

Core Competencies for Disordered Gambling Counsellors: A Modified Delphi Study

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Abstract

Counselling for disordered gambling has emerged as a unique professional field. Research and literature on treatment approaches and best practices has burgeoned over the past 30 years. This has included the development of journals, field-specific conferences, and professional training programs specifically dedicated to understanding and treating gambling problems. Mental health professionals are now expected to master field specific knowledge and undergo supervision prior to engaging in problem gambling counselling. In this paper, we share the results of a modified Delphi study in which 45 experts reached agreement on core competencies for problem gambling treatment providers. A total of 166 core competencies were endorsed as high agreement items. The authors share implications and the potential usefulness of core competencies for problem gambling counsellor professional preparation, workforce development, and quality of care.

Keywords: core competencies, disordered gambling counsellors

Résumé

Le counseling consacré au jeu pathologique est devenu un domaine professionnel à part entière. Depuis une trentaine d'années, les travaux de recherche sur les approches et les pratiques exemplaires en matière de traitement ont connu un véritable essor. Ainsi, on a vu apparaître des revues, des conférences spécialisées et des programmes de formation dédiés à l'analyse des problèmes de jeu et à leur traitement. Aujourd'hui, les professionnels de la santé mentale intéressés par ce domaine doivent acquérir des connaissances précises sur le sujet et travailler sous la supervision d'un spécialiste avant de s'y consacrer. Cet article présente les résultats d'une enquête Delphi modifiée à laquelle ont participé 45 spécialistes qui se sont mis d'accord sur les compétences de base à exiger des fournisseurs de traitement.

Au total, 166 compétences font l'objet d'un large consensus. Les auteurs discutent des implications découlant de l'enquête, de l'utilité éventuelle des compétences de base en matière de formation professionnelle, de perfectionnement de la main-d'œuvre et de qualité des soins.

Introduction

Counselling for disordered gambling has clearly emerged as a unique professional field, as evidenced by the development of specialized field knowledge and skills. Formal processes are in place in many countries to ensure those persons who claim this professional identity meet expectations of credentialing bodies that are informed by experts in the field. Field specific research and knowledge has burgeoned over the past 30 years as indicated by the development of journals, conferences, and professional training programs specifically dedicated to understanding and treating gambling problems. Given these advances, we are well poised to follow the lead of related fields by developing core competencies (Miller et al., 2010) that can help guide the professional preparation and evaluation of those practitioners specializing in disordered gambling counselling.

While still a relatively new area of exploration, research on counsellor characteristics and specific types of interventions that may influence the effectiveness of problem gambling treatment is beginning to emerge. Most notably, Rodda and colleagues (2018) recently completed a study of disordered gambling treatment literature that included a system for classifying types of interventions that may account for the level of treatment effectiveness. They identified eighteen types of change techniques that were represented in the literature. Mastery of effective intervention techniques is closely related to core competencies. Determining core competencies for problem gambling treatment providers is one way of responding to the call by Rodda and colleagues (2018) for further work to determine “why” and “how” treatment works (p. 223).

In this study, we asked the question, “What are the core competencies that problem gambling counsellors must master to be considered professionally prepared?” and relied on the collective wisdom of experts in the field to find an answer. These experts served on a panel that was charged with reaching agreement on the competencies they deemed important and relevant to problem gambling counselling. Here we share the resulting 166 agreed-upon core competencies that secured high agreement among this panel, along with items that experts either disagreed on or agreed were of low importance to such counselling. We discuss implications and potential usefulness of core competencies not only for problem gambling counsellor preparation and evaluation, but also for professional development and quality care assurance.

Brief Overview of Relevant Literature

Research on the treatment of disordered gambling has emerged rapidly over the past three decades. This development is particularly true in relationship to cognitive behavioural therapy (CBT) and motivational interviewing (MI; Echeburua et al., 2017; Pasche et al., 2013; Rizeanu, 2015). Interestingly, while evidence of treatment effectiveness across a number of approaches does exist, studies that have compared treatment models with one another (e.g., CBT with MI) have not determined significant differences in effectiveness or identified the specific interventions that contributed to the intended outcomes (Oei et al., 2010; Oei et al., 2018; Smith et al., 2013; Toneatto & Gunaratne, 2009).

Efforts have been made, particularly over the past two decades, to establish core competencies within most behavioural health disciplines, including addictions counselling, marriage and family therapy, psychology, psychiatry, mental health counselling and social work (Hoge et al., 2005). Core competencies define the knowledge and skills believed to be necessary to practice within specific professional fields effectively. As such, competencies are used to ensure the quality of healthcare by serving as benchmarks to guide professional preparation (e.g., formal education, workforce development), supervision, and evaluation. To our knowledge, no studies have taken place that focus specifically on developing a comprehensive set of core competencies for problem gambling treatment providers.

Merkouris and colleagues (2016) completed an extensive review of the literature to identify predictors of successful outcomes in the treatment of disordered gambling. Their analysis of 50 articles from 1990 to 2016 revealed a lack of attention to therapist characteristics. In another study investigating the relationship between client characteristics and treatment attrition (Dowling, 2009), no specific demographic variables were found to be significant; however, the author did also speculate that nonspecific factors, such as therapist personal characteristics, may in fact be responsible for differences in client retention.

Related studies have primarily focused on the relationship between therapeutic alliance and problem gambling treatment outcomes. For example, Smith and colleagues (2004) examined the relationship between therapeutic alliance and several problem gambling counselling outcomes, including problem resolution, satisfaction with service, and improved life skills. Findings indicated that therapeutic rapport was positively associated with all areas of problem resolution (e.g., gambling, financial issues, familial relationships), as well as satisfaction with services, and life skills (e.g., self-awareness, self-esteem, ability to accept responsibility). Dowling and Cosic (2011) investigated client engagement characteristics associated with treatment outcomes among 475 clients seeking treatment in an outpatient treatment setting and 15 problem gambling counsellors. Results showed, among other findings, that general functioning (e.g., satisfaction with outside relationships, ability to cope with challenges, optimism) outcomes were positively associated with client-rated and therapist-rated therapeutic alliance. In yet another study on predictors of treatment

outcomes, Guo and colleagues (2014) included 80 clients who attended disordered gambling treatment in Southeast Asia. These authors examined outcomes related to gambling frequency, symptom severity, and quality of life at 3-, 6-, and 12-months post treatment. Treatment satisfaction (e.g., confidence in therapist, therapist demonstrating an understanding of client's goals, therapist availability and openness to answer questions) was the only significant predictor of outcomes related to clinical and treatment process. These findings echo the research on common factors (Leibert & Dunne-Bryant, 2015; Sprenkle et al., 2009), including the relationship between therapeutic alliance and counselling outcomes across the helping fields (Holdsworth et al., 2014).

Rodda and colleagues (2018) reviewed 35 studies (across 37 published articles) on therapist-delivered problem gambling treatment to identify eighteen types of change techniques. In order of frequency, these change techniques included relapse prevention, cognitive restructuring, behavioural substitution, stimulus control, motivational enhancement, prompting goal setting, feedback on assessment, information gathering, decisional balance, social support, problem solving, self-monitoring, imaginal desensitization, exposure therapy, financial regulation, social comparison, and social skills training. While not specifically called out as such, this study, as well as the broader literature on problem gambling treatment, provides a rich resource for extrapolating potential competencies. Our research extends these efforts by identifying and building consensus among problem gambling treatment experts related to core competencies counsellors must master to be considered professionally prepared for practice.

Method

In our current study, we used a modified Delphi method to obtain a consensus from a panel of experts on core competencies for problem gambling treatment. Developed in the 1950s by Dalkey and Helmer (1963), the Delphi method uses a series of questionnaires, or rounds, to collect panelists' opinions on a topic. After each round, the responses are summarized and distributed to the panel for consideration in subsequent rounds until consensus is reached. In this way, panelists are given an opportunity to reconsider their views based on the summary of responses from a previous round (Hsu & Sandford, 2007). At the same time, the promise of anonymity allows panelists to voice their opinions without concern for those of others, which reduces undue influence by dominant voices (Dalkey, 1969).

Participants and Procedure

Panelists in this study were a multidisciplinary group of experts on disordered gambling treatment. They were identified based on their expertise in researching, publishing, and presenting on problem gambling treatment or providing clinical treatment to those persons with gambling disorders. Potential panelists were identified by reviewing the authorship of published research on problem gambling treatment; asking for peer recommendations; and reviewing conference proceedings.

A total of 57 potential panelists located across six countries (i.e., Australia, Romania, United States, Canada, United Kingdom, Colombia) were invited by e-mail to participate. Experts in providing problem gambling treatment were identified and invited to participate through the International Certified Gambling Counselor (ICGC)-II and Board Approved Clinical Consultant (BACC) Certification listservs. To be eligible for participation, potential panelists had to meet one of the following criteria: (1) have at least one publication on disordered gambling treatment, (2) be a ICGC-II and/or BACC certified problem gambling treatment provider, or (3) be a clinical supervisor or university instructor working with problem gambling treatment providers or trainees.

Fifty-two panelists met the inclusion criteria and completed the first questionnaire. Of those participants, 18 were identified through the reviews of published research, conference proceedings, and peer recommendations (response rate of $18/57 = 31.6\%$), and 34 were identified through the ICGC/BACC listservs. Forty-five of the fifty-two (86.5%) also completed the second questionnaire. Table 1 includes the professional backgrounds, education, publication and presentation records, supervision status, and regional context of panelists.

Core Competency Development

Between 2015 and 2017, the first author conducted process research on problem gambling treatment at a state approved, county-funded problem gambling treatment center within a university setting. Researchers reviewed transcripts of 50 disordered gambling sessions to identify approximately 75 change techniques. Researchers used concept mapping to identify initial groupings of change techniques. Members of the research team independently assigned items to themes or domains before coming together to compare lists and revise domains. Domains were adjusted to include all items, and items that were on different lists or appeared at first to belong to more than one domain were discussed until consensus was reached. As a result of this process, change techniques were grouped into five domains, including (1) knowledge of problem gambling and problem gambling treatment, (2) risk assessment and management, (3) treatment skills and interventions, (4) case management and ethical practice, and (5) sociocultural awareness and competence (McDowell & Berman, 2018).

We conducted a comprehensive review of articles on problem gambling treatment published between 1960 and 2019 to identify potential competencies. We located articles by conducting a systematic search of electronic databases (i.e., PsychNet, PubMed, SocINDEX, Psych and Behavioral Sciences/EBSCO, Social Science Citation Index and Academic Search Premier), hand searches of select journals, and reference sections of literature reviews. Search terms included problem* OR pathology* Or disorder* AND gambl* AND treatment* Or intervention* OR program* OR evaluation* OR provider. Manual review and SPSS software were used to identify duplicate records. A total of 445 articles included reference to treatment approaches. Two researchers reviewed abstracts and the content of each article to identify and record all suggested therapeutic interventions. One reviewer

Table 1
Participants' Professional Background Characteristics (n = 52)

Category	<i>n</i>	%
Professional Background		
Licensed mental health/ counsellor	21	40.4
Licensed drug and alcohol counsellor	5	9.6
Licensed psychologist	5	9.6
Licensed social worker	5	9.6
Licensed family therapist	2	3.8
Psychiatrist	1	1.9
Other	5	9.6
No professional license	6	11.5
Drug and Alcohol Certification		
Yes	26	50.0
No	26	50.0
Highest Degree Earned		
Doctoral degree	11	21.1
Terminal professional degree (MD, JD)	3	5.8
Master's degree	31	59.6
Bachelor's degree	7	13.4
Publications on Problem Gambling Treatment		
Articles	17	32.7
Books	5	9.6
Chapters	10	19.2
Presented at Conferences		
Regional Conferences	34	65.4
National Conferences	28	53.8
Current clinical practice		
Yes	42	80.8
No	10	19.2
Current clinical supervision		
Yes	26	50.0
No	26	50.0
Geographic Locations		
Eastern U.S.	17	32.7
Western U.S.	15	28.8
Midwest U.S.	13	25.0
Southern U.S.	4	7.7
Canada	3	5.8

also reviewed and added any additional problem gambling treatment interventions that were recommended in books, unpublished reports, manuals, and state guidelines that were published in the period between 1980 and June 2018. Results of this review informed our list of 191 potential core competencies. Thus, we added 116 potential competencies to the original 75 identified change techniques. It was not necessary for this list to be exhaustive given the conceptual framework of Delphi studies in which experts themselves have the opportunity to determine or add to items being rated for consensus by the panel as a whole, or both.

The research team used concept mapping to sort potential competencies into the five domains, previously identified. All competencies fit within these domains and no additional domains were required. Given the large number of potential competencies, we then sorted items into sub-themes, again using concept mapping. The research team reviewed and discussed the list of themes and subthemes to reach consensus. The competencies were sorted into five domains: (1) knowledge of disordered gambling and problem gambling treatment, (2) psychoeducation, (3) basic disordered gambling treatment skills, (4) case management and ethical practice, and (5) sociocultural awareness and competence. The third domain, basic disordered gambling treatment skills, comprised thirteen subdomains, including (1) assessing and managing risk, (2) initiating treatment, (3) completing assessments, (4) developing and using treatment or service plans, (5) facilitating therapeutic process, (6) addressing money, (7) applying cognitive strategies, (8) increasing mindfulness, (9) applying behavioural strategies, (10) applying emotion-focused strategies, (11) applying values strategies, (12) applying relapse management strategies, and (13) applying relational strategies. One item that was added by a panelist under the theme of general knowledge of disordered gambling referred to confidentiality (1.1.11). This item was left under this domain for the final Delphi round even though researchers later agreed it better fit under the domain of case management and ethical practice.

Delphi Method Round One

The Delphi process traditionally begins with an open-ended questionnaire in the first round. A common modification of this process involves the use of a closed-ended questionnaire that is based upon an extensive review of the literature (Hsu & Sanford, 2007). In this study we used a combination of closed- and open-ended questions in Round One to collect panelists' opinions on core competencies for disordered gambling treatment.

We initiated the first round by e-mailing potential panelists an explanation of the project and an invitation to participate. Those persons who accepted the invitation were directed to a web-based rating sheet that included 191 proposed competencies. Panelists were asked to rate each proposed competency on a five-point scale ranging from 1 = *Not relevant* to 5 = *Highly relevant and important*. Additionally, panelists were asked to provide comments on the proposed competencies and suggestions for additional competencies. After Round One data had been collected, we computed measures of central tendency and variability for all proposed competencies and e-mailed a summary of these findings to panelists. Additionally, we wrote 21 new statements based on panelists' responses to open-ended questions.

Delphi Method Round Two

Panelists were e-mailed an invitation to review a second round of potential competencies. The invitation included a brief explanation of the Delphi study method and a request for the panelists to consider their ratings given the responses of other panelists. Those who agreed to participate were asked to complete a web-based

rating sheet that included 203 proposed competencies: 182 competencies from Round One and 21 new competencies. Nine competencies that had been rated as relevant and important (i.e., a rating of 4 or 5) by all Round One panelists were removed from the rating sheet that was administered in Round Two. Key findings from Round One (i.e., mean, standard deviation, and percent agreement) were added alongside each competency listed on the rating sheet in Round Two. Additionally, each panelist was e-mailed a copy of the results from Round One, which included measures of central tendency and variability for each competency, and for each panelist, a listing of their ratings in Round One. In keeping with the promise of anonymity, individual-level scores from other panelists were not revealed. After data collection was completed, we computed measures of central tendency and variability for all proposed competencies and distributed a summary of the findings to the panelists. As stable agreement on a large number of proposed competencies had been reached after Round Two, no additional rounds were conducted.

Data Analysis

Analyses were conducted using SPSS V.25. For each proposed competency, we computed measures of central tendency (i.e., mean, median, mode) and variability (i.e., standard deviation and frequencies). Additionally, we computed the percentage of those who rated each competency as relevant and important (i.e., a rating of 4 or 5), the percentage of those who rated each competency as unimportant or irrelevant (i.e., a rating of 1 and 2), and the interquartile range, which was calculated as the difference between the 70th percentile and the 30th percentile. Agreement was determined when 75% or more of panelists rated a competency in either extreme (i.e., 1–2 or 4–5), and disagreement was determined when 30% or more panelists rated a competency in both extremes (i.e., 1–2 and 4–5) or when the interquartile range (IQR) was greater than 1.0 (von der Gracht, 2012).

Ethics

Ethics approval was obtained from the Human Subjects Research Committee (Institutional Review Board) at Lewis & Clark. The panelists participated voluntarily and with compensation of \$150 US per round.

Results

Overall, a high level of agreement was determined on core competencies among problem gambling treatment experts. Agreement was reached on 166 core competencies after two rounds (Appendix A). In addition, close to two thirds of competencies (109 out of 166, 66%) were rated by 90–100% of panelists as important and relevant. Over a quarter of competencies (44 out of 166, 27%) were rated as important and relevant by 80–89% of panelists, and under ten percent of competencies (13 out of 166, 8%) were rated as important and relevant by 73–79% of panelists. A total of 44 potential competencies were rated as relevant by fewer than 73% of panelists (Appendix B).

After Round One, agreement took place on 154 out of 191 competencies, as determined by 75% of more panelists rating these competencies as relevant and important (i.e., a rating of a 4 or 5). Of 154 competencies, 9 received endorsement by all panelists and were, therefore, removed from the rating sheet administered in Round Two. Thirty-seven of 191 proposed competencies were rated as relevant and important by fewer than 75% of panelists. Disagreement took place on ten of these competencies as evidenced by an IQR in excess of 1.0. Additionally, in one instance, 30% or more of panelists rated a competency in both extremes of the rating scale. Twenty-seven items were rated by 20% or more of panelists as moderately relevant and important.

After Round Two, agreement was found on 157 out of 203 competencies, as determined by 75% of more panelists rating these competencies as relevant and important (i.e., a rating of a 4 or 5). Of 157 competencies, 13 received endorsement (i.e., a rating of a 4 or 5) by all panelists. Additionally, 19 out of 157 competencies were newly introduced in Round Two, and 138 out of 157 were introduced in Round One. Of 138 competencies that were introduced in Round One (and endorsed in Round Two), 137 were endorsed by 75% of more panelists in Round One and one was endorsed by 73.1% of panelists in Round One. It is worth noting that 137 competencies that were endorsed in both rounds constituted 94.5% of competencies that had been endorsed in Round One (i.e., 137 out of 145 competencies, after removing 9 competencies that were endorsed by all panelists in Round One).

Disagreement took place concerning eight competencies in Round Two, as evidenced by an IQR in excess of 1.0. Of these, four had been endorsed by 75% of more panelists in Round One; two were disagreed upon in Round One; and two were newly introduced in Round Two. Thirty-four proposed competencies received mixed support in Round Two, with anywhere between 25% and 57% of panelists rating them as moderately relevant. Of these, eight were a subject of disagreement in Round One; the levels of support for these items declined in Round Two, and most panelists now rated them as moderately relevant.

Altogether, panelists agreed upon 166 core competencies for disordered gambling treatment providers, as shown in Appendix A. This included 9 competencies that were unanimously agreed upon in Round One; 13 competencies that were unanimously agreed upon in Round Two (one of which was newly introduced in Round Two); 18 competencies that were newly introduced in Round Two based on panelists' suggestions in Round One; 125 competencies that were endorsed in both rounds; and one competency that was endorsed in Round Two and that 73.1% of panelists in Round One rated as relevant or important.

Discussion

This study resulted in a robust list of agreed upon core competencies for problem gambling counsellors. While it is not possible to comment on all competencies, a number of trends pertinent to this discussion did still emerge. First, agreement

appeared to take place among experts that a unique body of knowledge and sets of skills do indeed exist, and that those persons providing counselling for problem gambling must master to be effective. Second, the results indicate that a number of competencies are in play, ones that require counsellors to tailor existing interventions to problem gambling treatment. Along this same line, a number of competencies focus on basic counselling process competencies that are widely accepted across disciplines. Finally, it is important to note that panelists endorsed family treatment.

While a number of core competencies are in keeping with the problem gambling change techniques identified by Rodda and colleagues (2018), several were not. Differences include a lack of endorsement among panelists in our study for imaginal desensitization, social skills training, and exposure therapy, as well as panelists in our study endorsing the importance of attending to the role of families in problem gambling treatment.

Unique Knowledge and Skills

All panelists agreed that it is important to screen accurately for and to diagnose disordered gambling, and nearly all agreed that it is important to understand gambling types as well as treatment resources specific to problem gambling recovery. All panelists further accepted that counsellors should know accepted counselling theories and best practice in problem gambling treatment. Panelists also by and large agreed on areas of psychoeducation that counsellors should be prepared to explain to clients, including the basics of problem gambling and recovery, realities of chance, luck and skill, biopsychosocial model of problem gambling and recovery, impact of gambling on the brain, stages of change, potential impact of gambling on the family, understanding of gambling as a conditioned response, and behaviours that support gambling (e.g., bailouts, loans). These findings indicate not only that experts view psychoeducation as an important element of successful treatment, but also that considerable agreement does exist about the type of knowledge clients need to encourage recovery.

Another area panelists endorsed that is specific to disordered gambling counselling involves assessing financial risks and identifying debt, taking steps to help families protect their finances, and identifying and reporting financial abuse of elders or vulnerable adults. Competencies related to finances also include the ability to explore the meaning of money, as well as track behaviours related to money and the access clients have to money. Panelists agreed counsellors should guide clients in establishing money barriers and help them develop and follow a budget. Agreement was reached on the importance of facilitating disclosure of debt to family, and helping clients accept financial responsibility or develop plans for restitution. Panelists added in Round One and agreed in Round Two that it is important to help clients increase accountability and transparency around money. This finding echoed change strategies identified by Rodda and colleagues (2018) regarding the importance of financial regulation in problem gambling treatment. Overall, these findings support the fact that a unique body of knowledge and skills does exist,

one that experts agree need to be mastered by professionals who provide disordered gambling counselling. This stance is further reflected by the expectation that disordered gambling counsellors should engage in continuing professional education related to problem gambling.

It is interesting to note that some knowledge commonly considered integral to the field was actually not widely endorsed. For example, although the history of gambling is often included in books and courses covering problem gambling treatment, this item had one of the lowest endorsement rates, along with an item on providing bibliotherapy, which is also frequently encouraged in the literature. Gamblers Anonymous (GA), gambling related self-help and support groups other than GA, and referring clients to GA pressure relief groups were endorsed at a higher level than bibliotherapy but did not meet inclusion criteria. Again, this is an interesting finding given the seemingly long-standing endorsement of GA among treatment professionals. Explaining gambling machines and the mathematics of probability were also not widely endorsed as integral to psychoeducation, nor was identifying and exploring the dream world.

While considerable agreement does operate as to knowledge and competencies unique to treatment of disordered gambling, a high level of agreement was also located regarding the importance of interdisciplinary knowledge. This included competencies related to identifying, assessing, and diagnosing co-addictions, as well as identifying, assessing, and diagnosing co-occurring mental disorders. Similarly, high agreement was discovered among panelists that counsellors should be aware of similarities and differences between disordered gambling and substance abuse disorders.

Tailoring Treatment

Panelists identified a number of competencies that reflect the importance of the Transtheoretical Model of Change (Blaszczynski & Nower, 2002), using applicable established treatment models, and applying general counselling skills to problem gambling counselling. For example, panelists unanimously endorsed the use of motivational interviewing to encourage readiness for change, set treatment goals informed by stages of change, and tailor interventions based on the stages of change. This is in keeping with Rodda and colleagues (2018) identifying motivational enhancement as an important change strategy in the problem gambling counselling. Panelists also endorsed counsellors being flexible in supporting clients in their goals of harm reduction or abstinence, assessing the benefits or positive impact of gambling (i.e., what the person who gambles is trying to accomplish or gets from gambling), and demonstrating accurate empathy and understanding of problems while remaining centered and not pushing for change.

Likewise, panelists endorsed treating disordered gambling using existing counselling approaches that have proven to be effective with other individual problems. For example, most panelists endorsed a number of competencies that reflected the use of

cognitive behavioural (CB) strategies. Competencies that reflect the application of CB interventions in ways that specifically address gambling problems include challenging and helping clients reshape cognitive distortions related to gambling, exposing logic errors (e.g., gambler's fallacy, magical thinking), unearthing gambling beliefs such as explanations of wins (e.g., attribution of skill and losses (e.g., bad luck), and identifying gambling traps (i.e., thoughts that it is possible to improve luck). The importance of cognitive restructuring was also identified as a change strategy in the study by Rodda and colleagues (2018). Panelists agreed that it is important to identify and address schemas that impact recovery, increase awareness of gambling urges, notice thoughts and urges, identify and develop plans for addressing triggers, generate rational self-statements, track gambling patterns, and plan with clients how to interrupt gambling patterns. Behavioural change and stimulus control were also identified by Rodda and colleagues (2018) as important change strategies in problem gambling treatment. Panelists also endorsed helping clients avoid exposure to gambling cues and situations and strategize stimulus control such as identifying high-risk situations. Related interventions that are found in the literature, yet lacked endorsement, included exposure therapy, metacognitive therapy, and social skills training. Imaginal desensitization received the lowest overall endorsement. This finding is in contrast to the study by Rodda and colleagues (2018) in which imaginal desensitization, social skills training, and exposure therapy were listed as core change strategies.

In a similar vein, panelists endorsed common counselling interventions that address values, emotions and trauma. For example, panelists agreed on the importance of helping clients replace gambling with non-gambling activities that support their values and goals, linking behaviour and thoughts to emotions, and helping clients identify emotions that trigger gambling urges. Panelists also agreed on the importance of connecting pleasure and/or suffering to gambling, helping clients develop a different relationship with feelings that trigger gambling urges, and facilitating emotional and self-regulation regulation. Panelists added in the first round and agreed in the second round that treatment providers must be able to help clients develop coping skills for underlying problems such as emotional pain, depression and anxiety. Applying principles of trauma-informed care, which is widely accepted in counselling and addictions fields was strongly endorsed by most panelists.

It is interesting to note that while unanimous agreement was realized concerning the importance of knowing accepted counselling models and best practices for problem gambling treatment, endorsement for using theory to guide counselling interventions did not meet inclusion criteria.

Common Counselling Process Skills

Facilitating the counselling process, overseeing case management, and mitigating risk are among expectations common across mental health disciplines regardless of the type of problem being treated. This includes the ability to build and maintain

alliance, reflecting study outcomes across counselling fields (Holdsworth et al., 2014) as well as those specific to problem gambling treatment outcomes (Smith et al., 2004). Endorsed competencies included the expectation that counsellors should actively structure the counselling process. This included the ability to prioritize interventions that target what is most important at any given time, deliver specific, focused in- and between-session interventions, and follow-up on interventions. Panelists agreed that treatment providers need to demonstrate competence in determining the most useful treatment (e.g., individual, group, family) modality to reach each goal, evaluate the effectiveness of counselling to guide treatment (e.g., use of outcome measures), and actively engage clients in treatment planning and setting goals (Rodda et al., 2018).

Panelists endorsed a number of case management skills that involve overseeing the continuum of care (e.g., medical needs, crisis intervention, relapse prevention), coordinating treatment with other care providers (e.g., other counsellors, physicians), and referring to other providers and resources as needed (e.g., financial planners, attorneys, peer mentors). Those working in outpatient services were expected to maintain working relationships with residential treatment centers and coordinate referrals. Panelists endorsed expectations that providers must demonstrate professional case administrative skills (e.g., case notes, professional reports), and adhere to codes of ethics and state laws for problem gambling treatment.

As would be expected of experts in any mental health discipline, disordered gambling experts agreed on the importance of identifying and mitigating risk. This included endorsing screening for interpersonal violence and risk of harm to self or others. Panelists reached high level agreement on the importance of reducing risk-related intention, engaging family to mitigate risk, and developing safety plans. In keeping with Rhoda et al. (2018) mitigation of risk also included helping clients understand relapse warning signs and helping clients plan what to do if they relapse.

The Role of Family

Panelists supported competencies related to understanding the effects of problem gambling on individuals and families, assessing the influence of problem gambling on individuals and relationships, assessing relationship issues, and the importance of family and social networks in the recovery process. Panelists endorsed including family members in treatment, developing therapeutic alliance with family members and facilitating in-session family interactions. Panelists also agreed on the importance of encouraging clients to attune to feelings of family members and communicate feelings directly to family members. Competencies related to identifying and naming problematic power dynamics effectively within family and social context were endorsed along with ensuring space is made in counselling to value the experience and expression of all individuals, including those with less power. Attention to power dynamics included endorsing transformative action to support equitable relationships that contribute to long-term recovery. It is important to note that a number of family-related concerns were not widely endorsed, including

attending to the needs of children, intervening in problematic relational patterns, reinforcing clear boundaries and hierarchies in families, and identifying or adjusting to stages of change among family members.

Even though many competencies that are associated with family therapy were widely endorsed, the use of relational or family therapy models were not, nor were theories of human and family development. What is striking here is the lack of endorsement for accepted family therapy models and specialized family therapy field knowledge in treating families struggling with and affected by disordered gambling.

Study Limitations

Many of the articles we reviewed in efforts to identify potential competencies described, supported, and/or referred in general terms to specific treatment models. We did not ask panelists to endorse treatment models. This would be an interesting study in itself. From our perspective, the goal of identifying an agreed-upon set of core competencies is not to support a single model of treatment, but to identify transtheoretical field-based knowledge and skills that once mastered, can be clustered and applied through guiding theoretical principles of specific models.

Study limitations also include the fact that not all problem gambling treatment experts participated in the study, and those who did participate primarily represented English speaking, North American treatment contexts, i.e., the United States and Canada. While invitations to participate were sent to identified experts in six countries and the International Gambling Counselor Certification Board listservs include professionals from a variety of countries, all potential panelists who chose to participate were from Canada and the U.S. This may have swayed results, as disordered gambling practice recommendations appear to vary across different regions of the world (Authors, in progress). We are uncertain as to reasons those outside Canada and the U.S. did not participate, however would urge future research efforts to find ways to engage a more global professional community.

Core competencies should be routinely reviewed and revised to ensure they adequately reflect emerging research and contemporary best practices. It is also important to note that some advancements in the field that perhaps should have been included as core competencies may not be widely known, and therefore not included in the final list because of low levels of endorsement.

While engaging panelists from across disciplines may strengthen the argument for agreed upon endorsement of core competencies, differences in numbers of panelists across disciplines may have also skewed results. Nearly half of the panelists identified as mental health counsellors, far outweighing those who identified as psychiatrists, psychologists, family therapists, and social workers. Given the differences in educational preparation and practice emphasis across mental health fields, it is likely that some competencies were not endorsed because those who might endorse them were underrepresented. Finally, we did not gather

information on panelists' practice settings, nor did we ask them to identify whether they offered face-to-face or online counselling or both. Future research needs to explore the impact of primary professional identity and practice setting on the endorsement of core competencies.

Implications and Conclusion

Numerous ways exist concerning how core competencies can be used to improve overall quality of problem gambling treatment. According to Miller and colleagues (2010), "In its most noble aim, competency assessment is primarily outcome oriented, with the goal being to evaluate the effective application of knowledge and skill in a practice setting" (p. 64). We agree with the goal of using core competencies to evaluate performance and set professional development goals for problem gambling treatment providers. We also expand this goal to include the value of core competencies for clinical decision-making, problem gambling counsellor workforce development, agency improvement, and state and national certification.

Knowing what advanced problem gambling treatment providers deem important in treatment can help guide new and developing counsellors through the plethora of decisions they face about what is most important and what they need to do to facilitate change. The core competencies have an important place in determining the focus and designing problem gambling counsellor training and professional workforce efforts. Collective evaluation of these competencies can point to gaps in preparation and help trainers pinpoint areas for professional development. Counsellors can use the core competencies as a self-assessment tool to gauge where they want to seek out additional training and expertise. Agency administrators can assess the readiness of counsellors to meet the core competencies as well as policies that enhance or detract from competent problem gambling treatment delivery. The core competencies for problem gambling counsellors can be used to inform the national certification exam, as well as inform supervisor evaluations and endorsements for Certified Problem Gambling Counselor applications when applicable at various state, national and international levels. Finally, competencies can be used to inform problem gambling treatment research.

Core competencies do not address or replace the need to develop evidence-based models for the treatment of disordered gambling, but to stand alongside these models to ensure counsellors are well prepared to provide such treatments. This study was a first step in identifying core competencies for problem gambling providers. More research is needed to expand agreement among experts across countries and to integrate further these competencies into best practices for problem gambling treatment and they will need to be updated as the field advances. Next steps include further defining and operationalizing competencies for use in evaluation and training.

References

- Blaszczynski, A., & Nower, L. (2002). A pathways model of problem and pathological gambling. *Addiction*, *97*, 487–499. <https://doi.org/10.1046/j.1360-0443.2002.00015.x>
- Dalkey, N. C., & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. *Management Science*, *9*, 458–467. <https://doi.org/10.1287/mnsc.9.3.458>
- Dalkey, N. C. (1969). *The Delphi method: An experimental study of group opinion*. Santa Monica, CA: The Rand Corporation. https://www.rand.org/content/dam/rand/pubs/research_memoranda/2005/RM5888.pdf
- Dowling, N. (2009). Client characteristics associated with treatment attrition and outcome in female pathological gambling. *Addiction Research & Theory*, *17*, 205–219. <https://doi.org/10.1080/16066350802346193>
- Dowling, N. A., & Cosic, S. (2011). Client engagement characteristics associated with problem gambling treatment outcomes. *International Journal of Mental Health and Addiction*, *9*, 656–671. <https://doi.org/10.1007/s11469-010-9298-x>
- Echeburua, E., Amor, P. J., & Gomez, M. (2017). Current psychological therapeutic approaches for gambling disorder with psychiatric comorbidities: A narrative review. *Salud Mental*, *40*, 299–305. <https://doi.org/10.17711/SM.0185-3325.2017.038>
- Guo, S., Manning, V., Thane, K. K. W., Ng, A., Abdin, E., & Wong, K. E. (2014). Predictors of treatment outcome among Asian pathological gamblers: Clinical, behavioural, demographic, and treatment process factors. *Journal of Gambling Studies*, *30*, 89–103. <https://doi.org/10.1007/s10899-012-9328-7>
- Hoge, M., Paris, M., Adger, H., Collins, F., Finn, C., Fricks, L., Gill, K., Haber, J., Hansen, M., Ida, D., Kaplan, L., Northey, W., O’Connell, M., Rosen, A, Taintor, Z., & Tondora, J. and Young, A. (2005). Workforce competencies in behavioral health: An overview. *Administration and Policy in Mental Health*, *32*, 593–631. <https://doi.org/10.1007/s10488-005-3259-x>
- Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014). Client engagement in psychotherapeutic treatment and associations with client characteristics, therapist characteristics, and treatment factors. *Clinical Psychology Review*, *34*, 428–450. <https://doi.org/10.1016/j.cpr.2014.06.004>
- Hsu, C.-C., & Sanford, B. A. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research & Evaluation*, *12*(10), 1–8.

- Leibert, T. & Dunne-Bryant, A. (2015). Do common factors account for counseling outcome? *Journal of Counseling and Development*, 93, 225–235. <https://doi.org/10.1002/j.1556-6676.2015.00198.x>
- Berman, R. & McDowell, T. (2018). *Core Competencies in Problem Gambling Treatment*. Northwest Institute of Addiction Studies, Portland, Oregon, USA.
- Merkouris, S. S., Thomas, S. A., Browning, C. J., & Dowling, N. A. (2016). Predictors of outcomes of psychological treatments for disordered gambling: A systematic review. *Clinical Psychology Review*, 48, 7–31. <https://doi.org/10.1016/j.cpr.2016.06.004>
- Miller, J., Todahl, J., & Platt, J. (2010). The core competency movement in marriage and family therapy: Key considerations from other disciplines. *Journal of Marital and Family Therapy*, 36, 59–70. <https://doi.org/10.1111/j.1752-0606.2009.00183.x>
- Oei, T. S., Raylu, N., & Casey, L. M. (2010). Effectiveness of group and individual formats of a combined motivational interviewing and cognitive behavioral treatment program for problem gambling: A randomized controlled trial. *Behavioral and Cognitive Psychotherapy*, 38, 233–238. <https://doi.org/10.1017/S1352465809990701>
- Oei, T. P. S., Raylu, N., & Lai, W. W. (2018). Effectiveness of a self-help cognitive behavioural treatment program for problem gamblers: A randomized controlled trial. *Journal of Gambling Studies*, 34, 581–595. <https://doi.org/10.1007/s10899-017-9723-1>
- Pasche, S. C., Sinclair, H., Collins, P., Pretorius, A., Grant, J. E., & Stein, D. J. (2013). The effectiveness of a cognitive-behavioural intervention for pathological gambling: A country-wide study. *Annals of Clinical Psychiatry*, 25, 250–256.
- Rizeanu, S. (2015). Pathological gambling treatment: Review. *Procedia: Social and Behavioural Sciences*, 187, 613–618. <https://doi.org/10.1016/j.sbspro.2015.03.114>
- Rodda, S., Merkouris, S. S., Abraham, C., Hodgins, D. C., Cowlshaw, S., & Dowling, N. A. (2018). Therapist-delivered and self-help interventions for gambling problems: A review of contents. *Journal of Behavioral Addictions*, 7, 211–226. <https://doi.org/10.1556/2006.7.2018.44>
- Smith, D. P., Dunn, K. I., Harvey, P. W., Battersby, M. W., & Pols, R. G. (2013). Assessing randomized clinical trials of cognitive and exposure therapies for gambling disorders: A systematic review. *Behaviour Change*, 30, 139–158. <https://doi.org/10.1017/beh.2013.15>
- Smith, S. A., Thomas, S. A., & Jackson, A. C. (2004). An exploration of the therapeutic relationship and counselling outcomes in a problem gambling counselling service. *Journal of Social Work Practice*, 18, 99–112. <https://doi.org/10.1080/0265053042000180581>

Sprenkle, D., Davis, S. & LeBow, J. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York, NY: Guilford Press.

Toneatto, T., & Gunaratne, M. (2009). Does the treatment of cognitive distortions improve clinical outcomes for problem gambling? *Journal of Contemporary Psychotherapy*, 39, 221–229. <https://doi.org/10.1007/s10879-009-9119-3>

von der Grach, H. A. (2012). Consensus measurement in Delphi studies: Review and implications for future quality assurance. *Technological Forecasting & Social Change*, 79, 1525–1536. <https://doi.org/10.1016/j.techfore.2012.04.013>

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Appendix A

Core Competencies

Item	Mean [§]	SD	Mdn	Mo	%
Domain 1: Knowledge of Problem Gambling					
<i>Competent problem gambling counsellors have working knowledge of:</i>					
1.1.1	4.18	.94	4	5	77.8%
1.1.2	4.62	.53	5	5	97.8%
1.1.3	4.76	.53	5	5	95.6%
1.1.4	4.36	.71	4	5	86.7%
1.1.5	4.69	.56	5	5	95.6%
1.1.6	4.60	.54	5	5	97.8%
1.1.7	4.53	.63	5	5	93.3%
1.1.8	4.87	.34	5	5	100.0%
1.1.9	4.58	.66	5	5	91.1%
1.1.10	4.04	.82	4	4	77.8%
1.1.11	4.87	.34	5	5	100.0%
1.1.12	4.73	.58	5	5	93.3%
1.1.13	4.20	.81	4	4	84.4%
1.1.14	4.87	.34	5	5	100.0%
1.1.15	4.49	.76	5	5	88.9%
1.1.16	4.49	.76	5	5	88.9%
1.1.17	4.60	.58	5	5	95.6%
1.1.18	4.27	.84	4	5	84.4%
Domain 2: Psychoeducation					
<i>Competent problem gambling counsellors are able to:</i>					
2.1.1	4.51	.63	5	5	93.3%
2.1.2	4.67	.52	5	5	97.8%
2.1.3	4.27	.69	4	4	86.7%
2.1.4	4.89	.32	5	5	100.0%
2.1.5	4.62	.72	5	5	91.1%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
2.1.6 Explain the realities of chance, luck and skill.	4.40	.65	4	5	91.1%
2.1.7 Describe the gambling action cycle.	4.40	.69	5	5	88.9%
2.1.8 Describe the stages of change.	4.60	.69	5	5	93.3%
2.1.9 Describe the potential impact of gambling on family.*	4.77	.43	5	5	100.0%
2.1.10 Point out behaviours that support gambling (e.g., bailouts, loans).	4.91	.29	5	5	100.0%
2.1.11 Share how gambling urges are a conditioned response.	4.73	.45	5	5	100.0%
2.1.12 Describe how behaviourism learning theory is associated with gambling behaviour.	4.02	.72	4	4	80.0%
2.1.13 Share a biopsychosocial model of gambling and recovery.	4.33	.60	4	4	93.3%
Domain 3: Basic Problem Gambling Treatment Skills					
Subdomain 3.1: Assessing and Managing Risk					
<i>Competent problem gambling counsellors are able to:</i>					
3.1.1 Screen for interpersonal/domestic violence.	4.71	.46	5	5	100.0%
3.1.2 Assess financial risks and identify debt.	4.80	.40	5	5	100.0%
3.1.3 Take steps to help family protect finances from gambling.	4.84	.37	5	5	100.0%
3.1.4 Ask appropriate questions to assess risk of harm to self or other.*	4.98	.14	5	5	100.0%
3.1.5 Intervene in thinking to reduce risk-related intention.	4.73	.50	5	5	97.8%
3.1.6 Develop safety plans and strategies for reducing risk.	4.87	.34	5	5	100.0%
3.1.7 Engage family to mitigate risk.	4.78	.42	5	5	100.0%
3.1.8 Identify and report financial abuse of elders or vulnerable adults.	4.67	.60	5	5	93.3%
Subdomain 3.2: Initiating Treatment					
<i>Competent problem gambling counsellors are able to:</i>					
3.2.1 Create and maintain therapeutic alliance with individuals.	4.87	.46	5	5	95.6%
3.2.2 Include family members in treatment.	4.62	.61	5	5	93.3%
3.2.3 Create and maintain therapeutic alliance with family/all involved in treatment.	4.51	.63	5	5	93.3%
3.2.4 Create and maintain within-family alliance.	4.22	.74	4	4	82.2%
3.2.5 Help clients set goals.	4.82	.49	5	5	95.6%
3.2.6 Be flexible in supporting clients in their goals of harm reduction or abstinence.	4.76	.53	5	5	95.6%
3.2.7 Offer initial self-management strategies to stabilize gambling.	4.67	.56	5	5	95.6%
3.2.8 Routinely screen for problem gambling.	4.87	.40	5	5	97.8%
3.2.9 Accurately diagnose problem gambling.*	4.88	.32	5	5	100.0%
3.2.10 Accurately diagnose co-occurring addictions.	4.78	.47	5	5	97.8%
3.2.11 Accurately diagnose mental health issues.	4.69	.67	5	5	93.3%
3.2.12 Accurately diagnose relational issues.	4.29	.66	4	4	93.3%
3.2.13 Identify the influence of problem gambling on individuals and relationships.	4.67	.56	5	5	95.6%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree	
Subdomain 3.3: Completing Assessments						
<i>Competent problem gambling counsellors are able to:</i>						
3.3.1	Identify multiple domains that affect and are affected by gambling (e.g., social, familial, biological).	4.71	.46	5	5	100.0%
3.3.2	3.3.2. Assess for co-existing addictions co-occurring mental health disorders.**	4.62	.72	5	5	91.1%
3.3.3	Identify medical and pharmaceutical contributors to problem gambling.	4.49	.66	5	5	91.1%
3.3.4	Gather the history of gambling problems.	4.62	.65	5	5	91.1%
3.3.5	Gather information on current types of gambling.	4.40	.78	5	5	86.7%
3.3.6	Understand the potential of genetic and biological factors in problem gambling (e.g., dopamine underactivity, potential genetic propensity).	4.18	.78	4	4	82.2%
3.3.7	Assess benefits or positive impact of gambling (i.e., what the person who gambles is trying to accomplish or gets from gambling).**	4.73	.54	5	5	95.6%
Subdomain 3.4: Developing and Using Treatment/Service Plans						
<i>Competent problem gambling counsellors are able to:</i>						
3.4.1	Help clients envision change and recovery to set goals.	4.80	.46	5	5	97.8%
3.4.2	Connect treatment goals to problem gambling.	4.76	.48	5	5	97.8%
3.4.3	Base treatment plans on stages of change.	4.36	.74	4	5	88.9%
3.4.4	Actively include clients in treatment planning.	4.93	.33	5	5	97.8%
3.4.5	Use measurable objectives from treatment / service plan to inform treatment.	4.67	.60	5	5	93.3%
3.4.6	Establish short-term achievable goals to help clients to begin experience successes early on.**	4.67	.64	5	5	91.1%
3.4.7	Regularly re-examine service plans and treatment goals with client(s) to update as needed.**	4.80	.46	5	5	97.8%
Subdomain 3.5: Facilitating Therapeutic Process						
<i>Competent problem gambling counsellors are able to:</i>						
3.5.1	Demonstrate accurate empathy and understanding of problem(s).	4.82	.49	5	5	95.6%
3.5.2	Facilitate and actively structure the counselling process.	4.49	.69	5	5	93.3%
3.5.3	Use interventions that are tailored to stages of change.	4.29	.84	5	5	80.0%
3.5.4	Use motivational interviewing to encourage readiness for change.*	4.71	.46	5	5	100.0%
3.5.5	Help reduce shame around gambling and gambling relapse.**	4.78	.47	5	5	97.8%
3.5.6	Help clients increase self-acceptance.**	4.73	.50	5	5	97.8%
3.5.7	Remain centered without pushing for change, i.e., accept ambivalence.	4.69	.60	5	5	93.3%
3.5.8	Evaluate effectiveness of counselling (e.g., use outcome measures) to guide treatment.	4.49	.73	5	5	91.1%
3.5.9	Prioritize interventions targeting what is most important in treatment at any given time.*	4.77	.43	5	5	100.0%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
3.5.10 Identify positive change and progress/instill realistic hope and expectation of change.	4.89	.38	5	5	97.8%
3.5.11 Deliver specific, focused in-session interventions.	4.58	.62	5	5	93.3%
3.5.12 Deliver specific, focused between-session interventions.	4.11	.88	4	5	75.6%
3.5.13 Follow-up on interventions.	4.67	.60	5	5	93.3%
3.5.14 Determine most useful treatment modality to meet each goal (e.g., individual, group, family).	4.71	.51	5	5	97.8%
3.5.15 Facilitate family in-session interaction.	4.04	.67	4	4	80.0%
3.5.16 Provide trauma-informed care.**	4.31	.87	5	5	77.8%
3.5.17 Facilitate problem gambling treatment groups.	4.27	.78	4	5	80.0%
3.5.18 Simultaneously address substance abuse in problem gambling treatment.	4.42	.69	5	5	93.3%

Subdomain 3.6: Addressing Money

Competent problem gambling counsellors are able to:

3.6.1 Track access to money.	4.29	.79	4	5	84.4%
3.6.2 Track behaviours around money.	4.71	.46	5	5	100.0%
3.6.3 Guide clients in establishing money barriers.	4.69	.51	5	5	97.8%
3.6.4 Help clients develop and follow a budget.	4.16	.74	4	4	80.0%
3.6.5 Explore meaning of money.	4.20	.84	4	5	82.2%
3.6.6 Facilitate disclosure of debt to family.	4.13	.76	4	4	82.2%
3.6.7 Help clients accept financial responsibility and develop plans for restitution.	4.58	.62	5	5	93.3%
3.6.8 Focus on financial accountability and transparency.**	4.60	.65	5	5	91.1%

Subdomain 3.7: Applying Cognitive Strategies

Competent problem gambling counsellors are able to:

3.7.1 Identify and help expose logic errors (e.g., gambler's fallacy, magical thinking).	4.42	.69	5	5	88.9%
3.7.2 Identify and address schemas that impact recovery.	4.29	.66	4	4	93.3%
3.7.3 Address reality/real-world problems directly.	4.64	.68	5	5	93.3%
3.7.4 Facilitate self-awareness and understanding of others.	4.53	.63	5	5	93.3%
3.7.5 Reinforce self-efficacy.	4.67	.60	5	5	97.8%
3.7.6 Problem-solve barriers to change.	4.69	.51	5	5	97.8%
3.7.7 Unearth gambling beliefs such as explanations of wins (e.g., attribution of skill) and losses (e.g., bad luck).	4.18	.83	4	5	77.8%
3.7.8 Facilitate the noticing and ongoing self-monitoring of triggers, thoughts, urges, etc.	4.82	.49	5	5	95.6%
3.7.9 Challenge urge thoughts by helping clients prepare and rehearse counter arguments.	4.13	.87	4	5	77.8%
3.7.10 Challenge and reshape cognitive distortions related to gambling.	4.38	.65	4	5	91.1%
3.7.11 Increase active awareness of gambling urges.	4.69	.60	5	5	93.3%
3.7.12 Help clients identify gambling traps (i.e., thoughts that it is possible to improve luck).	4.33	.88	5	5	82.2%
3.7.13 Help clients develop problem solving skills.	4.80	.46	5	5	97.8%
3.7.14 Help clients generate rational self-statements.	4.38	.65	4	4	95.6%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
3.7.15 Help clients explore the role of risk-taking in problem gambling.	4.29	.73	4	4	88.9%
Subdomain 3.8: Increasing Mindfulness					
<i>Competent problem gambling counsellors are able to:</i>					
3.8.1 Help clients connect with the present moment.	4.31	.79	4	5	84.4%
3.8.2 Facilitate mindfulness and centering techniques.	4.13	.89	4	5	77.8%
3.8.3 Encourage nonjudgmental awareness of the present moment.	4.20	.79	4	4	82.2%
3.8.4 Encourage distress tolerance.	4.24	.74	4	5	82.2%
3.8.5 Teach clients relaxation techniques.	4.38	.75	5	5	84.4%
Subdomain 3.9: Applying Behavioural Strategies					
<i>Competent problem gambling counsellors are able to:</i>					
3.9.1 Track gambling patterns.	4.51	.66	5	5	91.1%
3.9.2 Plan with clients how to interrupt gambling patterns.	4.73	.54	5	5	95.6%
3.9.3 Help clients identify gambling triggers.*	4.87	.34	5	5	100.0%
3.9.4 Develop plan for addressing gambling triggers.*	4.88	.32	5	5	100.0%
3.9.5 Help clients avoid exposure to gambling cues and situations.	4.49	.76	5	5	88.9%
3.9.6 Explore replacing gambling with non-gambling activities that support values and goals.	4.80	.46	5	5	97.8%
3.9.7 Strategize stimulus control such as identifying high-risk situations.	4.76	.48	5	5	97.8%
3.9.8 Provide ongoing review, reset, and re-engagement to create stronger patterns of behaviour that move clients closer to goals and values.	4.33	.74	4	5	88.9%
3.9.9 Help family members develop coping skills.	4.20	.84	4	5	77.8%
Subdomain 3.10: Applying Emotion-Focused Strategies					
<i>Competent problem gambling counsellors are able to:</i>					
3.10.1 Link behaviour to emotions.	4.64	.57	5	5	95.6%
3.10.2 Link thoughts to emotions.	4.67	.56	5	5	95.6%
3.10.3 Help clients identify emotions that trigger gambling urges.	4.82	.44	5	5	97.8%
3.10.4 Help clients develop different relationship with feelings that trigger gambling urges.	4.76	.48	5	5	97.8%
3.10.5 Connect pleasure and/or suffering to gambling.	4.31	.82	5	5	82.2%
3.10.6 Help clients develop coping skills for underlying problems such as emotional pain, depression, and anxiety.**	4.82	.44	5	5	97.8%
3.10.7 Encourage clients to communicate feelings directly to family members.	4.18	.68	4	4	84.4%
3.10.8 Encourage clients to attune to feelings of family members.	4.00	.83	4	4	75.6%
3.10.9 Facilitate emotion regulation.	4.29	.73	4	5	84.4%
3.10.10 Understand and apply mechanisms of self-regulation (i.e., under-regulation, is-regulation, expectations).	4.22	.77	4	4	84.4%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
Subdomain 3.11: Applying Value Strategies					
<i>Competent problem gambling counsellors are able to:</i>					
3.11.1	4.64	.65	5	5	91.1%
3.11.2	4.47	.76	5	5	84.4%
3.11.3	4.73	.50	5	5	97.8%
3.11.4	4.67	.60	5	5	97.8%
Subdomain 3.12: Applying Relapse Management Strategies					
<i>Competent problem gambling counsellors are able to:</i>					
3.12.1	4.84	.42	5	5	97.8%
3.12.2	4.90	.30	5	5	100.0%
3.12.3	4.96	.21	5	5	100.0%
3.12.4	4.22	1.04	5	5	80.0%
3.12.5	4.82	.44	5	5	97.8%
3.12.6	4.78	.74	5	5	93.3%
Subdomain 3.13: Applying Relational Strategies					
<i>Competent problem gambling counsellors are able to:</i>					
3.13.1	4.42	.72	5	5	86.7%
3.13.2	4.16	.80	4	4	80.0%
3.13.3	4.47	.59	5	5	95.6%
3.13.4	4.49	.69	5	5	88.9%
3.13.5	4.56	.69	5	5	88.9%
3.13.6	4.20	.81	4	5	80.0%
3.13.7	4.13	.84	4	5	75.6%
3.13.8	4.31	.79	5	5	80.0%
3.13.9	4.07	.81	4	4	75.6%
3.13.10	4.36	.68	4	5	88.9%
3.13.11	4.62	.58	5	5	95.6%
Domain 4: Case Management and Ethical Perspective					
<i>Competent problem gambling counsellors are able to:</i>					
4.1.1	4.18	.75	4	4	80.0%
4.1.2	4.60	.72	5	5	91.1%
4.1.3	4.60	.58	5	5	95.6%
4.1.4	4.27	.69	4	4	86.7%
4.1.5	4.62	.53	5	5	97.8%

Appendix A Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
4.1.6 Adhere to codes of ethics and state laws for problem gambling treatment.	4.96	.30	5	5	97.8%
4.1.7 Engage in continuing professional education on problem gambling treatment.	4.93	.33	5	5	97.8%
Domain 5: Sociocultural Awareness and Competence					
<i>Competent problem gambling counsellors should:</i>					
5.1.1 Understand unique needs in problem gambling treatment of those at all points in the life span, gender identities, sexual orientations, races, social classes, and cultures.	4.73	.50	5	5	97.7%
5.1.2 Recognize impact of social locations (e.g., race, class, gender, sexual orientation, age, abilities, nation of origin) and successfully navigate these differences in counselling relationships.	4.70	.59	5	5	93.2%
5.1.3 Demonstrate the ability to attune to the influence and impact of culture, race, social class, gender, abilities, and other aspects of social location on gambling, relationships, and recovery.	4.75	.49	5	5	97.7%
5.1.4 Effectively identify and name problematic power dynamics within family and social context.	4.14	.73	4	4	84.1%
5.1.5 Ensure space is made in counselling to value experience and expression of all individuals including those with less power.	4.75	.58	5	5	93.2%
5.1.6 Encourage transformative action to support equitable relationships that contribute to long-term recovery.	4.11	.84	4	5	75.0%
5.1.7 Advocate within the community for reduction of stigma attached to problem gambling and for adequate funding and public health resources for prevention and treatment.	4.34	.86	5	5	79.5%

Mdn = median; *Mo* = mode. The concept of family is broadly defined to include concerned others.

[§]Items are rated on a scale from 1 to 5, with 1 = *not relevant* to 5 = *highly relevant and important*.

*Item reached 100% agreement in the first round of the Delphi study in a sample of 52 experts. Statistics of central tendency and variability were obtained in the first Delphi round.

**Item introduced in the second round of the Delphi study.

Appendix B

Low Agreement Items

Item	Mean [§]	SD	Mdn	Mo	% Agree
1.1 Medical and pharmaceutical resources in the treatment of problem gambling.	3.98	.78	4	4	73.3%
1.1 Theories of human and family development.	3.69	.85	3	3	48.9%
1.1 Theories of relational / family therapy models.	3.71	.82	4	4	57.8%
1.1 History and social impact of gambling.	3.33	.77	3	3	33.3%
1.1 Steps, traditions and philosophy of Gamblers Anonymous (G.A.).	3.69	.87	4	3	55.6%
1.1 Gambling related self-help and support groups other than G.A.	3.98	.81	4	4	71.1%
1.1 Provide bibliotherapy resources.	3.04	.80	3	3	24.4%
2.1 Explain how electronic machines work.	3.44	1.01	3	3	44.4%
2.1 Explain mathematics and probability.	3.11	.88	3	3	31.1%
3.1 Engage outside systems (e.g., hospital, police) to mitigate risk.	3.82	.86	4	4	62.2%
3.5 Use theory to guide direction of counselling and counselling interventions.	3.78	.88	4	4	62.2%
3.5 Maintain meta view without getting caught in the system.	3.31	1.04	3	3	35.6%
3.5 Facilitate Seeking Safety Therapy.	2.76	1.09	3	3	20.0%
3.6 Locate and refer clients to pressure relief groups as needed.**	3.98	1.10	4	5	71.1%
3.7 Identify and explore “dream world.”	3.67	1.02	4	4	60.0%
3.7 Use externalizing language when talking about problem gambling.	3.02	1.12	3	3	33.3%
3.7 Help clients label types of gambling thoughts (e.g., anticipatory, relief-oriented, facilitative, permissive beliefs; superstitions; misunderstanding of probability).	3.51	.97	3	3	46.7%
3.7 Make probabilities more vivid.	3.22	.88	3	3	31.1%
3.7 Use imagery to inhibit the elaboration of desires.	3.20	1.10	3	3	35.6%
3.7 Use imaginal desensitization.	2.64	1.11	3	3	17.8%
3.7 Decrease cognitive diffusion.	3.27	.94	3	3	40.0%
3.7 Encourage clients to accept that it is an illusion to believe one can control what is random.	3.93	.89	4	4	66.7%
3.8 Help clients observe thoughts with curiosity and tolerance versus rumination and/or suppression.	3.91	.95	4	3	60.0%
3.8 Help clients increase tolerance of gambling urges without seeking to change their form or frequency (acceptance)	3.84	.93	4	4	68.9%
3.8 Determine clients’ metacognitive effect beliefs (e.g., what clients expect gambling would do to their boredom or worry).	3.58	1.01	4	3	53.5%
3.8 Determine clients’ metacognitive consequences beliefs (e.g., what clients believe would happen if they were unable to modify a cognitive state by gambling).	3.40	1.03	3	3	46.7%
3.8 Conduct an AMC analysis (activating thought, metacognitive plan, and affective consequences).	3.20	1.14	3	3	37.8%
3.8 Take a metacognitive stance (step back from thoughts and seeing them as ideas to be tested rather than facts).	3.40	1.12	3	3	44.4%
3.8 Challenge beliefs about the nature of urges by finding exceptions in clients’ histories (i.e., urges that could not be satisfied that faded on their own).	3.53	.97	3	3	48.9%

Appendix B Continued.

Item	Mean [§]	SD	Mdn	Mo	% Agree
3.8 Guide exposure to avoided cognitive states.	2.89	1.03	3	3	22.2%
3.8 Self as context (creating a safe platform from which diffusion and acceptance can be deployed).	2.91	1.04	3	3	22.2%
3.8 Help clients identify interpretive biases.	3.20	1.04	3	3	35.6%
3.9 Engage with clients in contingency management.	3.49	.92	4	4	53.3%
3.9 Facilitate social skills training.	3.51	.87	3	3	44.4%
3.11 Help clients access spirituality / religious beliefs to overcome gambling.	3.71	.94	4	3	55.6%
3.11 Identify and share counsellor's values that are embedded in practice.	2.16	1.22	2	1	17.8%
3.13 Attend to needs of children whose parent(s) gamble problematically.	3.82	.91	4	4	66.7%
3.13 Intervene in problematic relational patterns.	3.64	.93	4	4	60.0%
3.13 Identify the impact of relational power dynamics on gambling.	3.62	.91	4	4	55.6%
3.13 Reinforce clear boundaries and hierarchies in family structure.	3.53	.92	3	3	48.9%
3.13 Identify and adjust approach to stages of change of family members.	4.00	.85	4	4	68.9%
3.13 Intervene in outside systems to increase understanding of gambling and how these systems can best support gambling recovery.**	3.98	.84	4	3	64.4%
5.1 Intervene to interrupt power imbalances and support equitable relationships.	3.48	1.13	3.5	3	50.0%
5.1 Invite meta-view of individual / family / cultural / societal schemas.	3.14	1.05	3	3	34.1%

Mdn = Median; *Mo* = Mode. The concept of family is broadly defined to include concerned others.

[§]Items are rated on a scale from 1 to 5, with 1 = *not relevant* to 5 = *highly relevant and important*.

**Item introduced in the second round of the Delphi study.