

## **New Mexico Outpatient Gambling Treatment Provider Standards<sup>1</sup>**

These standards were developed to correspond, where appropriate, with (a) the Mental Health Comprehensive Behavioral Health Standards as cited in New Mexico Administrative Code Title 7, Chapter 20, Part 2; (b) the New Mexico Council on Problem Gambling Problem Gambling Counselor Certification requirements; and (c) best practice standards from the problem gambling treatment field at-large. For service definitions related to this set of problem gambling treatment standards refer to the definitions provided in the Mental Health Comprehensive Behavioral Health Standards (NMAC 7.20.2.7).

### **I. Accessibility – Providers of problem gambling treatment shall:**

- A. Deliver treatment at a physical location that conforms to the requirements of the Americans with Disabilities Act (ADA), to the extent reasonably practical.
- B. The hours of operation and service availability shall reflect the needs of the clients served.
  - a. A client with emergency needs shall have immediate access to a clinician who can assess and triage by telephone within thirty (30) minutes; and face to face within eight (8) hours.
  - b. A client with urgent needs shall be seen within twenty-four (24) hours.
  - c. A client requesting services shall be seen for a routine office visit within ten (10) business days.
  - d. Individuals not yet enrolled into service and requesting at appointment should be seen within twenty-four (24) hours, to the extent reasonably practical.
  - e. Make treatment available during both daytime and evening hours, to the extent reasonably practicable.
- C. Develop and implement a policy of delivering treatment in a non-discriminatory and culturally sensitive manner. Recognize and respond appropriately to the unique needs of special populations (e.g., language, illiteracy, disability, culture, race, gender, sexual orientation, age-related differences, etc.) which could include but is not limited to: Making reasonable modifications in policies, practices, and procedures to avoid discrimination (unless the program can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity) such as:

---

<sup>1</sup> Note: These standards are directed at clinical practice. Contract language will need to accompany the practice standards to address administrative items such as reporting requirements, performance measures, oversight methods including onsite reviews and/or utilization reviews, and reimbursement methods. Flexibility may be added to these practice guidelines by including contract provisions permitting case-by-case waivers to specific standards.

- a) Providing individuals capable of assisting the program in minimizing barriers (such as interpreters);
  - b) Translation of written materials to appropriate language or method of communication;
  - c) To the degree possible, providing assistive devices which minimize the impact of the barrier and;
  - d) To the degree possible, acknowledge cultural and other values which are important to the client including supporting the use of traditional healers and traditional healing methods, when advocated by the client and appropriate.
- D. No person should be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category. The provider should have written criteria for accepting or refusing admission requests, including steps for making referrals for individuals not admitted to the program. For those clients refused admission based on assessment, the provider should document the reasons for refusal and subsequent referrals within seven days following the refusal decision.
- E. In the treatment of clients under that age of fourteen the service plan must conform to the New Mexico Children's Code's, documenting, as necessary the involvement of the family, and if applicable, others involved in the under-aged client's care.
- F. Clients eligible to receive services will not be charged any co-pay or out-of-pocket expense for verbal counseling interventions.
- II. Eligibility – Persons acceptable to receive gambling treatment services funded through the one quarter of one percent (0.25%) of the net take of the gaming industry dedicated to compulsive gambling assistance plans.
- A. An individual may be eligible for funding if s/he presents for problem gambling treatment and reports that the problematic gambling primary took place in a venue within the State of New Mexico.
  - B. Funding eligibility is available to the primary gambling client, who meets the criteria for pathological gambling or sub-clinical pathological gambling.
  - C. Family members or significant others, impacted by another's gambling behavior, are also eligible for funding, even if the gambler does not seek counseling.
- III. Eligible Providers - Under the one quarter of one percent (0.25%) of the net take of the gaming industry dedicated to compulsive gambling assistance plans, an eligible provider is one who meets the following requirements to provide Fee-for-Service treatment:

## A. PROVIDER QUALIFICATIONS:

1. Education and Experience: one of the following provider categories:
  - a. Licensed Professional Clinical Mental Health Counselor (LPCC), NMAC 16.27.4
  - b. Licensed Marriage and Family Therapist (LMFT), NMAC 16.27.6
  - c. Licensed as a Mental Health Counselor (LMHC) (Practice under supervision), NMAC 16.27.9
  - d. Licensed as an Alcohol and Drug Abuse Counselor (LADAC), NMAC 16.27.11
  - e. Licensed as a Substance Abuse Associate (LSAA) (Practice under supervision), NMAC 16.27.13
  - f. Certified Alcohol and Drug Abuse Counselor (CADAC), NMAC 16.27.23
  - g. Licensed Psychologist and Psychologist Associate , NMAC 16.22.9
  - h. Licensed Psychiatrist or Psychiatric Nurse Practitioner , NMAC 16.10.2
  - i. Licensed Master Social Worker, LMSW
  - j. Licensed Independent Social Worker, LISW
  
2. Training: Both of the following categories:
  - a. Specialty Certification in Problem Gambling Treatment, in good standing, from one of the following:
    - (1) American Compulsive Gambling Counselor Certification Board
    - (2) National Gambling Counselor Certification Board
    - (3) American Academy of Health Care Providers in Addiction
    - (4) New Mexico Council on Problem Gambling
      - i. For individuals relocating to New Mexico from other states, the New Mexico Council on Problem Gambling will consider granting certification though reciprocity for those individuals who have been approved by a state agency as a compulsive gambling treatment provider in their former state of residence.
  - b. Continuing Education: At least 12 classroom hours of gambling specific training in the past two years containing at least two education hours in Professional Responsibility and Ethics. All providers shall maintain documentation evidencing compliance with this education requirement.
  
3. Problem Gambling Counselor Associate: All of the following are required:
  - a. Provisional Certification by the New Mexico Council on Problem Gambling;
  - b. At least 12 classroom hours of gambling specific training in the past two years;
  - c. Supervision received for a Problem Gambling Counselor Associate must be provided at a minimum of one hour for every 20 client contact hours by a Certified Problem Gambling Counselor with at least three years of problem gambling treatment experience. A Problem Gambling Counselor Associate

must continue practicing under supervision until the associate has acquired Full Certification as a Problem Gambling Counselor;

- d. Clinical documentation must be co-signed by clinical supervisors;
- e. Problem Gambling Counselor Associate status may be held a maximum of three years.

B. **CLINICAL SUPERVISION:** Problem gambling treatment providers who are not trained to diagnose or treat mental illness other than substance use disorders and gambling disorders, as determined by the scope of practice provided by their professional license, are required to make provisions for a minimum of two (2) hours per month of clinical supervision or consultation by a clinical supervisor with at least two years of postgraduate experience providing mental health services to adults. Supervisory staff who oversee the treatment of individuals with diagnoses other than substance use disorders and gambling disorders shall hold a license allowing them to diagnosis and treat a range of mental health disorders. Supervisors shall complete at least 10 hours of gambling specific education within the past two years including 2 hours on supervising gambling treatment counselors and maintain documentation evidencing each supervisor's compliance with this education and licensing standard.

C. **COMPETENCY:** Providers shall refer individuals to other professionals if an individual's clinical presentation is beyond the scope of the Provider staff's competency as determined by their certification restrictions, or license restrictions, or supervisor evaluation, or self-evaluation.

IV. **Accountability** – Providers shall deliver the services in accordance with the following standards:

A. **Guidelines for Treatment Services** – Providers shall provide a variety of diagnostic and treatment service alternatives to each individual receiving problem gambling treatment. Treatment plans shall be designed to meet the particular individual's needs and resources as identified in the comprehensive assessment. Providers shall offer, at minimum, the following types of problem gambling treatment services:

1. **Assessment** – The assessment involves a face-to-face interview with the individual completed within the fifth client contact following enrollment into the treatment program. The purpose of the interview is to collect and assess pertinent information regarding the individual's past history and current situation that results in a clinical diagnosis and a recommendation regarding the need for treatment. The Provider shall have the ability to perform a structured interview process to assess the existence of problem gambling and co-existence with other disorders including, but not limited to, substance abuse, mental disorders, and significant health problems. Suicide potential and potential to harm others must be assessed and clinical records must contain follow-up actions and/or referrals when a client reports symptoms indicating risk of harm to self or others.

2. Orientation: The provider shall give to the client, document the receipt of by the client, and make available to others, written program orientation information which includes:
  - a) The program or provider's philosophical approach to treatment;
  - b) A description of treatment services;
  - c) Information on client's rights and responsibilities, including confidentiality, while receiving services and following discharge.
  - d) Information on the rules governing client's behavior and those infractions that may result in discharge or other actions. At a minimum, the rules shall state the consequence of substance use and gambling while in treatment, absences from appointments and failure to participate in the planned treatment activities; and
  - e) Information on emergency services.
  
3. Individual, Family, and Group Treatment – Treatment sessions must address the problems of the individual(s) as they relate, directly or indirectly, to the problem gambling behavior.
  - a. **CRISIS INTERVENTION** – Providers shall accommodate after-hour crisis intervention as necessary. This may be accomplished through agreement with other crisis services or on-call staff.
  
  - b. **FAMILY & COUPLES COUNSELING** – To the extent reasonably practicable, providers should make efforts to accommodate the therapeutic needs of family members, partners, and concerned others of problem gamblers. This may be accomplished, in part, by forming working relationship with other problem gambling counselors and referring to colleagues the partner and/or family members of a problem gambler when either such requests are made or it is in the best interest of the gambler and family member(s) to work with different counselors.
  
  - c. **DISCHARGE PLANNING** – A recovery/wellness plan or relapse prevention plan shall be developed by the Provider in collaboration with the individual and placed in the individual's file. A wellness plan shall be initiated early in treatment and finalized prior to discharge. The client's signature and date is proof of participation in the discharge planning. If the client was not involved in discharge planning, the file must show documentation that the client was notified of file closure. The discharge plan/relapse plan must document the therapeutic closure of formal treatment for the identified individual as well as recommendations and community resources for ongoing recovery.
  
4. Continuity of Care (community resources) – Providers shall have the capacity to coordinate services and make appropriate referrals to other formal and informal

service systems, such as: mental health, Gamblers Anonymous, Gam-Anon, financial consultants, legal advice, medical, crisis management, cultural issues, housing, vocational, etc. The referral and follow-up action needs to be documented in the client's file.

## **B. Documentation**

Providers shall create and maintain the following documentation with respect to each individual receiving problem gambling treatment:

1. Identifying and demographic information for the individual including, at a minimum: name, address, telephone number, date of birth, gender, marital status, and emergency contact. Any additional identifying and demographic data reasonably required by funding body.
2. Intake assessment documentation for the individual, including:
  - referral source;
  - presenting problem;
  - gambling history;
  - current financial status assessment;
  - history of substance use and substance use disorders, including past treatment episodes, assessment of risk of possible withdrawal, and history of other behavioral addictions;
  - health status (e.g., last physical, diet, exercise), current medical problems including medication use;
  - mental health history and current mental health status (e.g., treatment history, psychiatric medications);
  - profile of family of origin and marital/relationship history which describes family composition and dynamics;
  - recovery environment;
  - strength and recovery assets;
  - education and vocational history;
  - legal history (including arrest and conviction history);
  - risk of harm to self or others (e.g., assess for suicide risk, intimate partner violence, child neglect and abuse, elder abuse)

The information gathered shall include an intake assessment summary containing a DSM IV diagnosis with supporting documentation, level of risk of

harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider.

3. An individualized treatment plan shall be developed in accordance with general professional standards for either substance abuse or mental health outpatient services. The treatment plan shall be completed within 30 days of intake or the third session following the commencement of treatment to the individual. The treatment plan shall:
  - a) address client-centered issues identified from the assessment and modified as appropriate,
  - b) be written with clear and measurable objectives that are consistent with the client's abilities and strengths and that the individual agrees to as the foundation of treatment,
  - c) include an adequate range of services,
  - d) include a financial plan,
  - e) include regularly scheduled face-to-face sessions,
  - f) document that participation of the family members was encouraged, and
  - g) reflect the theoretical treatment approach taken by the program in clinical sessions.
  - h) The treatment plan shall be reviewed and modified continuously as needed and as clinically appropriate, and documentation of a treatment plan review shall be no less frequent than once every 90 days.

The individual's signature and signature date will signify participation in the development and review of the plan. The treatment plan shall also be signed and dated by the clinician.

4. The individual's progress and current status in meeting the goals set in the treatment plan shall be documented within 72 hours of all clinical contacts. All progress notes shall be dated, indicate type and length of service, location of service, contain data from the session, clinical assessment, a clinical plan, and be signed by the person providing the service.
5. The following additional information shall be documented in the client file:
  - Documentation that the individual has been informed of client rights and responsibilities, including the Health Insurance Portability and Accountability Act (HIPAA) privacy rule and other confidentiality protections and exceptions;
  - Results of all examinations, tests, intake, and assessment information;
  - Reports from referring sources;
  - Correspondence related to the individual, including letters and dated notations of telephone conversations relevant to the individual's treatment;

- Information release forms, signed and dated with client and clinician's signatures;
  - Gamblers Anonymous or other community support network participation; and
  - Consent to treat form signed by the individual (see Section VIII)
6. Data collection forms and questionnaires, with compliance to data collection and reporting requirements specified by the funding body, when applicable.
  7. Within 30 days of the client leaving treatment, a treatment summary shall be completed stating the reason for discharge, progress toward treatment plan objectives, and recommendations.
  8. Clients not provided services for 30 continuous days should be notified by letter of their case file closure, invited back to treatment if appropriate, and a treatment summary should be completed within 60 days of last service.
- V. Financial - Providers of problem gambling treatment should implement a structured process for assessing client financial circumstances and needs of individual. Treatment strategies should be developed to address the individual's financial circumstances and needs that may include, but are not limited to:
- developing a financial management plan for the individual that includes a restitution plan, if appropriate;
  - connection with relevant financial assistance services;
  - developing a plan with the individual to cope and manage with loan/debt collectors, if appropriate.
- VI. Effectiveness – Providers should use appropriate treatment techniques and be able to document the effectiveness of treatment using measurable criteria, including:
- A. Have a system for measurement of progress and outcomes as stated in treatment objectives on the treatment plan.
  - B. Clearly define the process for internal program review and self-correction (e.g., Continuous Quality Improvement Protocols). A program shall develop and implement written policies and procedures that describe program operations. Policies and procedures shall include a quality assurance plan for ensuring that clients receive appropriate treatment services and that the program is in compliance with relevant administrative rules and other reporting requirements.

- C. If two or more staff provide services, the program shall have and implement the following written personnel policies and procedures, which are applicable to program staff and interns/students:
  - a) rules of conduct and standards for ethical practices of treatment program practitioners;
  - b) Standards for use and abuse of alcohol and other drugs with procedures for managing incidents of use and abuse that, at a minimum, comply with Drug Free Workplace Standards; and
  - c) Compliance with regulations related to employment practices.
- D. Implement a written treatment approach that is defined and supported in current literature.

VII. Efficiency – Providers shall provide services in the least restrictive setting and in the most cost-effective manner based on the individual’s needs, resources, and strengths as determined by the problem gambling assessment.

VIII. Client Protections and Rights – Providers shall:

- A. Maintain the confidentiality of all client records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.
- B. Develop and implement policies and procedures to safeguard and protect the case record of individuals against loss, tampering, or unauthorized disclosure of information. Maintenance of such records shall include adequate physical facilities for the storage, processing, and handling of the records. These facilities shall include suitably locked, secured rooms for file cabinets.
- C. Retain the records of individuals for a minimum of seven years.
- D. The client shall have the right of access to records. Access includes the right to obtain a copy of the record within five days of requesting it and making payment for the cost of duplication. The client shall have the right of access to the client’s own records except:
  - a) When the clinical supervisor determines that disclosure of records would be detrimental to the client’s treatment; or
  - b) If confidential information has been provided to the program on the basis that the information not be re-disclosed.
- E. Require each individual to sign consent to treatment statements which includes conditions under which confidentiality can (or must) be broken.
- F. Document, and inform each individual of the individual’s rights and responsibilities in treatment. Each client shall be assured the same civil and human rights as other

- persons. Each program or private-practice provider shall develop and implement and inform clients of written policies and procedures which protect clients' rights including:
- c) Protecting client privacy and dignity;
  - d) Prohibiting physical punishment or physical abuse;
  - e) Protecting clients from sexual abuse or sexual contact and
  - f) Providing adequate treatment or care.
- D. Documentation must include a formal grievance procedure with provision for appeals. The program or private practice provider shall develop, implement, and fully inform clients of policies and procedures regarding grievances that provide for:
- a) Receipt of written grievances from clients or persons acting on their behalf;
  - b) Investigation of the facts supporting or disproving the written grievance;
  - c) Initiating action on substantiated grievances within five working days;
  - d) Documentation in the client's record of the receipt, investigation, and any action taken regarding the written grievance.
- E. The client shall have the right to refuse service, including any specific procedure. If consequences may result from refusing the service, those consequences must be explained verbally and in writing to the client.