speculative until the validation study is completed.

Future revisions to the Gambling Screen or its scoring criteria will be made based on the experience of counsellors, and the results of the validation study currently underway. Further developments may include guidelines for the use of the Gambling Screen as an educational tool, or for group discussion.

Small Group Discussion Questions on Perceptions of Youth Gambling

DISCUSSION QUESTION 1

Societal values have changed. Gambling is generally accepted as a form of economic development, a source of government revenue and as a fundraising activity for local charities. How does this increased societal acceptance of gambling influence youth perceptions of gambling?

There was consensus among participants that increased social acceptance and involvement by adults in gambling activity has correspondingly caused youth to view gambling as a legitimate, normal form of recreation or entertainment. The perception that gambling is "fun", "exciting" and "okay" is perpetuated by a proliferation of promotions and advertisements urging people to support and/or play casino games, bingos, lottery tickets, horse racing and other gambling forms.

This positive message is further enhanced by youth observing parents, peers and friends who either gamble regularly or support games of chance offered by charities. Often, it's youth themselves who are asked to become involved in gambling-based fundraising efforts.

For the most part, participants felt youth did not have the opportunity to form realistic perceptions about gambling because current messaging is unbalanced. Unlike alcohol use, governments and industry do not promote personal responsibility and control in gambling. There is also a confusing and often-grey line between what is acceptable gambling for young people and what is not. For example, youth may observe that a teenager winning a cash prize at a school fundraiser bingo is considered appropriate but winning a bet on a horse race is not.

Most participants believed society's endorsement of, and relaxed attitudes toward, gambling has contributed to more youth gambling. However, the majority conceded the degree to which this has escalated the number and severity of problem gamblers among young people remains unclear.

DISCUSSION QUESTION 2

What barriers and opportunities do perceptions of youth gambling present for prevention and treatment programming?

Barriers

PREVENTION:

Society does not believe youth gambling is a problem.

Youth do not see gambling as a high-risk activity.

Gambling is not seen as a youth issue like drugs and alcohol.

Gambling is seen as a normal recreational or entertainment pursuit.

Family circle may promote or be passive towards youth gambling activity.

People who don't gamble are in the minority.

Lack of knowledge and awareness of risk factors encourages complacency.

Business/government/community's economic stake in gambling conflicts with a prevention message.

Gambling provides hope for a better life.

TREATMENT:

There is a stigma attached to seeking help.

Poor access because of distance, availability, etc. discourages youth from seeking treatment.

A gambling problem may be masked by other addictions or conditions.

There are few negative consequences to gambling even if it gets to be addictive.

- Youth who gamble, even illegally, are not seen by authorities as children who may require treatment.

Promotion of abstinence creates reluctance to seek treatment.

Opportunities

PREVENTION:

Youth are naturally curious and interested.There is currently a dearth of balanced information about gambling available to them.

Parents, teachers and other role models have significant influence over a teenager's critical thinking and decision-making. They should be relied upon to help raise knowledge levels among youth.

Public awareness of gambling risks is low and can be improved.

More research can be done on the extent and impact of youth gambling.

Partnerships and links among common purpose agencies can be improved.

- More professional development opportunities can be provided to youth workers.

TREATMENT:

Youth organizations are able and should be approached to deliver more messages to youth about problem gambling symptoms and treatment benefits.

Administering screening instruments through youth workers would help identify and isolate youth problem gamblers.

Telephone counselling would be a value added, useful, confidential treatment tool.

Gambling interventions need to be customized and tailored for youth.

DISCUSSION QUESTION 3

Should youth be taught to avoid gambling or to gamble responsibly?
Will safe gambling messages encourage some kids to gamble?

Participants agreed that calls for abstinence or messages that attempt to instil fear in youth do not work. A program that enables youth to make their own informed decisions about gambling was seen as a more viable approach. Sound information, open dialogue, and hands-on experiences in a non-threatening environment were seen as keys to generating healthy attitudes about gambling among young people. Factual, positive and affirming messages, delivered publicly and through an integrated network of youth focused organizations, was seen as a foundation for success.

There was little concern that safe gambling messages may encourage more youth to gamble. While participants recognized the importance of expressing and positioning messages in ways which would interest and impact youths positively, the majority felt existing levels of youth gambling would not rise because of a safe gambling campaign. In fact, the reverse was true. The lack of such messaging, said participants, was a contributing factor to youth problem gambling. As a result, it was reasonable to assume that youth who understood and appreciated gambling's risks were less likely to engage in any sustained, high-risk behaviours.

section**four**

Intervention Points and Strategic Considerations

Overview

The final working session challenged participants to translate what they heard and discussed at the Think Tank into practical prevention and intervention ideas and strategies. Since participants represented a diversity of experiences, responsibilities and jurisdictions, pragmatic details such as environmental influences or available resources were left undefined. Rather, groups were asked to offer ideas and insights that could be shaped and applied to fit individual circumstances "back home".

Groups were asked to identify one or more issues and outline their approach in resolving each issue using the following formula:

1. Issue
2. Strategy
3. Target groups
4. Rationale
5. Key Steps
6. Expected Outcomes

Issue Summaries

NOTE
The following issues are numbered for reference purposes only and do not denote priority. Issues 1-6 represent issues that were identified by two or more groups.

ISSUE 1

Lack of Knowledge Among Young People Increases Gambling Risks

Lack of education and awareness among young people (12-17) regarding the potential risks associated with gambling contributes to high-risk behaviour. It may also explain why youth underutilize gambling treatment programs, giving the estimated number of youth who are problem gamblers or who could benefit from intervention measures.

A suggested key strategy to deal with this issue involved an intense media campaign that appeals to young people's emotions and encourages them to talk about gambling with parents, teachers and peers. Partnerships would be formed with youth orientated organizations, businesses and community groups to support the campaign.

Successful drug and alcohol awareness campaigns (e.g. Dialogue on Drinking) have focused campaign messages on encouraging dialogue among stakeholders. It was suggested something similar could be done to spark discussions on gambling between young people, parents and youth, teachers and professionals, etc. "Just Ask" and "Let's Talk About It" were two slogans suggested by participants. Messages would be developed in conjunction with youth, to ensure role models, language and visuals will attract their interest.

It was anticipated such an approach would reduce gambling activity among 12-17-year-olds, increase the number of young people seeking help for a gambling addiction, and increase the quality and frequency of parental discussions with their children regarding gambling.

ISSUE 2

Impact of Adult Gamblers on Youth

Adult attitudes and behaviours toward gambling have a profound impact on youth. Direct experience with parents or others who have gambling problems place children at a high risk of replicating such behaviour, either as children or later as adults. A core strategy to deal with this issue involves providing treatment services to children exposed to unhealthy gambling behaviours.

The primary target of such an approach would be children of a parent or parents in treatment for problem gambling. They are in a high-risk situation and can be easily identified and accessed. A key aspect of the treatment program would be teaching parents better parenting skills and encouraging families to engage in healthy lifestyles. To be successful, the treatment process would need to involve a team of professionals and immediate family members.

It's expected such an approach would reduce the number of children at risk of developing a gambling problem.

ISSUE 3

Understanding the Extent of Problem Gambling

The lack of accurate data concerning the extent and impact of gambling involving young people makes it difficult to set priorities, develop programs and measure successes. To address this issue, a combined strategy of research and information exchange was suggested. The research component would seek to answer four core questions:

1. Why is there a discrepancy between gambling prevalence survey studies and the actual number of people seeking out prevention and treatment programs?
2. What is the current level of awareness regarding youth and gambling?
3. What is the impact of adolescent gambling and betting behaviour on young people?
4. What is the relationship of gambling to other potential problems faced by young people such as drugs, alcohol, etc.?

The information exchange component would encourage professionals, parents and young people to discuss gambling issues frequently and openly. Forums, workshops, classroom debates and other communication opportunities would be created to stimulate such discussions.

A wide range of stakeholders, including young people, gaming commissions and computer companies, were seen as potential partners in developing and implementing these strategies. It was suggested a detailed strategic plan with communication goals and well-defined criteria for research would be needed to launch this approach.

The expected outcome would be increased clarity and awareness concerning the severity and extent of youth gambling.

ISSUE 4

Lack of Life Skills and Resources for Youth

As they grow and mature, youth often lack the proper resources to deal with challenges like gambling. Unhealthy behaviours and addictions are largely systemic in nature and can only be broken by a global, systemic approach. It was suggested a comprehensive life management program for school aged children — that addresses gambling together with other

developmental challenges like drugs, sexuality activity and alcohol — would reduce risk and increase resiliency.

Developing, administering and supporting such a program was seen as a community responsibility. A coalition of stakeholders — schools, social agencies, police, government, parents, youth, etc. — would develop approaches and determine the best method for delivering resources. Although skills training may be taught in school classrooms, it was deemed important that the overall approach integrate all community-based, youth-focused programming.

Key steps in making this strategy work include defining community strengths, identifying gaps, developing initiatives, defining outcome indicators, preparing baselines based on group factors, and providing specialized training to educators and others.

It was expected that such a coordinated approach would reduce youth gambling activity and provide young people with the skills they needed to respond appropriately to gambling (among other things). Developing personal resources in young people at any early age would have enduring value and benefit throughout their lives.

ISSUE 5

Promotion and Normalization of Gambling

Promotion and marketing of gambling activity is heavily weighted towards presenting gambling as a normal, accepted form of recreation and entertainment. There is concern that this contributes to high risk gambling behaviour among young people and a lack of public concern regarding illegal gambling activity among young people.

A strategy that counters existing marketing messages with factual information about risks was seen as a way to balance perceptions about gambling, and youth and gambling. It was assumed that public responsibility would encourage the gaming industry, regulators, governments, the media, social agencies and others to become stakeholders in a broad campaign to raise public awareness about gambling's impacts — both pro and con.

Key steps would include consolidating research and information on youth and gambling, engaging professional marketing expertise to develop a campaign, and gaining commitments from stakeholders to disseminate messages and information.

It's expected this approach would give young people more personal knowledge about gambling, which in turn would reduce the number of youth engaged in high-risk behaviours. Increased factual knowledge among adults is expected to correspondingly reduce illegal gambling activity involving young people.

ISSUE 6

Public Policy on Gambling

Lack of concise public policy on dealing with the impacts of gambling in society contributes to the fragmentation of planning, programs, and dollars. A research and consultation based strategy that provides accurate statistics and trend analysis to politicians, community leaders, planners, gaming officials, etc. was thought to be an effective way of providing solid direction to public policy.

This information pool would include data on topics like gambling availability and activity, public awareness and perceptions of benefits and risks, effectiveness of prevention and intervention programs, problem gambling prevalence, and social impact studies. To be viable, all stakeholders involved in public policy and program development related to gambling would need to be involved or at least supportive of such a strategy.

It's expected this approach would result in planning, programs, services, and research that are integrated and flow from well-defined public policy.

Other Issues Raised by Working Groups

Peer support: There is a need to identify youth leaders and form peer groups to support teens who may be engaged in frequent, high-risk behaviour.

Family climate: Appropriate family lifestyles and environments need to be encouraged and promoted as a major protective factor for youth.

Gambling opportunities: Gambling opportunities for youth need to be restricted and reduced. Lack of recreational options, poor or non-existent adult supervision, and relaxed enforcement of gambling rules and regulations were all cited as contributors to high levels of youth gambling activity.

Involvement of non-traditional partners: Casinos, gaming suppliers and lottery ticket merchants need to become involved in youth gambling prevention and treatment programs as sponsors and stakeholders.

Minority differences: More knowledge needs to be gathered on how ethnic and cultural background impacts youth gambling behaviour and, subsequently, how prevention and treatment approaches can best be tailored to meet the needs of youth within these groups.

Responsible choice: Kids need to know the facts about gambling but they also need to be taught personal responsibility in making choices about (informal and formal) gambling.

section**five**

Appendices

Appendix A

This appendix contains transcripts of the questions and answers that followed the presentation of research papers. It also provides a record of the small group presentations made to the last plenary session of the Think Tank.

Youth Gambling Prevalance Studies

presented by Dr. Randy Stinchfield

Plenary Session
held Thursday morning,
October 21, 1999

QUESTION 1

Nevada has had legalized gambling for years and years. Has that state done studies on youth gambling and problems associated with it?

Dr. Stinchfield:

No, I haven't and that would be interesting because gambling has been legal there for so long and it's such a part of the culture there. I know there are not more treatment programs in Nevada than there are in other places.

The legal age is 21. The only problem with that is, when you go to a casino, the casino is very family oriented. You see kids walking right through the gambling floor, with their parents or on their own. You have Circus Circus, which really caters to kids. You have to be aware: are we training kids to become gamblers from those experiences?

QUESTION 2

Many of the studies that you talked about were three to four per cent problem gamblers: in Alberta eight per cent. In Alberta's native population, 13 per cent of youth had problem gambling concerns. Is that consistent in other studies that you know of?

Dr. Stinchfield:

Absolutely. I don't have a slide on it but that's exactly true with ethnic minorities as well. In the Texas study, it had mentioned ethnic minorities, particularly Native Americans, tribal nations, Mexican Americans — which has a large population in Texas — those ethnic minorities are definitely gambling at a higher rate. They also have higher rates of problem gambling.

That would be another good question to look at. Why is that occurring? I don't know exactly other than that, often times, ethnic groups are

basically at risk for a number of problem behaviours. Alcohol and drug abuse, for example. So it is certainly something we want to look at and study more carefully because they do have higher rates.

QUESTION 3

I had a question about natural recovery or spontaneous recovery. We talked about adolescents who, as with other addictive things, will peak and then go on to not have problems in their lives. Is there any research being done right now or discussion about any research that will identify what some of those key factors are in spontaneous or natural recovery?

Dr. Stinchfield:

I've only seen a few studies on natural recovery. I know there's one being done in Alberta at Calgary by David Hodgins and there was a presentation from a fellow from Nevada who was also doing one. I know David Hodgins' study is still in progress. They're all fairly new so I haven't seen too many results yet from those studies to indicate what factors lead to natural recovery.

We have so many youth who probably do have a problem but are not showing up at treatment programs. It would be interesting to know if those youth are actually vacillating in terms of their problem severity, so they're not coming, or if they know they are getting into trouble and are basically self-correcting.

QUESTION 4

What do you think of Dewy Jacob's hypothesis that states and provinces that have lotteries increase adolescent gambling not only in lotteries but in general. Do you see any proof for that in the literature?

Dr. Stinchfield:

There's a mixed bag we are looking at and so it's hard to know for sure. I mean to me it's an attractive idea that the more gambling that is available the more people are going to gamble. As a result, you are going to have more problem gamblers.

It has appeal but the actual data hasn't really borne it out other than data from Minnesota where you now have 12th Graders who are gambling at

the lottery. There are more 12th Graders gambling at the lottery at the weekly or daily rate but we haven't seen an increase in pathological gambling rates from that.

QUESTION 5

I was interested about one of your comments about the sting operations and one of the forms of punishment that you suggested was sending the staff to education. Would you consider the same sort of punishment for the kids that are going through the education?

The follow-up to that is, realistically, the literature with respect to alcohol and drugs and education suggests that they're not very effective. The school based education programs are not effective so why would you suggest that anything with education in the school system with respect to gambling would be any more effective?

Dr. Stinchfield:

Your first comment makes sense to me; to have both the vendor and the kid have to go through it. There has to be some effort to enforce the legal age limit. I think once people are aware that there is this penalty and there are stings happening I think there's a greater chance that people will be trying to keep kids from gambling.

As to your next comment about school based education: I think that gambling is new and I think kids don't know much about it in terms of probability or what happens in a slot machine or what happens inside a VLT. I know there are some prevention efforts that get at that. To me, that makes sense, that you at least want to teach kids what they're getting involved in and that, if they do chose to gamble, this is what they're going to be participating in. They need to use rules, set a limit on how much they are going to spend, how much time they're going to spend, etc.

I don't know school based prevention for alcohol and drug abuse that well. I know the methodology has not been great. It's hard research to do so I'm hoping that those prevention efforts would be helpful. I think for some kids they would be.

QUESTION 6

I'm not aware of any study that has tried to measure prevalence in any specific ethnic group except for the aboriginals. Secondly, it's a different thing to look at problem gamblers and say there are a significant number of ethnic minorities in this group of problem gamblers. It's different to say that then to say ethnic minorities have a high prevalence of problem gambling.

Dr. Stinchfield:

Right. Part of the issue you're bringing up is that most surveys are general population surveys and so the numbers of ethnic minorities that actually get in a general population survey are very small. You may only have a couple of members of an ethnic minority in your sample so you don't want to say anything about problem gambling based on that.

It's not like the Alberta study where you actually go out and get data from a particular group. In Minnesota, since we were administering surveys to the entire public school population, our samples of Native Americans and African Americans are actually in the thousands of cases. We're actually getting large enough sample sizes that we can make statements about that larger group. But from general population surveys, you're absolutely right. It's very difficult and you wouldn't want to make any statements about it.

QUESTION 7

We're doing a pilot in Moose Jaw right now involving a sting operation project. We've had youth go into stores and attempt to purchase cigarettes. We had 21 stores out 50 sell to minors. These are 16-year-olds. We did follow up with enforcement officers in the province and sent out education and warnings that you can be fined. Later on only two out of the 50 stores sold again.

The education actually worked plus there was one of the stores that got caught twice for selling to minors. First time there was a thousand dollar fine, the second time they could have their privileges of selling tobacco for a whole year revoked because that's part of the Statute. I think it might be something that could be looked at in the future with gambling because it's the same type of thing. It might be a little more effective than just education.

Dr. Stinchfield:

Thank you. The media has followed kids into a casino under cover — that's happened in Minnesota — and watched them play Blackjack. When they show the tape on TV and to the chairman of the casino they say they will do whatever it takes to keep kids out of there. It's brought to their attention, it's brought to the public's attention and I think that's helpful.

QUESTION 8

A lot of information came out here this morning and it was all great. I'm just wondering, are there one or two or three good resources that we can keep in touch with to keep abreast of what's happening in gambling?

Dr. Stinchfield:

I'm aware of a number of web sites, particularly up here in Canada, that keep very up-to-date information. I know that there's one in Manitoba operated by the Additions Foundation of Manitoba (AFM) www.afm.mb.ca that you can go to and it has links to other sites. For example, the most recent survey done in Manitoba. You can link to a site to get information about that.

I know Harold Wynne has a book about gambling and they add to it every year so that would be another source. The National Research Council has a site at <www.nas.edu/nrc> and you can access <www.problemgambling.com>

QUESTION 9

I was just wondering if there are any plans to revise the SOGS to make it more reflective of the current DSM4 criteria?

Dr. Stinchfield:

I just was on a panel in Boston in August with Henry Lesieur, who is one of the developers of it and I don't think so because he's too busy. He was a chair of a Sociology Department and now he's in graduate school for Psychology so he is way too busy to do anything. I don't think Sheila Bloom would have any interest in doing it so unless someone came along...

What's basically happened is that other instruments have been developed. It basically depends on what you want to get at. If you want to

get at pathological gambling and the number of people who are pathological gamblers, then you want to use diagnostic criteria. The only role I would see for S.O.G.S. is as a screen instrument to narrow down your group. If the S.O.G.S. says five or six per cent are likely to be pathological gamblers, then you only administer your diagnostic interview to that small group.

At present, I don't know if anyone is planning on revising S.O.G.S. But a number of people are using a two-stage method. They administer the screen instrument and then do a follow-up with the positives to find out if they actually are pathological gamblers. Just to narrow down your group because if you do a diagnostic interview, particularly with a clinician in a person-to-person interview, you don't want to do that to everybody. There's such a small number who would actually be relevant for you, so you use a screen instrument like S.O.G.S. to narrow it down to just a handful of people.

QUESTION 10

One of the best examinations of the phenomena of maturing out that I've come across was published a few years ago by the Bachman, Johnson and O'Malley group out of the University of Michigan-Ann Arbour. The group that does the monitoring published a supplementary report on young adults and in that report they talked extensively about the maturing out phenomena and the factors that young people reported as contributing to that phenomena.

Dr. Stinchfield:

That's another very good resource because it's updated every year. We need to have in gambling a national study like that that's also stratified so you can break down what's going on in a certain region. I know that group has been approached and asked if they would be willing to include gambling items and so far there's been no success basically because they're under a grant from the National Institute on Drug Abuse. Gambling is not relevant to them.

Those of us who are interested in gambling need to try to get something like that in place. What happens to kids? We need to find out what's happening with their gambling as they get older.

Relevance of Resilience to Adolescent Gambling: Implications for Intervention

presented by
Dr. Miriam Stewart

Plenary Session
held Thursday afternoon,
October 21, 1999

No questions were asked following Dr. Stewart's presentation.

AADAC Youth Gambling Screen Description and Results of a Pilot Study

presented by
Dr. Harvey Smith &
Heather MacDonald

Plenary Session
held Friday morning,
October 22, 1999

QUESTION 1

I have a question for you on your study. On question number one you said that 75% answered zero that don't participate in any activity. Does that mean we say that 75% somehow participate in one kind of gambling?

Dr. Smith/Ms. MacDonald:

Yes, and that's very similar to the across the province (Alberta) surveys that were done as well. Sixty-eight per cent at that point were involved in some form of betting. The question is, is that problematic or not? What level are they involved in those things because, as we talked about in our groups yesterday, if we want to use the word gambling to include all of those kinds of activities some of them are fairly innocuous in their level and intensity and consequence. Gambling and betting behaviour in general is pervasive in our society in so many different forms so the question is, of those 75%, we need to look at those and decide is it a problem or is it not a problem? In the case of screening, might it be a problem and do we need to look further at it? Do we need to refer that person for assessment or at least ask them further questions?

QUESTION 2

I noticed in the activities list and I know in Manitoba we have a lot of 50/50 raffles with draws to raise money for kids at hockey games and minor sports. Is there something similar to that in Alberta?

Dr. Smith/Ms. MacDonald:

I'm sure that's very prevalent in Alberta as well. Are you asking whether we should include it in that category? It's a good question. I'll take that back because I honestly don't know whether we want to. How broad do we want to get? Do we want to also start including all minor hockey fundraising, those kinds of things? For a screen instrument for problem gambling, I'm not sure whether that would be just encouraging more responses that we then have to weed out later as being not really indicative of the problem.

In the focus group study, when we were asking the reasons why people gamble, one of the reasons was it was a way of giving to charity. Some people did report that as one of their rationale. I don't know if that's an excuse for why people gamble but that did come up as fairly common feedback.

QUESTION 3

You made a comment concerning the time period of your instrument. The question or the expression that was the least understood was the time period. If I ask did you do such and such in the past six months, even for us as adults, we may well have understood six months to mean since last June. Six months is a long period for teens. We need some kind of anchor like the beginning of this academic year or since last summer. If we frame it this way, I think we'll be avoiding a lot of vague answers. I don't know if you had any experience with that, regardless of whether it's three months, six months or 12 months.

Dr. Smith/Ms. MacDonald:

Yes. The more complicated those categories get the more difficult it is for youth. Especially if we're asking, "How many times in this time period have you done this?" It gets very difficult for them and they quite often answer those incorrectly. Our drug and alcohol screening suffers from that. In this case, we're asking them frequency within the recent past. I'm

hoping that'll get around that problem as opposed to asking them how many times but you're right. Whether we do it for one year doesn't make a difference. Kids still try to anchor it to this academic year, or over the summer holidays.

QUESTION 4

I was interested in your pilot. You had left off the frequency question, if I understood it correctly? And also the other one was the concern for your gambling behaviours. I was just wondering why you did that?

Dr. Smith/Ms. MacDonald:

Well actually it's the other way around. We didn't have it in originally and we put it in. It wasn't intentionally left off the pilot study. There was a real emphasis in the early version of the gambling screen to keep it short. It only had eight items and we just knew that we needed to add those two items even though it lengthened it to 10. But those two items were very, very important. And so the pilot study was done early on with an earlier version of the gambling screen before it reached the stage of having those two items put in it.

Plenary Session
held Friday afternoon,
October 22, 1999

Small Group
Presentations to
Plenary Session

Intervention Points
and Strategic
Considerations

Salon A & B Working Group

Already I've heard some repetitiveness in terms of some of the ideas that came out of our group. We had three issues that we addressed in the group. The one I'll present is the one that came out of our first morning of discussion when we heard that youth are not accessing treatment in the same kinds of numbers that are targeted for prevention or are being predicted as problem gamblers. So we thought that may be something to address. We need to be sure that when youth are ready for treatment that we have an appropriate intervention. We need to know that. We need to know that now.

We thought it would be a multi-level kind of target group. All youth at the prevention level because we do not know enough about who might actually be having the problems within those groups at this point in time. The second group would be significant adults who can help identify youth who may be experiencing problems; for youth at risk. Our group spent a lot of time talking about incorporating gambling into all the other tremendous efforts we have out there to provide youth with life skills kind of training.

Strategy and approach: we got really funky here and said we need to address their emotional level. We made a phone call and booked a rock star for a music video. It's kind of like, "You can be bad, you can be sad, you don't need to bet on the dog that's mad."

We want role models that are youth appropriate. We would like male and female appropriate role models. We think that's really, really important in this media campaign. We could come at it a couple of different ways for youth. For example, "Know your odds both in the math curriculum and on the billboard." We might be looking at multi-level kinds of strategic approaches. We'd have literature where the youth are at and that means not just the location but where they're at in their heads and where they're at in their heart.

That moves us into identifying stakeholders. We thought we needed a multiple level of stakeholders: most people that work with youth as well as youth. The easy answer to why we're doing this is to inform but it's more of a general public awareness to address the issue of why do we only see the problem in gambling as the one that we don't do personally become involved with. For example, when I buy a lottery ticket that's not a problem but people that play the VLT's have a problem. What's going on there? Let's find some answers for that.

In all of our initiatives, the first key step was let's get youth into a forum like this. We need to hear from them. They need to be involved. The other step is to look at community collaboration among the resources out there.

The expected outcome is that we will have in the future less youth who experience problem gambling so we won't repeat some of the things we've seen with other societal issues. The other outcome is we will be able to properly engage youth who have a problem so that we'll actually see them in our treatment facilities.

Salon C Working Group

The issue that we chose to work on was the need to clarify the uncertainty about the extent of the problem and the need to be concerned about it. It's a two-fold issue. In reality we really still don't know what it is. The second part of that is everybody's uncertainty because of our lack of awareness and communication around the core issue.

The target group ... we really started to list people and then we ended up listing almost everyone that works with youth: service providers, allied professionals, drug/alcohol workers, ourselves in particular because we need to have clarity and credible information about parents and youth. Those could be prioritized as we're working on this issue.

There were a number of strategies. First of all, a research strategy. We came up with four kinds of questions that would be good to look at. First of all, why is there a discrepancy between survey numbers and what we're seeing. We've heard that mentioned again and again yesterday and today. The second one is what is the current level of awareness? If we're going to talk about increasing awareness we need to have a measurable baseline.

The third one is the impact of betting and gambling on youth. Even if the prevalence is really high, so what? We need to be able to measure what is the impact of adolescent gambling and betting behaviour on their lives. Is it significant? Or is it not? And finally, the issue of concurrent gambling to other problems that we're presently addressing in youth. How much do they co-exist? Did the gambling exist prior to other problems? Was there prior gambling and betting behaviour, which might have been a gateway or antecedent to the problems we are seeing and dealing with now.

Another strategy would be service messages, TV, radio, media, newsletters, professional newsletters, and journals depending on the target group that we're looking at. Another strategy would be just asking youth that we're now working with. Asking them more about what their experience is with gambling and betting.

Another strategy would be the message that we're giving out. The message that we want to give is that this issue needs to be explored and needs to be further understood. We want to get away from the debate, "Is this just based on opinion and personal values?" We thought a tag line for this could be "Just ask". So parents could be "just asking" their kids, we as professionals could be "just asking" our clients, teachers could be "just asking" their students, students, youth could be "just asking" each other. We're going to trademark that. We've already sent a copyright patent on that application.

And finally, another strategy would be using more training opportunities for information exchange such as the one we've experienced here, within agencies or within governments; opportunities for staff exchange and familiarization across gambling to other problem areas.

All of the groups we listed under our target groups are potential stakeholders. Youth especially should be considered a stakeholder and involved as a partner this endeavour. We also thought that gaming commissions and the gaming industry could be stakeholders and partners. They will have the best interest and be able to discern between harmful and non-harmful gambling. They might pull funding after they see the research outcomes but up until that point they're good for funding. We also thought the toy industry might be a potential partner for funding and research with all the high intensity games that are out now. Again, interest may be based on whether there is potential to increase a pre-disposition for future problems.

The rationale for this issue and this approach is that we need to seek clarity and not sweep it under the rug. That's the message we need to take out for this work. We need a credible and authoritative message and we need the clarity to back it up.

Key steps were to develop some goals and objectives, develop a communications plan, more detailed strategic plan, and research proposals around the issue.

Expected outcomes: increased clarity and awareness around youth and gambling issues.

Salon D Working Group

Our group had the benefit of very creative thinkers. A need that we identified was the lack of resources preparing youth to deal with the challenges they face in each developmental stage. We envisioned a comprehensive program that would prepare youth for life using a life skills personal development approach. This approach would prepare youth for each issue that they might face in their development.

Target group: thinking big, K-12. We did recognize of course that youth in the latter end of that spectrum are higher at risk youth and may be out of the educational system at that point. We left that as a caveat aside.

The strategy is a comprehensive life management curriculum inclusive of life skill strategies that would reduce risk, raise protective factors and increase resiliency. There's recognition that every issue that youth face can be identified or strategies applied. So they'll get someone coming to the school system to deal with alcohol abuse, dealing with sex issues, dealing with whatever the current issue of the day is and our group in their wisdom thought that perhaps we should look at preparing youth generally for coping with those challenges rather than specifically, issue by issue.

We thought of building partnerships around individual stakeholders, provincial education departments, local school officials, and community agencies. We recognize the tension that exists within the educational system and that there's competition to get on the curriculum.

The rationale is that it's not a piece meal approach but a coordinated approach. It develops skills youth can use in any challenge that they face. Early enforcement, learning and reinforcement are important.

Key steps we would employ include consultation with youth, with educators. We'd identify outcome indicators, compare groups to other schools, and then develop and deliver a curriculum with specialized training for educators.

Club Room Working Group

Our group had a lot of general comments and we certainly were taking a look at some of the global issues in a lot of the strategies we had. We sat down and said many of these we're not going to be able to take back and work on ourselves but that generated most of our discussions around the large issues.

One of the ones we came up with was to take a look at affected youth, specifically the affected youth of gamblers who are in treatment. In Saskatchewan, we have a population who we know through all the research, or we think we know through all the research, is at risk. And many of us have the experience of working with children with parents who have disorders and what that means. For us, gambling certainly seems to be part of that world.

The target group would be the affected youth, children whose parent or parents are in treatment. The strategy approach is of course to provide education to the gamblers in treatment about what their behaviour may be doing to their children. This is a population we're normally not bringing into treatment when we're dealing with the parents. We're not doing that and of course we say, "Well, maybe we should".

We want to increase parenting skills because certainly what we see with many of the parents who are in treatment is they lack very good parenting skills. Of course, we want to increase healthy family lifestyles. That's another thing we know of gamblers in treatment, that their lifestyles tend not to be very healthy in a number of areas.

The stakeholders are various treatment professionals and of course the parents, the treatment clients themselves and the spouse. The rationale for the approach is we see children who grow up in homes where parents have significant problems. They appear to be very high at risk to develop similar or other at risk behaviours themselves. Also, they are a captive population. We have the folks in treatment, this is a wonderful opportunity, and we should start dealing with them on the parenting issues.

This is a great idea but we don't have the approach down yet so we need to develop that. The expected outcomes: we'd be very conservative. We'd look for a decrease of risk factors and an increase in the protective factors.

Gateway Room Working Group

First thing we're going to do is our issue identification. It's going to be awareness and education, which sounds very broad, but we'll narrow it, don't worry. So that's where we're going to target. That's the issue we need to target. We feel that kids lack some awareness and education about gambling itself. Our target group is going to be all youth, 12-17 and this will include some of the subgroups you see on the flipchart. Youth generally, youth who gamble and some affected kids.

Our strategy is a media campaign. We have unlimited funds remember. So we're going to do it on an assault media campaign using print, electronic media methods. We had a big debate about what message to give kids in this campaign so we ended up saying what we'd like to do rather than a "Let's talk about it" media campaign. In other words, we will invite kids to talk with each other. We will invite them to talk to their parents, with their teachers and their friends about gambling; so it's a dialog campaign.

You remember the dialog on drinking campaign? This will be a dialog on gambling the dog campaign. We're going to develop rationale for this. We felt we could partner in the developing of the campaign with some of the businesses where kids hang out, like 7-11s. The gaming industry and media outlets could help us with the messages; also youth groups, parents, self-help groups, schools.

We think this strategy has a wide coverage. Some of the things we're going to do will have a strong impact with little vignettes and opportunity for partnerships. Steps will include developing a work plan for the project, meeting with partners, developing key messages in consultation with kids... but we wouldn't let the kids write them all. We think that adults should be involved in creating some of the messages and packages.

Produce the ads, deliver the ads. We're going to develop some dialog packages to send out to people so they'll see the campaign. Then we'll send out to a parent for example how to talk to your kid about gambling; here's some vignettes you can use to raise the issue at home. We'll do

that for kids and some other groups. Then we'll evaluate the strategy, see if kids saw it.

Some outcomes? We want political support. We're going to actually try to reduce gambling in the target group of 12-17-year-olds. We've almost never seen as an outcome of a campaign. This will cost government money because if you want to raise awareness it is a valid outcome to say we will reduce some of the gambling that's going on.

We will increase the target group seeking help. Any campaign we do might result in more requests for help. So our campaign would increase the target group seeking help. It would also increase requests for the information packages I referred to.

Another outcome: increased quality and frequency of parental kid interactions about gambling. We would try to measure how many interactions there would be around gambling. We would also expect increased calls to the help line, again, as a treatment spin off from this.

Expected outcomes would that youth would have skills to respond to specific gambling or whatever challenges they're faced with. We'd see an actual reduction in gambling and certainly an increase in social and interpersonal function generally.

Tache Room Working Group

We looked at a very global sort of approach. The community has to accept the responsibility for investing in the future of our children and youth. Very, very broad, broad statement but it gets at the idea of partnerships, of getting people together. Kids need a set of skills and by teaching those skills we can pass on some key decision-making and coping skills.

The target group would be the entire community.

Strategy approach: develop a coalition of stakeholders. We did have some success stories. Now those were in some smaller communities. I don't know. Maybe it gets more complicated when you get to a large city but where people were getting a whole group of stakeholders together for regular meetings and saying "Where are we going? Where are we going to go with this?" they experienced success.

Secondly, develop a vision for youth, by youth. Do it with the youth, create it with the youth, build it, involve them. There's ownership, they've

got energy you can take advantage of. I don't want to have youth as a problem but as a resource and asset. That really came through strongly. Develop skills in community development and mobilize the community including schools and all the social agencies.

Our rationale? It's systemic. To break a cycle before it starts you need to be systemic and global in your approach. We know that youth are being affected by adult gambling. We can be pretty darn sure some of today's youth will grow into problem gamblers later. It's not entirely clear what amount of youth problem gambling exists right now but coping skills will affect that. We had an anecdote of the child affecting something from the bottom up by learning about smoking and telling the parent, "Don't smoke it's bad for you". Getting them involved is critical.

Keys steps include identifying community strengths. Don't wait for others to do it. Identify gaps. Develop initiatives. We have our circle of community, family, youth. It's all inclusion.

Expected outcomes? An increase in healthy activity. You can't just take away something. You've got to have places for youth to go, ask youth what they do... use their language. Other issues we talked about included a balanced message. If we don't give them a balanced message, if we say gambling is bad, then we lose ... we have no credibility. And that's a real big issue.

We need to distinguish between informal and formal types of betting because there was a consensus that informal betting may not be the problem. It may only be institutionalized forms of gambling. Try not to lump those things together.

Appendix B

List of Planning Committee members

THINK TANK CHAIR: Gerry Kolesar,
Addictions Foundation of Manitoba

MEMBERS: Bev Mehmel,
Addictions Foundation of Manitoba

Marcy Dibbs,
Alberta Alcohol and Drug Abuse Commission

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List of Sponsors

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- Saskatchewan Health
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- Health Promotion and Programs Branch, Health Canada
- Manitoba Gaming Control Commission

Manitoba Hotel Association

List of Participants

The following participants attended the Think Tank on Youth and Gambling, but were unable to participate in a specific Working Group:

Miriam Stewart, Ph.D., University of Alberta, Edmonton, Alberta

Heather MacDonald, Alberta Alcohol & Drug Abuse Commission, Edmonton, Alberta

Other Think Tank attendees are listed according to the working group in which they participated.

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