Hearing from the Helpers

A podcast from the Northwest ATTC
Hosted by Mitch Doig
https://attcnetwork.org/northwest-helpers

Episode 4: Seeing the Whole Picture with Tana Russell

Tana Russell:

For anyone listening, if you or someone you know is struggling with gambling related harms, there is help and hope. If you are in Washington state, you can call the Washington State Helpline, which is 1-800-547-6133. But if you are anywhere in the country, the National helpline is 1-800-GAMBLER and calling that number is free. It's confidential. You reach a live human being every time you call, and they can connect you with help services from certified gambling counselors to Gamblers Anonymous meetings to other support. And if you're a family member or a loved one, you can call it yourself. They don't need you to run, get the person gambling and get them on the phone. You can call, you can get the resources, and you can also get the help. So it's quite versatile. And if you don't feel like calling, there's also text and chat.

Mitch Doig:

For a moment, I want you to think about the word addiction. What comes up for you? Do you think of a loved one? Yourself? What else comes to mind? I'd be willing to guess that you thought of substance use first. I've been practicing in behavioral health for over a decade, and that's what comes to mind first for me too. However, the landscape of addiction and recovery supports outside of the realm of substance use does exist.

Unfortunately, these services are at times less commonly known or even available due to their specialty, despite the impact that they can have on the lives of people who need direct support as well as their families who need that support too. And oftentimes this is coming at no cost due to public funding.

Years ago, I was working with someone who had met their goal of achieving abstinence from substances, but their life seemed to be getting worse without any explanation. Despite having a well-paying job, suddenly they were experiencing money problems and would often express fears that they would lose their home, car and even that their significant other might leave them. I was perplexed, why is this happening now even though this person had addressed their substance use disorder? I remember right before I was about to ask what caused all these financial stresses, they said, "I just have to have one big win and it'll all be better."

Suddenly, it all made sense. She might've addressed her substance use issue, but something else, something potentially even more devastating had taken root in her life. I wasn't equipped as a professional to support with this, but thankfully the gambling support services were available and they were ready for them.

Today's guest is someone who had a direct impact on this podcast series. It was her suggestion that providing a perspective from a certified gambling disorder specialist could be a great direction, and I was excited when she was willing to do an interview so she could provide this perspective herself. Tana Russell lives in Washington state and is a state certified gambling counselor who now supports the training and certification requirements of those seeking to become gambling counselors. She, like all of our guests, found their way to their current work as a result of following their passions and efforts to help people as effectively as possible. I'm excited for you to hear her story today.

Tana Russell:

Hi everyone. My name is Tana Russell. I am the Assistant Director at the Evergreen Council on Problem Gambling and been with them since September, 2019. So I was literally working in the office for no more than a few months, and then the pandemic hit, and that was my first year in the new job.

Mitch Doig:

That was part of the five-year plan, right?

Tana Russell:

Right. Yeah, yeah, I planned that.

Mitch Doig:

Not that I try to do this too much, but I can definitely relate. I became a clinical director of an organization in February of 2020.

Tana Russell:

Oh. Oh, so you had a whole 30-day warning.

Mitch Doig:

Yep. Yeah. My first senior leadership meeting was, "Hey, there's this thing happening and I think where we might have to close the office down for a couple days."

Tana Russell:

And you're like, "I just started this job. Am I still going to have a job?"

Mitch Doig:

Yeah. I was wondering am I still going to have a job. Am I still going to have a planet? Where are all these things?

Tana Russell:

We still have a planet. Yeah, I know the feeling. Yeah. We used to do 100% in-person trainings, and that's what we're known for is our trainings. And so we had about six months to turn it into

100% online and still try to get in the same number of training hours or training days for the whole year. So we ended up doing back to back. Six months, one ended up getting canceled, so it ended up being five in a six month period of virtual workshops we'd never done before. I'm pretty sure I started getting some extra gray hairs.

Mitch Doig:

Yeah, I was going to say, I can only imagine how many ulcers, gray hairs and premature aging, just that part of everybody's life cause.

Tana Russell:

Yeah, after that, we were all like, okay, never again are we going to do that. And our boss, Maureen Greeley, the executive director, she's fantastic. She started implementing self-care days for the staff, so it's not a day off per se, but we don't actually do work work. It's work on self-care to help our mental health and we'll sign on as a team and have some discussions. We've cooked meals at home and then signed on and shared because at the time, we couldn't be in the office together. So we would "share meals" virtually and share what we did for our self-care and mental health that day and things like that. Anyway, it's neat.

Mitch Doig:

I actually think that's really cool. One of the things that I talk a lot to people about is I think there's self-care in the general sense, but I think in this work, self-care tends to almost be the mental version of physical therapy. You're undoing stress to your body, to your system in a very different way. And I think it's really neat that you're being provided time to do that on the clock. That seems really...

Tana Russell:

It's a blessing.

Mitch Doig:

Yeah.

Tana Russell:

Yeah. Yeah. We really appreciate her for doing that.

Mitch Doig:

It's great. Yeah. So sorry for the slight derail. So how did you come to this field?

Tana Russell:

Yeah, so yeah, I got my bachelor's in criminal justice and the idea was basically just to use that till I figured out when I wanted to be when I grew up. So my last, I forget if it was my last whole year of college or just one semester, don't even remember. But I did an internship at the local Community Corrections Parole Office, and this was in Arkansas, so I did my internship there and then later got hired there after I graduated. So at 21, I became a parole officer. And I worked at that facility for eight years, went from parole officer to parole agent and then to a counselor.

I did my training. I already had my bachelor's, but then I had to go back and do all this extra training to become a counselor. Finished that, got certified and for a year did nothing with it, just still working full-time as a parole officer. And then was trying to decide, okay, I've got one year before the renewal of this thing, am I going to use it or not? I got to do something with it to be able to actually work as a counselor full-time, and nothing was coming up.

But then eventually one of the clinical directors retired, a series of promotions and a job came open. And so in 2000, let's say nine, I think around the end of 2012, beginning of 2013 is when I first started working full-time as a counselor, same facility. So I went from being a parole officer there to a counselor there, which was an interesting transition. But as an officer, they called me the counselor officer because I wasn't your typical law enforcement personality we'll say, compared to some of the staff. And so I ended up getting the max supervision caseload, which included a lot of the clients I know and love working with.

There were, in this particular group, long sheets of felonies on their records. Most were substance related, some violent. Usually really struggling on probation or parole. But even though I might've been the one taking to court, they liked me because I wasn't mean. I'm not mean. I wasn't on their back about it. I'm like, "Listen, just do what you can to fix this, and I'll tell the judge what you're doing." Whatever. Facts are facts, it's your life. And so when I became a counselor, the clients were like, "Good, that's a better fit for you."

And so I felt like as an officer, I could do it because I worked hard to do it. But that environment, it really did serve the purpose I had intended at graduation, which was it exposed me to the court system, to law enforcement, to treatment facilities, to jails, to prisons, to community services, to all of these things. I ended up getting connected to through the case management of the caseload. And so I got to see for six years how all of those other adjacent fields worked and operated. And that's where I got the feeling my natural skills and strengths fit with counseling better. And so that's why I made that transition. So it was a very natural transition for me to get into that. And then when I moved up to Washington in 2015, well, it was a stack of paperwork about an inch thick. Trying to get all these Arkansas licenses to transfer to the Washington Department of Health took a while, but it got approved. And then I became at the time what was called a CDP, Chemical Dependency Professional, and now they call it an SUDP Substance Use Disorder professional. So that's what I am now.

Mitch Doig:

Can I ask, because you actually answered something about the jump from corrections or criminal justice into counseling, but what was the drive for criminal justice to be that thing where you could see, is it just because it had a lot of access points to the system or something else? Because usually you see somebody getting an BA or BS general when they're exploring what they want to do.

Tana Russell:

Yeah. So my first major was elementary education, and I did one field placement at an elementary school, and the next semester changed my major to criminal justice.

Mitch Doig:

That's how you know.

Tana Russell:

I am much more comfortable in a room full of adults with felony convictions than I am in a room full of other people's children. Okay? We'll put it that way. I just was like, "No. Kids are not for me." But I've always had this friendly, upbeat personality, and I think I was steered that direction by other people in my life, got into it and was like, "Oh, absolutely not."

Mitch Doig:

So everybody was like, "You should be a teacher." And then you got a little bit of a taste and realized...

Tana Russell:

Well, I was like, "Bless them all. Not for me." Yeah. I don't remember what drew me to criminal justice in the first place. I made As in every psych class I took in college, abnormal psych and statistics, which sounds all mathy, but it's actually quite related to behavioral health and our research studies that drive our field. Surprisingly, I didn't think I would use it at the time, but I think in those two classes, I actually had the highest grade in those class, which said something to me that this was a strong suit of mine. I was definitely not a straight A maker in college. By senior year, it was bare minimum, but I got through and I think that's what steered me that way. And I think in my first couple years I took an intro to criminal justice course and just really fell in love with it. I think law was one of my favorite classes, but I had no interest in becoming an attorney. So basically just exploring things in college got me into it.

Mitch Doig:

I'm almost hearing too, there's the search for the why almost that seems something that interests you. If you're understanding abnormal psych, the statistics part about this, I could see why maybe criminal justice at that point, why are so many people involved in this? But then interestingly, you get involved in that system and now it's like, "Okay, so now I can help in this different way as a different way of helping."

Tana Russell:

And like I said, I really enjoyed my law classes, but I knew I didn't want to be an attorney. And criminal justice seemed vague enough that it didn't pigeonhole me into a single career track. That if I decided I wanted to change my mind, it kept some doors open to me and I hadn't lost all of this money in my degree, if that makes sense. Yeah.

Mitch Doig:

Obviously. I think you've almost proved that too by saying I've done criminal justice and then found this branching tree of where it took you.

Tana Russell:

Yeah. Yeah. It worked out well for me. And side note, I don't know any of the people that I went to school with are actually working in the field that they got their degrees in anymore. Who knows what they want to do at 18?

Mitch Doig:

No, there was somebody not too long ago. It was a friend of a friend's younger brother who recently, I think was in his senior year of high school and was panicking. He says, I don't know what I'm going to major in next year. And I said, "I don't think anybody you're going to school

with really knows. I think some people think they know." I always tell people I was an English major. I was going to go be a journalist. Look what I do now. I don't do that.

Tana Russell:

Yeah.

Mitch Doig:

What was those qualities that you had said a lot of the people you work in with as a officer or corrections officer, parole officer? Parole officer?

Tana Russell:

Yeah.

Mitch Doig:

What were those qualities that they were saying like, oh, this was a better fit for you as a counselor?

Tana Russell:

I was first introduced to motivational interviewing as an officer. They brought it in and taught all the officers. And if you're not familiar with motivational interviewing, in its entirety, there's a lot of acronyms. Here's all these different tools and acronyms for how to work with people in these different kinds of situations, amplifying ambivalence and rolling with resistance and reflective listening and all this stuff. But really all it comes down to is helping someone come to their own conclusions, steering the conversation in a certain way that is non-argumentative. And it was very successful for the officers in teaching them to be able to have conversations with clients that were non-defensive, non-argumentative, non-judgemental. It really was very helpful in that.

And once I got the spirit of MI, once I got the hang of that, that really spoke to me a lot. And as an officer, it's very much, let's just make sure they're following the rules. And the primary concern is safety of society. The worst thing that can happen is someone commits a violent crime that could have been prevented with-

Mitch Doig:

Some sort of intervention.

Tana Russell:

Something got neglected. Right, exactly.

And in my conversations with clients, I just saw a lot of the needs and support they needed to be successful. And of course, there's a lot that works against them. You have someone with a felony record. Now their income is limited because they have a felony on their record, but they have the same living expenses everyone else has, including all of the court related fees, which includes legal fees, victim restitution, court fees. They pay for their own supervision on probation and parole, so they have a supervision fee they have to pay all of these extra things add up to what can be hundreds if not over a thousand dollars a month. And so they need all the help and support they can get.

And so a lot of my work was in that case management side and helping them to get connected to counseling. I had a guy who he drank too much, drove in his car, got in an accident that killed

someone, so he got charged with negligent homicide or manslaughter. I can't remember, one of those. Ended up going to prison serving time. This is a regular person. First charge was the death of someone he didn't know. He comes out on parole, and I said, "Did you get any mental health counseling while you were in there?" He goes, "Absolutely not. I said, "Would you like some mental health counseling now?" He's like, "Yes, please." And so he had just been dealing with that. He's like, "I deserve to go to prison for what I did, but I don't know how to live on the outside now." Because he served several years dealing with that, no help through it. Right? Imagine that.

So that need is where I saw my interest going. It's helping people to get that healing and support they needed so that they could live that life behind. And I saw so many people with criminal records, 10, 15, sometimes 20 years in who changed it all and turned things around and were successful in their careers, had healthy relationships, were stable, were abstinent from substances, and were completely different people by the time they completed their probation or parole or whatever they were on. And so I saw so many people doing it successfully. That was just really inspiring and attractive to me to be able to be a part of helping them do that.

Mitch Doig:

Well, it's funny to... Not... Well, it's funny in hindsight because when you first described your approach as a parole officer, you had said something along the lines of, if you're doing what you're doing, it's just the truth. It's just facts. And my brain immediately was like, "Oh, that's really respecting autonomy," which is another really good principle of motivational interviewing, and I'm listening to you talk about really seeing the other person for all of the experiences that one, they had before they got to you. But two, the experiences that they're having now. I think a lot of people don't realize the challenges of coming out of a prison system. And now, like you said, everything's more expensive. You have fees. I've always found it interesting that it's harder to find work, for example, if you have a theft charge than a murder charge, in some cases. Try moving into an apartment with an arson charge, for example. And that's a lot that can be stacked against you.

Tana Russell:

Yeah. The type of charge matters in their ability to live in society.

Mitch Doig:

And I think it's really neat to hear that your approach in that space was from a place of, I'm understanding all of that. Now, it doesn't mean that you necessarily say everything that you did is okay because now this is what you're going through. But it is to say it'll be challenging. And I'm here with you. I'm doing that case management, that care coordination.

Tana Russell:

Yeah. Do you want to hear a really funny story?

Mitch Doig:

Of course.

Tana Russell:

So I had this one guy who fled, we call that absconded, right? Absconded supervision. So my, officer's role in that situation is basically submit the paperwork that issues a warrant and then wait until they get picked up. So it was like three months later, he came back into the state and got arrested on a traffic violation or something, and got picked up on that warrant. So he ends up making his bail, comes into the office and talks to me and he goes, "You're going to be in court with me, right?" And I'm just like, "Yeah. And you know I'm the one who put all of these charges in that report, right?" He goes, "Yeah, I know. I just want you there." And he's like, "Honestly, if I were you, I would've submitted that thing a long time ago. I took off on my motorcycle and I just decided I was going to leave the state." He's like, "I knew. I knew you'd have to issue a warrant eventually. He's like, "I'm surprised you didn't do it sooner."

He knew exactly what he was doing, came back, knew he'd be getting arrested, was surprised. I tried to give him time to get back and get back in compliance as long as I did, and still wanted me in court with him for, I don't know, emotional support. I don't know, but.

Mitch Doig:

It's an interesting thing because I feel like it is neat to hear that this, in a funny way, he's saying, I didn't do this against you, and I know you didn't do this against me. It's just consequences for behavior. And also, yeah, let me make my choices, and I still like you.

Tana Russell:

I thought that was really funny.

Mitch Doig:

Well, I've had a-

Tana Russell:

I'm like, well, you're here now. Let's move forward and we'll see what we've got by the time you go to court.

Mitch Doig:

Well, and I think that that's the interesting, I don't know, potentially transformative change that could happen in the system. I worked with teenagers for years, and I'll never forget this teenage boy who came into my office in tears, and he was like, "I need to see you. I need to see you. I need to see you." And I pushed off an appointment and I said, "Okay, I'll see you really quick. Something's clearly going on." And he had said, "Hey, I drank again. My probation officer's going to be furious." He had a lot of different words to say than furious. "And I'm freaked out. I don't know what to do." And I said, "Well, what if we just called and asked what would happen?" And he said, "Well, I know what's going to happen." I said, "Yeah, but what have you done historically?" He said, "Well, I've just ran off. I've dodged him. I haven't called."

And it was really fascinating to be there while he had this conversation. And his probation officer said, "You know what, man? It sounds like you're learning, and I'm sorry you're going through this. Please don't let this happen again, and I'll see you Monday. But thank you for being honest. This is new for you." And I think that acknowledging new behavior is also one of those things that people tend to have similar reactions that this person did to you where they said, "I still want you to be there for me." They were best, I wouldn't say best friends, but they had a really great working partnership from then on just because he was seen finally.

Tana Russell:

Yeah. And the officer didn't take the client's behavior personally. And didn't try to parent or punish him over it, just said, "Okay, I'm glad you told me." Here's what we need to do to move forward.

And what's interesting is, as a counselor, that same skill ended up being needed. I was writing a lot of court reports in the previous career, and then as a counselor, I worked with a lot of clients who were legally involved. So still had a lot of court reports to write. And a coworker of mine, I'll quote her and maybe tell her about it later, she said, what she would say to clients is, "On these reports, I'm required to write. I'll just report the facts. If you don't like the facts I report, give me different facts." So here's maybe the downsides that might be on here, but here's the upsides. What can we include to show progress? Or you're working to resolve whatever happened or whatnot. So it's a similar skill is not taking things personally and just helping the person learn what they can from it and just continue moving forward. But there's no shaming them. They do enough of that themselves. They don't need it from anybody else. And just helping them to identify the next best step to take.

Mitch Doig:

I like that you're bringing in this concept of shame is something that you're hyper aware of that people are already doing and I'm-

Tana Russell:

Hyper aware of.

Mitch Doig:

I also hyper aware of. And I could actually tell that because of the way you were describing the person who he was driving under the influence and somebody died, the language that you're choosing to use, most people, I think... I don't condone driving under the influence. And also, statistically, what we know is people who are found to be driving under the influence, it is usually their first time. They made a mistake by getting behind the wheel. It's not the people who are repeatedly doing that this tends to happen to. And I think that your language around this is, at least from my perspective, but it is less shameful. It's not, how dare you? It's like, oh, we're in this situation together.

Tana Russell:

Well, I can imagine how I would feel if it was me. Right? That's life devastating. And there's two traumas there. The trauma of the family who lost their loved one and there's trauma because it was technically an accident. Right? Preventable?

Mitch Doig:

And I think that-

Tana Russell:

Yes, by not driving under the influence, but not like he meant that to happen at all. So there's two traumas.

Mitch Doig:

Well, and I think the sad thing that you pointed out as soon as he came out too, which is, and you need mental health treatment in order to move beyond that, because then I think we get him into that interesting conversation about recidivism. If we don't do something to actually provide an intervention that might, for example, I've worked with somebody who had the exact same situation that you're describing, didn't receive care, and then had three more DUIs because they just found themselves in the bottom of the bottle for the rest of their lives from then on.

Tana Russell:

Absolutely.

Mitch Doig:

And I think that that could be prevented too.

Tana Russell:

Yeah, absolutely.

Mitch Doig:

That was a soapbox.

Tana Russell:

Yeah. And maybe one thing, here's another thing I think got me in this work or maybe kept me in it. I don't remember which job I had when this happened, but I had at least two different clients, two female clients, completely unrelated, who basically told me the same story. And you might want to put a... You can add-

PART 1 OF 5 ENDS [00:30:04]

Tana Russell:

Basically told me the same story, and you might want to put a, you can edit this out if you want to put a trigger warning at the beginning. It is child abuse I'm going to talk about, but they both had experiences where as a children, their mothers would give them injectable heroin and then sell them to men so that she could get more substances. That was their experience as children. That's what brought them in. Then they grow up to be adults and society says, you're responsible for your choices. You got you here. That was so eyeopening for me, and I really respected these clients to a degree because I'm thinking, had that happened to me as a kid, I probably would've turned out worse than you. I don't know. The fact that you're still here and you're trying and you've accomplished this, this, and this, in the face of everything they dealt with, seeing that resilience and that willing to keep fighting for healing and recovery despite having things working against them by no fault of their own at a young age.

Mitch Doig:

I've sometimes described the work of most parts of behavioral health as almost like undoing people's past. That was no choice of their own a lot of times. I worked as the sole male employee of a program for teen girls who were victims of domestic sex trafficking. I wish this wasn't true, but for most of them, I was the first safe male in their lives. The first person to say-

Tana Russell:
[inaudible 00:31:51].

Mitch Doig:
Yeah, and number one, the amount of pressure that was at times to be like, oh my gosh, I don't want to screw this up for them and to know-

Tana Russell:
I can't [inaudible 00:32:00] anything.

Mitch Doig:
Yeah. Well, the hard part too was-

Tana Russell:
Got to be very careful about everything. Yeah.

Mitch Doig:
Well, and there's a double-edged side to that too, which is I didn't want to be too safe to the point of saying there will be as many safe males as me in the future too, because I kind of know the trajectory of what you're describing. I think I would see it happen a lot where you'd have a youth in that situation who would go to court and then you'd have a judge or an attorney on the other side or a parole officer or a caseworker for example, say, "Well, they need to stop doing this. They're causing so much, insert whatever the trouble is." It's like, or people are kind of the result of other people's consequences, sometimes other people's choices. It's hard to be able to give people that autonomy moving forward if they've never had it. I think you're kind of describing a situation where both of those women had a lot of choices made for them that really, I guess it's kind of playing cards. You only get the hand that you're dealt and it's great that there are people like you to say, "You know what? I might be in a worse place. You've actually done really well. You're resilient," that people [inaudible 00:33:13]-

Tana Russell:
No, I didn't say that.

Mitch Doig:
Oh, of course, of course.

Tana Russell:
Let me just be clear. I did not say that, but I'm thinking I don't remember what I said other than thank you for telling me. I respect how much that took to say is usually what I go with. Yeah, just having that mental, I think that mental ability to put yourself in someone else's shoes, even for just a second, I think can put us in that head space where we are firmly planted in compassion, and all those judgmental thoughts that might be what other people would think or say or how they would respond, they just disappear. They just completely disappear and you're just firmly planted in compassion and recognizing that this person, that's equity, isn't it? That some people who have things working against them in their life need some of that extra support to get them to a place where they've got the same chances as everybody else who didn't have

those things working against them and who in fact, had things inserted into their life by no choice of their own that benefited them, and gave them protective factors and gave them an advantage.

Mitch Doig:

That perspective of how, I guess, being able to put yourself in somebody's shoes as kind of an act of compassion, an act of accurate understanding, accurate empathy if you will. Is that something you feel like you learned throughout your career or is that something you had and brought into your career?

Tana Russell:

Definitely, I would say learned. Well, not 100% learned. I've always been somewhat of an empathetic person naturally, but I'll give you an example of a learned experience, and this is actually what got me thinking about gambling as a disorder and eventually became a specialty track for me. It was early on in the counseling career for me, and I don't remember if I was still doing groups with another counselor, I was just doing by myself. At the time in Arkansas, there were no casinos. I think there are now since I moved away, but at that time there weren't. If people wanted to go to casinos, they had to travel out of state, they'd usually go down to Louisiana. We did have an old lottery, but that was about it. I was of the thinking like everybody else that I knew and worked with that gambling equaled casinos. If we don't have casinos, then we don't have anybody that can have problems from gambling. That was the logic.

Mitch Doig:

There's some math there.

Tana Russell:

Right. I'm sitting there in the treatment group and we're just chit-chatting before the group starts, and I have been seeking retribution for this ever since. I don't remember what we were chit-chatting about, but I remember I made a joke about gambling. As a counselor, I made a joke about gambling and the guy literally sitting immediately next to me in the group looked at me and says, "You realize that's my other addiction, right?" I was like, "Wait, what? Nobody's taught me about this. This has not been a subject in any of my training." The only thing I had heard, anybody, counselor, officer, anybody in my professional field say about gambling to that point was, "We don't need to worry about it here. It's not an issue. It's not a thing." All of a sudden this client gave me that reality check, and it wasn't until a few years later that I ended up getting training in that as a specialty, but that's what opened my eyes, that gambling problems are not, you cannot be so narrow focused about what constitutes as gambling or what can cause gambling problems. It can be an addiction, et cetera. That was a learning moment for me.

Mitch Doig:

I also love how common it is. Somebody told me this a long time ago. They said, "You'll go to your schooling, you'll do whatever you're going to see, is you'll do whatever, but ultimately most of the lessons you tend to learn come from clients and it's a humbling experience," but I don't know that there's a better way to even do that as well.

Tana Russell:

Yeah.

Mitch Doig:

Was that kind of the reason that you made the jump to gambling or was there a different-

Tana Russell:

No.

Mitch Doig:

I'm just curious if it had that kind of an impact. Okay.

Tana Russell:

Yeah, so no, it didn't have that much of an impact. I moved to Washington in 2015 and I started working for a company called Providence. Great company, still love them, left on good terms. When I got this job, they're fantastic, but when I was working there, I was the only person who was a specialist in tobacco and they had one other counselor who was the only person who was a specialist in gambling. Anytime either of us got sick or went on vacation, those groups or whatever services had to be canceled for the clients. There was nobody else who could cover for us. He and I got cross-trained, him in tobacco, me in gambling, and that was it. That's how we got into it. It was strictly practical, basically just to try to care for our clients. If something happened to either of us, we had someone who could cover and keep people's services going and keep their groups going and everything.

I mean, when clients would ask me, "Have you ever been addicted to gambling?" I say, "Nope," and here's how we got into it and tell them what I told you. The reason I'm still in it, the reason I stayed in it is because I fell in love with it, fell in love with the work. It's challenging, it's always changing. There's always more to learn. The clients are a little bit different, just type of clientele and that's fun to work with. They're fantastic and I recognize that there's so few people doing it, we need more. We need more people doing this work. I didn't want to ... Just stayed in it. I didn't want to leave it.

Mitch Doig:

This has actually been something that's always kind of fascinated me is the specialty addiction sub roles, I guess within our field, gambling being one, tobacco being another. I guess from your view, why do we separate those two? What makes gambling addiction so much different than substance use disorders?

Tana Russell:

There's others as well, right? Like opioid therapy programs. I did that for a while. I worked for a facility that did medication assisted treatment, opioid replacement therapy program. That's also a specialty. Even some others can be, each type of substance has things that are a little bit different from the others. Alcohol, tobacco and gambling are a bit unique in that they're all legal and they're everywhere and people cannot escape the triggers for it. You don't go to work and hear people or most, well, I guess it depends on where you work, but for most people, they can go to work and they're not going to get exposed to casual conversations about heroin or cocaine or meth or whatever while they're on their shift or with customers, things like that. It's pretty safe. Employment's usually a recovery safe environment for most people in most situations, but they can go to work and they're going to get invited to things where there's

alcohol. People are going to be going to take smoke breaks and people are going to be talking about gambling between colleagues, with customers, with supervisors, everyone. To me, those are all a bit unique in that sense. Tobacco is kind of unique in that it always seems to get left out in terms of drug alcohol treatment services.

Mitch Doig:

I would say too, there's also a lot of arbitrary things that people will say if you stop using a substance like weight to stop using nicotine, for example.

Tana Russell:

I've been trying to dispel that myth my entire, I'm like, listen, the worst thing you can do is to approach someone who says, "I really want to quit this, this, and this," and then to discourage them from their own intent for their own healthy decision. You don't have to beat it over their head and say, "Hey, you need to quit all at once," if they're not ready, but if they say they're ready, please do not discourage them from [inaudible 00:42:35] ...

Mitch Doig:

It a funny thing-

Tana Russell:

... Because it's actually better.

Mitch Doig:

Well, yeah, it's a very interesting thing, I think, about the field. If we were to compare it to, for example, diabetes care and if somebody came into your office and you were working with them and they said, "Okay, I want to change my diet. I also want to start an exercise plan and I think I want to drink more water and I want to quit smoking," wouldn't, in that setting, nobody would be like, "Don't do all of that at once. You're setting yourself up. Just pick one." We would never do that.

Tana Russell:

Yeah, they all ... Success in one helps success in another and they all feed on each other in a positive way. The skills you use for one thing transfer to another and being successful in one area gives you more motivation to keep working on the other. It's the same thing with recovery, whatever. For most people, they're all dealing with multiple things. I'm going to work on my depression and I'm going to quit smoking and I'm going to quit drinking and I'm going to quit gambling, and that's whatever. That's fine. All trying to make positive progress even in tiny incremental amounts and any of those things is going to move them towards their final goals faster than just trying to focus on one at a time.

Mitch Doig:

It's fun hearing you talk about this work a little bit because it seems like you are somebody who's a little bit similar to me that new things that we learned about our chosen profession are exciting, that continual growth, and this has been something that's come up every single person I've interviewed so far, not on purpose, but has talked about, no, it's great because I'm always growing and I'm always learning and there's always something new. I guess my question about that though is making that jump from substance use like an SUDP or CDP at the time, to

gambling. What changed about your work fundamentally? Because again, we separate these two things and I think for good reason at times, but what changed fundamentally for you?

Tana Russell:

Well, a lot about it is the same. Basically, when it comes to treatment for gambling disorder versus substance disorder, a common thing you might hear is 80% similar, 20% different. Okay, so 80% similar. Both gambling disorder and substance use disorder are going to completely derail a person's priorities, mental health, relationships, they throw everything into chaos. They both will do that. Where they are different, they're very, very different. I had so many clients come into treatment for gambling disorder who would say that they had been in treatment before, either with seeing a private practice mental health counselor, or they'd done substance use treatment before or something.

If they tried to talk about gambling with those professionals who did not have any or insufficient training about gambling disorder, they could tell immediately that this person was not able to help, and in some cases it did harm. When they came into treatment with me and I'd had all this specialty training and you have to work with a supervisor, you have to pass exams, you have to do this through practice hours, all of this kind of stuff to help you be trained and competent and learn, they could tell a difference that I understood why saying, "Why don't you just stop going into a casino," is not at any more beneficial than saying to someone, "Why don't you just stop being depressed?"

Mitch Doig:

I was thinking when you were talking earlier about how just prevalent gambling is, for example, I was thinking about all the apps on my phone that now have a loot box kind of element where you have a percent chance to get a skin for an item or things like that. I realized how much of, probably at some rate, even your Instagram feed, the way it scrolls up and it's like you don't know what you're going to see probably feeds into that same part of our brain. I could see that being reminiscent at times for our lizard brain in the back being like, "Hey, there's that dopamine you've been craving a little bit."

Tana Russell:

Yeah, I mean, the access to dopamine through gambling is different from substances. Now, substances all vary from each other as well, right? Cocaine's going to dump quite a bit of dopamine and be short-lived, meth is going to dump it all and it's going to be there for the next eight hours. With gambling, you can, for example, on slot machines, you get dopamine release for anytime you win, obviously because that's exciting. Also, every single bet that you make, regardless of the outcome you get dopamine from because there's this moment of waiting for the result.

Mitch Doig:

A little bit of anticipation.

Tana Russell:

Exactly. I've just made the bet. Depending on the design of the game, they're all digital these days, but so there's not any actual reels, right? It's just a screen, but it'll have some sort of activity going on the screen while they're waiting for the result to reveal, did I win? Did I win? Did I win? That's dopamine. Then you also have dopamine anytime there's what's called an

LDW or loss disguised as a win. I make a wager of 100 credits on several lines, some of those lines lose, some of those lines win, the winning lines, give me 75 credits back.

Mitch Doig:

You're not all the way down. It's still a little bit of a win.

Tana Russell:

How did I come out on that? I just lost 25 credits, but because it won on certain lines, what's the machine going to do? It's going to say, you won and make noises and flashy lights and things. A, do I get dopamine from that? Yes, I can get dopamine from losing and in my, what I call memory piles, is my brain going to store that in the times I won pile or the times I lost pile? Is it going to store that in the times I won pile, even though it was actually a loss. It's very easy for A, people to think they are winning more than they're losing. A, because of that B, because the bets are usually cents or dollars at a time, whereas if they do win or when they win, it might be tens of dollars, hundreds of dollars, even over 1,000. Because the win numbers are larger than the bet numbers, plus there's losses being added to my win memories, which shouldn't be there. It's very easy for people to think that they've won more than they lost, and in an hour, I think they can make several hundred bets in an hour. Two dopamine hits, at least one dopamine hit for every bet and two dopamine hits for several of them in an hour, and then you do that for five hours.

Mitch Doig:

I'm almost kind of imagining too, it's this interesting thing of me. This is only on my mind because last year I did a bunch of stuff with, I had to go fill bags of sand at this place near me, and I remembered one of those bags broke in my car, but I wasn't super aware until I went to lift it out and all of the sand kind of fell across the backseat of my car. Yeah, it was really great.

Tana Russell:

I hurt for you.

Mitch Doig:

Yeah, it was really great, but I'm imagining there's this slow hole that's essentially happening in this bag of money that people are just like, "Oh yeah, it's still full," and it just feels that way even though you're dumping scoop after scoop, but it's a continual trickle of what you're actually losing.

Tana Russell:

Actually, that's quite an accurate analogy, and part of that is because of the, I feel like an idiot that I just went blank at the moment. The win ratio that's advertised will be like 85% return, sometimes even 90% return, meaning of all the bets made, the facility, the casino is giving back that much in wins. People think, "Oh, that's going to be a lot," but what they don't realize is, A, you're probably not getting it. B-

Mitch Doig:

I was going to say, you're not there for 24 hours and 85% of that whole day is not you.

Tana Russell:

Yeah. B, that is not per machine. That is per bank of machines. Sometimes several banks share that and B, or C, what it's actually meaning is for every bet the casino is keeping a percentage. Win or lose, they're taking their take from every bet, right?

Mitch Doig:

Well, I would imagine too, something that seems really different about gambling compared to substance use, hearing you describe it this way, is also that temporary relief you get in that moment where you don't know if you've won or lost too, that feels like you're almost like supplying your own relief even though it hasn't been a win in that moment.

Tana Russell:

Yeah, and that feeling is very real and has physical effects. For example, people who are in physical pain can have pain relief from gambling. Individuals who have PTSD symptoms can have relief of those PTSD symptoms from gambling, relief of depression symptoms, relief of anxiety symptoms, relief of any negative emotion. It's very effective at numbing whatever we want. Is it actually bringing joy though, is the question? There's a strong argument for not real joy. I had a client who called meth her synthetic happy, and I like the term synthetic happy. It's gambling kind of that artificially high dose of dopamine without quality substance around it, without a quality relationship experience is kind of a synthetic happy, which feels better? Eating brownie and ice cream, which is one of my favorite desserts or a really great hug, and I love you from a child who thinks you're the world. One is obviously like-

Mitch Doig:

[inaudible 00:53:36] my ice cream now.

Tana Russell:

Right. Right. One is a deeper quality, more memorable moment. Even though the other, brownies and ice cream, I might be in a state of bliss until I finish the bowl, but it's not really bringing me true happiness, if that makes sense.

Mitch Doig:

No, that does. I think the hard part too is one of those is kind of in your control and the other isn't perhaps too. You were kind describing PTSD symptom relief. If you can get a little bit of temporary relief, I can see, not that I'm a hard sell on this, but I can see kind of the reason that just saying don't go to a casino, doesn't work. Even if that is the solution, let's assume that if it were that easy, still though, there's a relief you get from that moment. There's still a drive, there's still something else to be working on that isn't the gambling issue necessarily, perhaps.

Tana Russell:

Yeah. In addition to relief of negative things, they might not want to feel, there is also an addition of positive things. For some, it is also their social network time. They know people there, they go there, they all get in a van at their senior-assisted living center and ride over together and hang out together while they're there and share meals and come back. Whatever it is, or their time to escape the stress of what's going on at home, even the violence that might be going on at home. For someone to come in and say, or here's another example, it might be part of their family. Everybody in their family bets on sports. Everybody watches sports, everybody bets on sports or everybody plays this game together at family get-togethers.

For someone to just swoop in and without taking the time to understand what they are getting out of gambling, that's positive, and to just say, "Well, you just have to stop it all," with no consideration of what that would actually mean for that person. Well, if you're their counselor, they're probably not coming back. You might've just lost that relationship. If you're a friend or family member, they're just not going to listen to you. Can they get those things from somewhere else? Sure, but not by tomorrow. It's going to take some time to figure out what exactly is the purpose it's serving for me? Can I get that somewhere else in a way that is recovery safe and guilt-free doesn't have consequences?

Mitch Doig:

Can I ask, because this is the fun part where I think of the interviews I've done so far, you might be the only person who has a role that I have not had in some capacity or have not supervised even. I'm curious, what if you were to briefly, semi briefly, you could be as long about this actually, if you want to actually describe the course of somebody's gambling treatment, what does that look like? Because hearing this assessment, let's try to figure out why gambling, what's it doing for you? I'm assuming also what the cost, but what does the course of a gambling treatment episode look like typically?

Tana Russell:

Well, let's back up a little bit and let me explain the continuum of care for gambling first. For listeners, if you don't know what that is, not everybody has the same needs. That makes sense. For some people, at the snapshot in time that I might come into contact with this person, they could be on the end of the continuum where they are not gambling at all. Okay? Never have, never will. However, what people can mistakenly believe is people who don't gamble can't have gambling-related problems. They can.

Let's say I'm that person. I don't gamble, but my husband does, and he just lost my paycheck. Right? On that end of the continuum, there is still some help services that can be helpful for impacted loved ones of a person who gambles. There's no gambling. Then there's what we might call recreational gambling, responsible gambling. Seldom. We used to use the term social gambling, but we don't. These days, I think that term has morphed a bit more to types of gambling that are related to social media platforms. Things you might play on your mobile device, invite a friend, get lives, yada, yada, yada. I don't use that term on this continuum anymore. This is, for example, I might fall into that category, 'cause bought lottery tickets in my lifetime.

Mitch Doig:

It's like non-problem, but has gambled.

Tana Russell:

Yeah. Has gambled. Not against it, but it's not a regular thing. It's not part of any kind of lifestyle. It's very, very seldom. Then there's people that are kind of serious recreational gambling where it's more in line in the realm of a hobby for them. It's a regular activity for them. It's something they like to do. A regular percentage of their monthly income is going to go towards it. They might not identify themselves as a "gambler" per se. They might not use that term, but it's definitely more regular than the person who's just every once in a while bite my a ticket or might on vacation or something. Right.

Mitch Doig:

I'm picturing people I've met who say, "I don't gamble. I play cards."

Tana Russell:

Right, or I don't gamble. I just bet on sports.

Mitch Doig:

Yes.

Tana Russell:

Right, or I don't gamble, I just play bingo, or we don't gamble in this family except when we're at church events and they have raffles. Yeah, that was mine.

Tana Russell:

Except when we're at church events and they have raffles. Yeah, that was mine. So those people who are in that mild to more regular recreational category, can they still benefit from services? Yes. And the conversation may be, here's how to play responsibly so that it never starts to become problematic. Or if you see any warning signs, any risks, that it's starting to head that way, here's ways to gamble responsibly and set limits to back it off. So those kind of harm reduction, responsible gambling messages, incredibly effective, and that is most of the population. In Washington at one point, it was like 94% of adults had gambled at some point in their life. So that group I just talked about can be 80 to 90% of the general population. Then you've got the population that is in that at risk category. Maybe not a pattern of problems yet, but some concerns.

So they see gambling as a source of income rather than an expense for entertainment or an expense for recreation, or just an expense to play a game. They're seeing, "Oh, I could make money off of this", which you might hear from a lot of people, but that's actually a very risky mindset when it comes to gambling. Or maybe they're starting to push what they're spending, not causing any major problems in their life. Maybe they don't have all the extra spending money that they would otherwise, but it's not putting them out financially. It's not causing arguments yet. But in my mind, if I was talking to this person, I'd really be hammering home those, what would it look like if it did start causing you problems. If you keep increasing over the next three months, the way you've been increasing over the past three months, how much will you end up spending every time you go, "Can you afford that?" These kinds of, "Let's look at what you're comfortable with, what you're not comfortable with", and try to help them to back off the risky behaviors.

Mitch Doig:

Almost like safety planning, basically.

Tana Russell:

Yeah, safety planning, lots of harm reduction. Do they need treatment? Probably not. Is it a gambling disorder? Not even close yet, but it could become a gambling disorder very quickly. And then there's what we would call the problem gambling category, which is now we're starting to see a pattern of those problems. It's not a one-off, oops. It's not just a mindset. They are actually having some degree of financial problems, relationship problems, mental health problems, sleep issues. It's just not to the degree of it being diagnosable yet. Now, here's where the treatment side comes in, because for substance use disorder to be diagnosed, there's 11

diagnostic criteria and a person has to meet only two, and that is a mild substance use disorder. For gambling however, there are nine. There's only nine criteria but a person has to meet four and that's a mild gambling disorder. So by the time they get to the point of being able to be diagnosed with a mild gambling disorder, that's actually the equivalent of the point a person is at in terms of life impact of a severe substance use disorder.

Mitch Doig:

I know, because I'm in Oregon, and I know for us, gambling treatment services are paid through lottery dollars. I don't know if that's the same in Washington, but I'm just curious, does that diagnostic qualification, is that a requirement to access care, at least in Washington?

Tana Russell:

In Washington it is not. In other states, I don't know. So on that there are no federal dollars for gambling disorder the way there are for substance use and opiate. So every state has to fund it themselves. And of course, where's that funding going to come from? In most states, at least a portion of it, not uncommonly, the largest portion of it, is going to come from the gambling industry. The industry is actually contributing financially to treatment services, awareness, outreach, research, prevention in a pretty significant way. And that is often overlooked. And I think that's to be... Yes, there might be some tax or mandates around that, but for example, in our state, the tribes negotiate how much they give, and they are usually the ones negotiating it higher. And then sometimes we'll meet what was agreed upon in the negotiation and then surpass it. So the tribes with their casino dollars are often surpassing that and contributing more. So that's not often known, but yeah, that's how it gets funded per state.

Mitch Doig:

So that continuum of care that you described then is accessible through those dollars then?

Tana Russell:

Yes, yes. So a person can, at least in our state, even if they don't meet four out of the nine diagnostic criteria and they can't get that diagnosis, they can actually still get treatment. And there's a different code for that, which I won't get into because that's all clinical documentation stuff, which gets very boring. But there is actually a code that is billable to say their lifestyle has been impacted by gambling and betting. And then you would just say, "And here's how blah, blah, blah, blah, blah, blah." Document everything that obviously they're having. Because with substance use, if a person meets two or three diagnostic criteria, that's diagnosable. But with gambling, if they meet two or three diagnostic criteria, it's non-diagnosable, but they're still having problems and they can still be helped. It's just documented differently but appropriately and it can still be treated and billed.

Mitch Doig:

That makes me, I guess, wonder, so this is an interesting... It sounds almost in some ways you're talking about semantics then. It's like when does a stone become a pebble become a boulder kind of thing.

Tana Russell:

Did the client care about any of this? No. No. They don't really care so much what terminology or diagnosis code you use. They're like, "I'm here for help. Can you help me?" Yes.

Mitch Doig:

I think that is the nice, the fun part about seeing... That's one of the things I admire about I think the gambling continuum is that if you are saying, I need help, the help's there. Whereas I feel like a lot of other times we're like, "Well, I'm sorry you meet one out of the nine." Even though you've just said "I'm having relationship problems", but we could send you somewhere where you could just focus on the relationship, even though you're saying it's the substance use that's causing the relationship problem, for example.

Tana Russell:

And how many times have we heard from family and affected loved ones of a person with a substance addiction who is at their wits end over what they are seeing happen to their loved one with the addictive disorder, and they are the ones who end up calling treatment facilities saying, "Hey, can you help this person? Can you help this person?" And sometimes those conversations are unfortunate. They may be told only if they come in, here's resources, whatever, and not much can be done. But for gambling, I don't know how it is in Oregon, but in Washington, the family can get treatment too.

So if the family or loved one calls and they're in distress, "Hey, this person I love is destroying both their life and mine from gambling. I'm trying to find them help", the specialists, the certified gambling counselors or whatever facility they're working at can actually respond and say "Yes, and even if they never show up, I can help you. Do you want to talk to me for a minute?" And that family member, again, they don't have a gambling disorders, and so they can actually see the counselor to put their life back together, protect their finances so the gambling doesn't take it, work on their own emotional health and repairing all the damage in their life. Whether or not the other person ever stops gambling ever comes into treatment, doesn't matter. So that's different. So the conversation can say, "Actually, you can get help."

Mitch Doig:

That's really good too 'cause I think that one of the hard parts for me for a lot of, at least from my lens as a substance use counselor, is a lot of times that work for the family has to come from a community approach, some sort of Al-Anon or some sort of other group that is in services. And I think that I'm also very aware that I'm imagining that family support for gambling includes in here, some risk prevention you might consider for your own finances, so that you can not be impacted as severely if it continues to go south, for example.

Tana Russell:

Exactly. Oh, and to circle back to your question you asked about 20 minutes ago, so what does course of treatment look like? So with a person with a gambling disorder, let's say they come in and they're like, "Hey, this is destroying my life. I need help." So you've got a person who's already on board with gambling is the issue I'm trying to be free from. The first phase might look like, let's stop the bleeding. They may come in and say, "I want to be completely free from this." So that lets you know, okay, abstinence is the goal as opposed to harm reduction, cutting back. So if abstinence is their goal, great, let's stop the bleeding and now let's put your life back together.

For the family member or a loved one, if they're not gambling, and sometimes they are, but their gambling isn't the problem in their mind, the other person's gambling, but let's say they're not, then there maybe isn't that stop the bleeding phase, but there's still the, let's put my life back

together phase. So their track and treatment and the person with the gambling disorders, track and treatment as far as the things they're working on is quite parallel.

Now for the person with gambling disorder, they might have, depending on where they're at and what's available, private practice, certified gambling counselors, they can see one-on-one. They might have agencies they can go to. A lot of agencies that maybe primarily do mental health or SUD treatment services may also have a gambling track, outpatient or residential. They can go to residential treatment for gambling depending on the severity of what they're dealing with, co-occurring disorders, suicidal ideation, whatever their situation is, their housing and environment.

Mitch Doig:

It's funny to now see this connection back to the thing that you described as part of the reason why you ended up joining counseling was you're doing all this care coordination and all this case management anyway, and I'm seeing the role of a gambling specialist is actually figuring out how many of these community and other resources we're going to have to pull in for this to be a solid chance of recovery to have all those needs met.

Tana Russell:

Yeah, absolutely. And I would, when I'm maybe first introducing some new clients to a group, often what I would do is try to nip a mentality in the bud, so to speak, and say, "Listen, if..." I've had clients who came in with this mentality of what's the one thing, what's the one thing I can do to be successful doing this, I have to tell them, "Listen, if all you're willing to do is one thing, it's probably not going to be a successful journey for you. But if you're willing to try as a many things as possible until you find what works well for you, and then combine those and continue doing all those things long-term, you're going to give yourself a much better chance of success." So getting them out of this mentality of what's the one thing I have to do to how many things can I do so that they're much more supported.

They can do group treatment, individual treatment, they can get their family involved, they can go to gamblers anonymous, they can volunteer in their community, they can reconnect with their other community groups. If it's church volunteer, whatever they might like to do, work on their diet, nutrition and exercise, try deep breathing and meditation. I mean, they can do all kinds of things. And it's funny how they'll... I might have people begrudgingly try something new. "I don't know about all this deep breathing stuff." And then after a week they're like, "Okay, I like it. This is working for me."

Mitch Doig:

Yeah. It's actually part of the reason that I grew to love being a counselor is you're describing how much, and I know you're describing this for how good it is for the clients, but it's also part of one of the reasons I really like being a counselor is the variety you get of range of topics to discuss all that important to somebody's health and wellbeing. For addiction we have six dimensions that we can look across and... Does gambling... Actually, that's a question. Does gambling use the same ASAM dimensions?

Tana Russell:

Yeah. The ASAM book actually has a rather small chapter, but it's a chapter in the back about gambling disorder in there and tobacco is back there with it too.

Mitch Doig:

Yeah, I was going to say it's always nestled in there too 'cause I think that that's the thing that I was talking with, there was a peer named Grace who I interviewed for our first episode, and she talked about how much her work is sometimes teaching people to do life a different way. It's not so much saying that you've never known how to go to the grocery store, but you've developed a behavioral pattern of your life looks like X, Y, and Z every single day. And I imagine for somebody who's gambling your life might be get off work, go to the lottery bar, sit there for a couple of hours, eat some french fries, go home, go to sleep, go to work, so on and so forth.

And that might be not as common as I'm thinking it is, but then if I'm just thinking fundamentally you're describing somebody's entire workday, they might be, look, anticipating this thing. They're describing impacts to the diet. You're describing a lot of intake, their social interactions, are they smoking cigarettes that during that entire time their sleep schedules may be out. All of these things suddenly are getting uprooted by potentially changing one of those behaviors. Suddenly all of that's up in the air. That's a lot of work for one person to take on.

Tana Russell:

Absolutely. Yeah, absolutely. So substance use disorders take up a lot of time and do take up a lot of money. They're expensive. Gambling disorder is a little bit different here in that it tends to end up causing larger financial impacts faster just by nature of the product. And not only is there the time spent gambling, which is hours, but one of the diagnostic criteria is preoccupation. And that is beyond just craving. It is not just I crave gambling or the rush or the wind or the numbing out. It is when do I get paid? What can I do to make it through to payday? Can I get in advance? What can I sell to gamble? What am I going to tell my partner about where I'm going to be tonight? Or what am I going to tell my boss about why my lunch break was two hours?

Then you may even have collectors calling while they're on the job. It can end up not only occupying their time, their physical hours of their day, but their mental time as well for the entire day. So it's very all consuming. And then the only treatment they can get is one hour a week. Maybe that's all that's available to them in their area, which is very real. I don't know about in Oregon, but in Washington we only have a few groups that meet multiple times a week. And so when they're spending hours every day, there's a lot of work to do to fill that time and not just to fill it randomly, but with something that is enjoyable and productive.

Mitch Doig:

Well, I think that's something for a lot of conditions though too. It's one hour of any therapy, one hour of even a doctor's appointment really doesn't treat a health condition. It's like all that other stuff.

Tana Russell:

The work happens outside of the treatment center.

Mitch Doig:

Well, and I am guessing too, there was a client that I met with years ago who was somebody who identified as not being in remission from her substance use disorder, but was in remission for her gambling use disorder and was describing the amount of, I'm guessing this is what the occupation you're talking about or preoccupation, she would describe her car was in repossession, but she would park it in other people's garages to make sure that it wouldn't get

taken. Her house had a lien on it. All of these things she was constantly worrying about to continue gambling. I imagine that's also part of that preoccupation.

Tana Russell:

Absolutely. Yeah.

Mitch Doig:

She would describe this to me. I was just thinking the amount of anxiety that I would feel with one of those things, even the fear of one of those things, let alone actually having to balance all of those.

Tana Russell:

So you can see why this has physical health effects, heart palpitations, ulcers, migraine headaches, insomnia, digestive issues. I mean, any kind of health condition that we know comes from chronic stress, which is a lot.

Mitch Doig:

I guess here's something I'm curious about from your perspective, because a lot of times when I've talked with people who are, for example, embracing harm reduction for substance use disorders, they talk about the substance use is being a normal part of a lot of developmental behavior. Where does gambling fit into that from a human condition? I guess is that a very normal thing for us to want to risk and reward or how does that, I guess, equate from?

Tana Russell:

Yes. So tell me if I end up answering your question or if I go down some rabbit trail.

Mitch Doig:

Who knows if I even needed to ask the question. It's more my curiosity now.

Tana Russell:

So there are archeological signs about gambling, warnings about gambling too much. Basically, as long as there have been records of human existence, humans were playing games and betting on those games. So there's something inherent about enjoying an activity, a game or event where you can't predict the outcome more when you've got something on the line. Now, historically, often gambling would be used for other things like redistribution of wealth, redistribution of land, raising funds for a family in the community or for a benefit for the entire community. And in some cases, even today, it's still used that way. Think fundraisers, raffles, auctions, silent auctions, there's charity gambling, which are all these nonprofit kind of things, even community events in certain cultures and ethnic groups. So that still exists, but then there's also this very modern commercial selling a product. It's in the hospitality and entertainment industry kind of thing, but there's definitely something inherent there about the enjoyment of gambling, I guess.

And of course there's some degree of what's going on in our brain that can make us subject to want to keep gambling. So our brains are designed to make order out of chaos. You walk into a room that's not well lit, you might see things that aren't there for a second just because there's a shadow and your brain's filling in the gaps. You're like, "Who is that?" And it's just your jacket hanging on a hanger on a hook. Our brains are very good about filling in gaps when we have

limited information or sorting things and ordering it. That's how we see 3D. That's how we process and move through the world.

So you walk into an environment like a casino, for example, it is utter chaos. There's so much sensory stimulation, there's lights, sounds, the game outcomes are all completely random, but our brains do what they're designed to do and they start sorting this information and decide things like, "Well, that machine is hot because I just saw it win one or two times today, so it's hot, so I want to go play that one", or someone see the same event, and they'll say, "Oh, well, it's done for the day, so I shouldn't play that one." They have the opposite conclusion. Or I just need to, "Oh, look, I won wearing these socks, so I'm going to wear these socks again next time I play. Or they check... There's just lots of superstitions that come with gambling because we might see something happen and draw a conclusion about it, and now every time we see that happen, it will reaffirm that belief completely ignoring all of the times that it doesn't happen.

Mitch Doig:

It's always funny to me like again, the power of our funny brain chemicals where if you were to say something rude to me, I would latch onto that more than if you said the good thing. But if something really quickly gives me some happy chemicals, I'll remember that as the, what is it? The GABA uptake is like, "Hey, do that again. Do that again."

Tana Russell:

Yeah, exactly. Exactly.

Mitch Doig:

When I asked, I was like, I don't even know why I asked this. But then I realized as you were describing, I'm like, oh, wait, this is something that's here to stay then, it's that same realm of why substance use, fundamentally, I believe in prevention, but my brain's so wrapped up in the world of treatment because I've just seen that's just part of human behavior a lot, that it's hard for me to figure out how do we ever prevent this from being a problem. Realistically, for some people, there will just be a runaway effect. And so you're describing, "Look, from the dawn of time, we've been somehow placing something on risk in the hopes of a greater reward maybe", and they're just being this needed role of when it does go wrong or if it goes wrong for some people, there's a support there that's needed.

Tana Russell:

And the other thing is this instinct to escape and to numb out. There's nothing inherently wrong with wanting to numb out bad feelings. Sometimes we need a little bit of relief, but when a potentially addictive activity becomes our only coping skill for that relief, and it starts to train the brain, this isn't just a recreational activity or a recreational beverage or whatever, this is actually solution to my bad day, it's a solution to my negative feeling. Now I'm going to start thinking about it even when I'm not having a bad day, even when I'm not having that negative feeling, I'm going to be thinking about it.

Mitch Doig:

There's a person in my area named Kathy Moonshine who does a bunch of DBT work, and she did a lot of work with kiddos and for young kids and for DBT. It's a complex intervention for some adults to grasp sponsorship so she started adding cool things that were a little bit more accessible. And one of those, she talks about the concept of turtling, and she's like, "Turtles can

go in their shell, but they eventually have to come out." And I think that's the hard part for using any of these other coping skills for escape. If you never stop escaping, it's just like never coming out of your shell. There's costs of that.

Tana Russell:

Yeah/ Absolutely. If you're not investing in your quality relationships, they're human too. They're only going to put up with so much.

Mitch Doig:

Well, and it's hard because like you said, the large numbers, potentially the costs that are associated with gambling, I think that it could be a here today, gone tomorrow thing, like you talked about a house payment, for example, not going through or three or something like that. That could be enough for a relationship to end. That could be huge. Even if it was-

Tana Russell:

And imagine-

Mitch Doig:

Even if it was a one-time loss.

Tana Russell:

And imagine if you remortgage the house and lose the house. If you lose your children's college fund, you've both been saving investing in. If you spend your spouse's retirement that they worked 30 years for.

Mitch Doig:

I'm guessing that none of what you've described was based off of real examples. No, I'm kidding.

Tana Russell:

Right. Right. So you can see why the divorce rate is so high, suicide ideation and attempt rates are so high. It is just incredibly devastating and very underestimated.

Mitch Doig:

And I would say the hard truth that's emerging for me is you've also said there's so few specialists out there that it means the access, it could sometimes be an issue for something that has such a gravity too

Tana Russell:

I'll give you an example from Washington State. So I contacted our Washington Department of Health. This is several years ago, so these numbers are going to be really out of date now, but I asked them how many certified substance use disorder professionals are in our state? And it was about 4,500 at the time. How many mental health professionals are licensed in our state? They're like, "Listen, there's so many different licenses to choose from in that field." So they're like, "Listen, here's the link on our website. Go count it up yourself." So I had to go through and like, "Okay, this category, that category LMHC and LCSW and MFTs and all that kind of stuff",

and it came out to about 32,000. How many certified gambling counselors are in our state is usually between 35 to 40, tops.

Mitch Doig:

Wow.

Tana Russell:

Yeah. And technically I'm one of them, but I'm not practicing at the council now. I don't do any treatment services, no billing services. I train other counselors. I do still get to interact occasionally on the phone with people seeking help and things like that. So the counselor isn't lost in me, but there's no conversations or interventions or services I'm billing for in that regard anymore. So I'm technically one of the numbers, but not helping to provide direct treatment anymore. But I'm trying to help by training other people to get this as a specialty and really grow those numbers.

Mitch Doig:

Could you tell me what success looks like for you as a gambling provider? And I always like to add the caveat, or actually, I always like to add a caveat of for you, not for your clients, but you've already said, my clients, they have their own facts, their own kind of opportunities. So what are the things that you look for? Like, "Oh, today was a really good day in my work as a gambling specialist."

Tana Russell:

Well, I'm trying to remember back when I was seeing clients and doing groups every day. That's hard because.

Tana Russell:

That's hard, because it's so ingrained in us to not own our clients' success. Their success, their life, they did it. I don't go home with them, I don't make their decisions, right? I think for me, the good days were when I felt like I was able to give a client something new to consider that they would not have thought about had they not been seeing me, right?

It's not like I have any power to control their decisions or fix anything for them, but as professionals, we do want to be effective. We are providing a treatment service, there needs to be a reason that they're seeing us instead of some other service, right? What can they get out of seeing a professional counselor that they can't get from going to a free 12-step meeting, right?

So, that's kind of where I tried to focus is what quality can I provide for them to consider that they might have some insight? Sometimes that didn't actually come from me, but just from my ability to give them a space in a room with others, and a conversation to talk about where they got all kinds of insight from their peers in the room, right? Their peers in the room could say something and it would really hit home, and I might've said the exact same thing the day before and it meant nothing, right? But because it comes from a peer, it can just be more valuable, and that's fine. I loved it when that happened.

We're in a weird profession where our goal is to treat the person to a degree that we never see them again, right? We're not trying to secure lifelong customers.

Mitch Doig:

Yep.

Tana Russell:

This is the opposite of most business models that are trying to get people to be loyal product consumers or whatever, and in our business, we're trying to get them so they don't need us. But like you said, that's unfortunately the reality of our field is at least for the foreseeable future, in the lifetime of our careers, substances are always going to be around, gambling's always going to be around, and human nature is always going to be around. So we want to prevent as much as we can prevent, but also realize that there's never going to be an end to the treatment service we can help provide.

Mitch Doig:

Yeah, I always used to tell people, "I hope one day I'm out of a job and the problems that exist that cause me to have a job." I know that day will never come-

Tana Russell:

I know. I mean, what a different world that would be.

Mitch Doig:

Yeah, it'd be fabulous, right?

Tana Russell:

It would.

Mitch Doig:

But realistically, I used to say something to some of my clients where I'd be like, "Look, in the nicest way possible, I hope I never see you again, but no, my door's always open if you need to see me again." I think that that's kind of what you're describing, is did they get some sort of interaction or insight, some sort of reflection while they were with me to make that more likely?

Tana Russell:

Yeah, and every once in a while, and you've probably had these experiences too, you run into somebody you worked with years ago just randomly, can be grocery store or whatever, and they're like, "Hey, you were my counselor, I knew you from this." They're like, "Hey ..." They just drop on you this update of here's how I'm doing, I'm doing great. You accidentally get to see a person thriving, which is what you hoped for, but obviously you often don't get to know that information, so that's always fun.

Mitch Doig:

Yeah, it sucks, because you're never entitled to that information-

Tana Russell:

No, no.

Mitch Doig:

Because when it happens, it's such a treat though.

Tana Russell:

It is.

Mitch Doig:

I had a really fun experience. I had moved on from working with adults and I've been working with teenagers, and I go out into the lobby and my teenage clients was like, "Hey, I have somebody I want you to say hi to." I said like, "Okay, I don't see anybody in the lobby." They're like, "Oh, they're outside."

I go outside and it's one of my former clients who had never expressed interest in being abstinence from substances, I never pushed them towards that, they never wanted to do community support group meetings. My new client introduced me to my old client and said, "Hey, this is my sponsor, they said they know you."

Tana Russell:

Oh, how beautiful.

Mitch Doig:

It was such a great moment, but you never plan on that, but what a cool moment for that to have happen.

Tana Russell:

No. Yeah, they found their own path.

Mitch Doig:

Yeah.

Tana Russell:

That's awesome.

Mitch Doig:

I think the fun part too is when that's happened sometimes, they'll even say like, "Nope, it got really bad, but then I remembered this one little nugget that we talked about. It's not because of you, but here's where we are." That's all fun too.

Tana Russell:

That's awesome.

Mitch Doig:

One of the questions that I've been enjoying asking people who have been doing these interviews with me is what's something that you would've gone back to tell your past self about this field before you'd entered it if you could?

Tana Russell:

First of all, I would've gone back to my early days of training as a counselor and told myself about gambling addiction, right? It was all substance, substance, substance, substance, and

maybe gambling might've been mentioned in this clump of, oh yeah, and there's other behavioral addictions like gambling and sex addiction and whatever, but it was not a piece of the training. Yeah, so I would have started that early on.

The other is with tobacco. So when I first started doing tobacco treatment, I was at that same parole office still, and again, the contagious mindset that unfortunately I had at the time was our clients don't want to quit. They all complained about having to be in the tobacco group, okay? They all was, "I don't want to be in here, I don't want to quit," blah, blah, blah, blah. Well, they're legally involved, so their choices were restricted, so they had to be in there, so they suffered through 15 minutes with me talking about tobacco.

What ended up happening in the months after starting that group is they all started quitting, right? I like to say they quit in spite of me, not because of me, because I was doing the bare minimum and I didn't think they really wanted to quit, but we need to do this, and then they all started quitting, right? I'm like, "Okay."

It only took a few months to turn me around and make me see reality, and eventually I started converting the rest of the officers and saying, "Dude, they want to quit, they want to quit tobacco. They might gripe and complain about having to stay in this group, but they actually are killing it. They're doing really great." Or we'd have people who came in, didn't really want to quit, but then as they saw everybody else doing it and being successful, they decided, "Oh, well, they can do it, I can do it," and then they actually did.

So yeah, I would have probably gone back and told myself to stop listening to everybody else. Stop listening to everybody else naysaying this and naysaying that, but at that point in time, I was just trying to learn everything I could from everybody, and I didn't know that there's certain mindsets and statements I should not have been learning from.

Mitch Doig:

Yeah, one of the things that I'm most thankful for in my career is I had a supervisor who he ... I always like to joke around, he saw a better counselor in me than really existed at the time. Part of the reason I say that is I would be like, "Oh, I want to go to this training." He'd be like, "That's really awesome, but I think because you don't want to go to this one, you should probably go to it."

For a while, I was really grumpy about that, and then what started to happen is I actually realized this interesting thing that I think, again, human nature always exists, as you had said. We tend to kind of one, follow people who role model behavior for us, and because he was role modeling like, "Hey, there's something in you that's pushing away from going to learn about this, go learn." I started actually looking at conference schedules and saying, what looks uninteresting to me? Then doing that reflection and saying like, "Oh, maybe ..." 'Cause I just feel uncomfortable with the idea of talking about this with clients and pushing myself to go learn about it, even if I never got to do anything with it. Smoking was one of those.

Tana Russell:

Or did you feel like, "Oh, well, I've had all that and so I don't need to learn anymore."?

Mitch Doig:

Yeah, well, what's funny is for me, I'll research something to death if I'm interested in it (laughing).

Tana Russell:

Yeah.

Mitch Doig:

So sometimes that would happen, but a lot of it was my own discomforts. Honestly, nicotine cessation was one of those things for me too, is my clients would always grumble about not being able to smoke, so why would I go do this? Then I realized, because let's just assume at the very minimum one client would come up to me and say, "Hey, I really want help with this."

If I was incapable and I had made a decision about not getting that education, that's on me, and so there's a really cool opportunity I think in this field. If you're somebody who really likes to grow and learn consistently, you could have a lifelong career out of just learning new things and never get bored. At least I haven't.

Tana Russell:

Absolutely. Shoot, I've gone blank on who said this. I've got it on a PowerPoint slide somewhere, but it's something like the key to successful growth as a clinician is constantly reaching just beyond your state of competency. You're not practicing outside your competency, but you're constantly pushing yourself to become more competent in other areas, right? You do that through training, you do that through mentoring, through supervision, through consultation with other people who can help you be competent and responsible as you develop that skill. There's no end, there's no end to it.

You know what? And that's the other thing that gets me excited about the gambling field, right? If another type of alcohol was released, for example, it's not going to drastically change our understanding of alcohol use disorder, right?

Mitch Doig:

Yeah.

Tana Russell:

Now, opiates have had some pretty significant developments over the years, so maybe gambling's a little more comparable to that, but a new type of gambling comes out and all of a sudden the people who have a gambling disorder to that game look very different than the people who have a gambling disorder to another game.

Here's another thing that's different from gambling and substances. With substance use disorder, they're all diagnosed separately. There's alcohol use disorder, there's opiate use disorder, there's cannabis use disorder, and on down the line, but with gambling, there's only one label, which is just gambling disorder.

I'm hoping that one day that'll be changed and it'll have some type of specifiers to type, because a slot machine gambling disorder looks very different from a sports betting gambling disorder, looks very different from a poker gambling disorder, looks very different from lottery or scratch-off gambling disorder, very different from Bingo gambling disorder. It could be separated out or specified into these different diagnoses to a degree and more study and research being done on how it presents by type.

Just like with substances, with the clients I used to work with, it wasn't uncommon for me to finish a substance use assessment and have five or six separate diagnoses in different states. Some mild, some moderate, some severe, some in early remission, some in sustained

remission, some are actively destructive. For gambling disorder, sometimes it's similar in that way.

So in Washington State, sports betting has only been around for about a year. At ECPG, we've been really working hard to insert and bring in experts about sports betting into our conferences and workshops in these past few years, because it's a whole new beast. People who have a gambling disorder specifically to sports betting look different than what we've seen before, and so there's this constant changing environment, right?

Just in the past year or two, we had sports betting come around. The state lottery created their own voluntary self-exclusion program, the state card rooms created a statewide self-exclusion program. We've got new legislation, all of these things completely change the field. We're hoping to get Medicaid to start covering it in the next few years. It's a lot you have to keep up with, which for some might be a deterrent, but for me, that's exciting.

Mitch Doig:

There was counselor I used to work with that he ... it was when I might've still been doing my initial internship, but he had said, "The day I've seen everything in this field is the day I leave." I said, "Oh, do you know how close you are to that?" He's like, "Oh, that'll never come."

Tana Russell:

Right.

Mitch Doig:

I think that you're kind of describing a similar mindset, it's always going to be evolving and that's part of the community.

Tana Russell:

Yeah, if I'm not learning, I'm dead.

Mitch Doig:

Yeah, that's why it happened, right?

Tana Russell:

Yeah, yeah.

Mitch Doig:

You had also said when you started, part of the thing you would've told your past self was learn about gambling, learn about tobacco or nicotine cessation, and you had said there were some mindsets that maybe I wanted to ignore.

Another part of this is what are the mindsets or attitudes or values that you hope new people coming into the field have, start to embrace, are the shining light of? 'Cause I'm a big believer that I think the people coming in can be some of the biggest dangers in the field sometimes.

Tana Russell:

Absolutely. I would say find yourself a mentor in this field who has a mindset that you're just like, "Whoa, this person thinks differently," right? Sometimes what that might look like is being

... our field is very evidence-based dominated, and that's good. There's a reason for that. However, unfortunately, that evidence is also very dominant demographic.

Mitch Doig:

Yeah.

Tana Russell:

That's the population a lot of this research comes from is a dominant ethnic culture with private insurance willing to participate in research studies, accessible by phone and internet easily, right? It's just a different clientele often, and of course it varies research study to research study. But I get to work with a lot of researchers in this field, a lot of the PhDs producing this work, and they are the first ones who will say, "Here's the limitations."

Of course they publish a whole section on limitations in every study that they do, and they're constantly saying, "Because of this, we need to study this other thing." Many are intentionally making specific research studies just on Hispanic Latino youth, just on specific groups or specific issues, because they're so underrepresented and understudied. So the effect that that has been on our treatment practices is if we stick only to the "evidence-based practices," we can be completely blind to the culturally-based practices, which also have evidence, just maybe not in the academic system that's been established.

So, I think that ability to say, "Yes, we'll use evidence-based practices here, here and here, or this workbook or whatever, but we need to think outside the box of that," right? There are certain situations where it's very appropriate, right? Yes, if we're doing an assessment, we need to screen for suicidal ideation, we need to screen for homicidal ideation, we need to screen for trauma, we need to screen for medical conditions, right? These are evidence-based practices that are good and appropriate and always should be done.

Then there's some things that maybe we need to think outside the box of. Okay, sure, maybe 12-step groups are fine for some people, but maybe for others, their biggest support instead is going to sweat lodges, something else.

Mitch Doig:

The same person that I was describing earlier who was saying, "I know you want to go to this training," but one of the things that he kind of did for me was how much of those things that you're describing are our definition of perfect versus what actually could be amazing change for this person? He would talk to me, for example, about describe family the way they would describe family. What would be supportive to them?

I had a client one time who went and did these car meetups. There was no substance use around, people had to drive their cars to get to them. There's no gambling around, there's no other unsafe behaviors that this person was familiar with. Who was I to say, "Sorry, that's not a 12-step meeting." It was beneficial to his recovery, and I think that you're kind of describing-

Tana Russell:

It's a supportive group.

Mitch Doig:

Exactly, right?

Tana Russell:

Yeah.

Mitch Doig:

So, I'm hearing you say evidence-based practice as a foundation and adapt to the person when necessary. I think that a lot of that has do with access, like you said, demographics, but also just meeting people where they are and what they need.

Tana Russell:

Yeah. Yeah, exactly. You know what? Our paperwork can become a real barrier there sometimes-

Mitch Doig:

Yeah.

Tana Russell:

So I was regularly going offsite to do assessments at one point, right? I was doing assessments in jails and schools and our inpatient psychiatric unit, all kinds of things, and I ended up changing how I asked the questions when I was just collecting their basic demographic data you have to fill in, right? What I started asking is stuff like, what's the race you claim? What's the gender you claim? What's the marital status you claim, right? For my treatment purposes, it doesn't matter.

Mitch Doig:

Yeah.

Tana Russell:

For the data, I got to check something, I got to check a box. But what I found is when I would ask that question, they'd kind of chuckle for a minute. They're like, "I see why you ask it that way," and they would always say something that wasn't a box.

Mitch Doig:

Yeah.

Tana Russell:

"I am 50% this and 25% that and 25% that, and I'll figure it out how to put it on the form," right? "There might be another line I can use." Or what language do you speak? They'll be like, "It's not on your list on that form, I speak this language too." Right? It kind of right off the bat helped develop a little bit of a rapport, because they recognize that I'm not pigeonholing them as this is a 38-year-old white male, bah, bah, bah, bah, bah, bah, bah, as if that's their whole identity.

Sometimes we have to work around the forms a little bit. We still have to do it. We have to document everything, we have to bill appropriately. We got to keep our doors open and our business running or we can't help anybody, and I think we can do that in a way that is more effective for our purpose for being there.

Mitch Doig:

I'm also kind of remembering, again, the version of you that said, I always did a little bit more or pushing yourself a little bit further past what you think you're competent for, all of those kinds of things. It's like, let's not make the system that's existing the client's problem, let me take that on a little bit off of them if I can.

Tana Russell:

Yeah, and so one of the things I did in years past was I became a trainer facilitator for a program called Darkness to Light, which is about prevention of child sexual abuse and how to respond when you discover that's going on. I started using this phrase, and now I use it all the time, which is we cannot put it on the shoulders of a person in their most vulnerable moment to disclose their deepest, darkest secret to a complete stranger. It is the professional's responsibility to A, create a safe space and then to ask the question, right? Create a safe space for them to be able to be open and honest about what's going on and for us to initiate the conversation.

So, I'll tell you a story here. I had a client who by the time she got into treatment, she shared this story that she would sit at, in her case, a slot machine and pray to her higher power that anybody would come over to her and say, "I'm worried about you. Are you okay?" She said, "I didn't feel like I had the strength to get up from my chair, go find a staff member and tell them I think I'm addicted to gambling. Can you help me?" Right? And hope that they could handle that and would not completely ruin their day or freak them out, or that they would judge her, whatever. She said, "But I did feel like had someone approached me and asked me, hey, I'm worried about you. Are you okay? I would've had the strength to just say, no, I'm not," right?

That's to me the power of the professional role to be able to take the initiation of hard conversations, embarrassing topics, vulnerable moments on our shoulders, and not let any fear of what might be said be a barrier to giving that person an opportunity to talk about it. Because there's so much, what I've seen anyway, there's so much of what people experience in their day-to-day life is not enough opportunity to talk about the things that are bothering them or worrying them or negatively affecting them. They just don't get an opportunity to talk about stuff.

So as a professional, to be able to give them that opportunity and a safe space where they're not going to be judged, I'm not going to run screaming from the room, I'm not going to freak out, right? I'm going to ask them, are you thinking about killing yourself? Are you being abused by anyone physically, sexually, anything? Are you feeling like you're addicted to gambling? Whatever the question is that I think needs to be asked in that moment, I can just give them a question that they can just respond to, rather than them trying to figure out how to work that into their time with me.

Mitch Doig:

I'm, again, kind of going back to the start of our conversation today and remembering you saying, essentially being the person who's putting yourself in their shoes, would it be painful? Would it be more traumatic for me to answer this question? Hopefully that answer is no.

Somebody a long time ago told me, at the end of the day, our job realistically is to be the person worth talking to. I like that you're saying and to create a space where it's worth talking about those things, and I think earlier you had even said without the added shame or guilt of that being piled onto.

Tana Russell:

Right. Yeah, I mean, imagine, if it's their reality they're having to live with every day, the least I can do is talk about it.

Mitch Doig:

Okay, what does it take to become a certified gambling counselor in Washington, at least? 'Cause I'm assuming you have to already have some background in counseling, all of those things, kind of similar as you do in my state.

Tana Russell:

Yes. Yes, and most states are pretty similar. Oregon and Washington's pretty similar, and also the international. So essentially, yes, you do have to already be licensed as a counselor in something, be it mental health, substance use, whatever.

The training doesn't teach the person how to be a counselor, it's expected they already know that. It's teaching them how to apply those skills to working with a person who's dealing with gambling-related problems. That's why it doesn't have to be an entire another two, four year program, right?

Mitch Doig:

God no.

Tana Russell:

Because there's 80% similarity, remember?

Mitch Doig:

Yes, yes.

Tana Russell:

So, you don't have to reteach 80%. The 20%, however, also is not going to be covered in a person's first basic training. So, degree requirements may vary in our state as bachelor's or equivalent. The equivalent just means if they have a two-year degree, then they need to have been licensed, typically in our state it'll be the SUDPs. Be a licensed SUDP for more hours, just more hours of practice.

So then they get the training, specialty training on gambling disorder, usually 30 hours. It's 60 for the next level, which is level two. They have to get practice hours that are supervised. So they don't have to have a gambling supervisor onsite, there's not enough of them to be able to do that, so it's usually virtual or a distance supervision.

So they're meeting with the supervisor regularly, and this is in addition to whoever is their supervisor at the facility they're working at, right? So it's understood they're going to have two supervisors right now, and one is just gambling. Why their supervisor onsite can't supervise their gambling clients, because their supervisor onsite probably knows nothing about gambling.

Mitch Doig:

Yeah.

Tana Russell:

Right? Often the staff knows more about gambling disorder than their onsite administrative supervisor. That's fine, they don't have to. That's why they're going to contract with a gambling counselor supervisor to work with them, because they need to develop their competencies in this field, and there's only so much you can learn in a training program. As you said earlier, the clients are going to teach you way more, way faster. So as they get new clients, they staff all of those clients with that gambling supervisor and work together on what their treatment program is going to be and how they can help this person.

It's usually about a year and a half to two year process. There's also an exam, which is the same exam as the national. IGCCB holds the gambling counselor exam, and so our people just register for that exam through them and their site. It costs them a little bit more. If they're not pursuing the national, if they just want to pursue the state level, in our state they can do either or both, doesn't matter. It's the individual's personal choice.

However, in our state, we also have developed an exam alternative. Now the international credential through IGCCB isn't going to accept it, so this is only appropriate for people who plan to continue to live and work in Washington State, right? But the exam alternative is a written case conceptualization, which will get reviewed by a panel of three. This has actually only been released in the past year, year and a half. We haven't had anybody apply for that yet, and we kind of-

Tana Russell:

For that yet. And we anticipate about a two-year delay, because a lot of people who had already started the process were already planning to take the exam, will probably stay on that track. So it'll take a while for new people to get to the point that they're ready to apply for that and use that option. The reason our certification committee made that move is they were all in agreement that a written multiple choice exam maybe isn't the best measure of a person's ability to work face-to-face with the client.

Mitch Doig:

No, no, yeah.

Tana Russell:

And we also experienced some barriers when a test anxiety, which isn't an issue in counseling practice, but is an issue for getting the certification, or language barriers, if English isn't your first language, multiple choice questions are not how you're used to speaking English.

Mitch Doig:

That's so true.

Tana Russell:

That is not everyday use of the language. So that seemed like a barrier as well. So with the written case conceptualization, hopefully, it will reduce those barriers but still be challenging enough that it is an accurate measure of a person's competency. If they really want to write their case conceptualization in their native language, they could. We can get that document translated because it's written. So that's fine. And so language grammar doesn't have to be an issue. It's about the person's competencies in the case that they've submitted. So that's why it's there.

Mitch Doig:

Well, it also makes sense in some ways too, because they're undergoing supervision with somebody who's already been doing this, so they should actually have quality mark by the time this has occurred anyway. So again, they're not teaching them how to take tests, they're teaching them how to conceptualize and provide treatment care.

Tana Russell:

Exactly, exactly. That's the idea. So at least people have an option there. They can still do the exam, and most... Everybody has so far. Hopefully, we'll get some people who do like that case conceptualization option, and it'll be a benefit to some. We'll see.

Mitch Doig:

Well, thank you for doing this. It's really fun to talk to someone who I think has a very similar mindset about... a growth mindset, a continual learning headspace, but also the space of compassion and concern for the other. So one, thanks for helping bring in the future of the field, but two, just for having this conversation with me.

Tana Russell:

Well, thank you for inviting me. It's been a lot of fun.

Mitch Doig:

This podcast episode has been made possible by the Substance Abuse and Mental Health Administration and the funding it provides to support the Northwest Addiction Technology Transfer Center and its mission to provide technical support and training for the workforce throughout Health and Human Services Region 10, which includes Alaska, Idaho, Oregon and Washington. For more information, visit our website at www.attcnetwork.org. Thanks for listening.

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