

Shaping the Standard: Community Input to Inform Nevada's Problem Gambling Screening Policy

Findings and Implementation Considerations
from the 2026 Planning Initiative

Purpose of this report

To synthesize partner input from the 2026 Nevada Division of Public and Behavioral Health problem gambling screening planning process and translate that input into practical considerations for standards, implementation supports, and future program development.

Prepared for

Nevada Division of Public and Behavioral Health
Problem Gambling Program





Executive Summary

The Nevada Division of Public and Behavioral Health (DPBH) is preparing to establish a problem gambling screening requirement for Behavioral Health Certifications for Excellence in Nevada (BHCEN) certified substance use treatment agencies. The initiative is intended to improve treatment outcomes and reduce gambling-related harm by increasing recognition of gambling as a potential co-occurring behavioral health condition.

The 2026 planning process combined a partner survey with World Café discussions designed to identify implementation barriers and generate practical solutions. Workshop materials emphasized from the outset that screening is a starting point rather than a complete intervention: clients may not recognize newer activities such as sports betting or crypto trading as gambling, screening tools do not perform equally well in all settings, and completion of a screen can create the false impression that gambling-related concerns have been adequately addressed.

Partner discussions reinforced that a successful screening initiative will require more than adoption of a screening instrument. Providers need practical instructions for administering and interpreting screens, clear guidance on what follows a positive result, accessible training, defined roles and scopes of practice, reliable referral pathways, and implementation support that reflects the realities of an already constrained behavioral health workforce.

Central conclusion

The screening requirement is most likely to improve outcomes when it is implemented as part of a broader system for recognizing, discussing, responding to, and referring gambling-related concerns, not as a stand-alone compliance activity.

Six cross-cutting findings emerged from the partner discussions:

- 1 Problem gambling should be addressed as a co-occurring behavioral health condition rather than as a separate service silo.
- 2 The broader behavioral health workforce needs baseline competency, but every provider does not need to become a gambling treatment specialist.
- 3 Screening should be integrated into existing intake, assessment, and clinical workflows whenever feasible to reduce perceived burden.
- 4 The response to a positive screen must be as clear and practical as the screening process itself.
- 5 Referral capacity, consultation support, and accurate resource information are essential implementation infrastructure.
- 6 Implementation should be phased, supported, and evaluated using measures that extend beyond screening completion rates.



For DPBH, these findings point toward a screening standard supported by a concise provider toolkit, a standardized response pathway, tiered workforce training, centralized referral and consultation resources, and ongoing technical assistance and evaluation. Together, these components would allow the initiative to establish a reasonable baseline expectation across BHCEN-certified agencies while preserving clear pathways to specialist care for clients whose needs exceed the provider's role or competency.

I. Background and Purpose

DPBH's strategic planning calls for BHCEN-certified providers to screen for gambling issues. The June 2026 workshop described a phased implementation roadmap: discovery through surveys and World Café discussions in spring 2026; development of standards and toolkits during summer and fall 2026; an estimated spring 2027 effective date for new BHCEN gambling screening requirements; and ongoing program support and evaluation after implementation.

The stated goal of requiring problem gambling screening is to improve treatment outcomes and reduce harm. At the same time, workshop materials explicitly cautioned against treating a screen as a sufficient intervention. Screening tools can be misunderstood by clients, may not capture newer or gambling-adjacent activities, may function differently across settings, and can lead providers to believe that completion of the screen alone addresses the issue.

Policy design implication

The screening standard should define not only when and how screening occurs, but also the minimum expected response when gambling-related concerns are identified.

The workshop was therefore designed as a structured working forum to identify implementation approaches that would be clinically sound, operationally feasible, and responsive to treatment-setting realities. Rather than asking whether problem gambling should be addressed, the planning process focused on what agencies and providers would need to do so successfully.

Planning questions

- How can Nevada increase the capacity and capability of the mental health and addictions workforce to address problem gambling as a cooccurring condition?
- How can implementation minimize perceived burden in settings where clinicians and peer support specialists already face competing responsibilities?
- What resources are needed to make a new screening requirement feasible?
- What referral options are needed for people motivated to change gambling behavior?
- What should be included in an implementation toolkit for BHCEN-certified agencies?

II. Methods



The planning initiative used two complementary forms of partner input: a survey of BHCE-certified agencies and a facilitated World Café process in which participants rotated through small-group discussions, building on ideas from previous conversations to identify common themes and insights. The survey was fielded for approximately two weeks in March 2026. Agency administrators were invited by email to complete an online questionnaire addressing current problem gambling screening practices, services offered, gambling's perceived impact on recovery, program capacity, and barriers to better addressing gambling-related concerns.

Survey findings were then used to frame the World Café discussions. Three workshops were offered: one in Reno in conjunction with the March 27, 2026, Nevada Problem Gambling Conference, one in Las Vegas at the Nevada Public Health Annual Conference on April 21, 2026, and one on June 10, 2026, a virtual workshop that was held to allow easy access to participants across the state. These workshops included five short discussion rounds focused on training, competing clinical priorities, resource constraints, referral options, and toolkit content. Participants were asked to move beyond identification of barriers and propose solutions that could support successful implementation within substance use treatment agencies.

This report synthesizes the themes documented in the workshop materials and consolidated discussion summary. It is intended as an implementation-oriented synthesis rather than a verbatim record of participant comments. Findings are organized around cross-cutting themes that appeared repeatedly across discussion topics and that have direct relevance to policy design, toolkit development, training, referral infrastructure, and evaluation.

Interpretive approach

Because many ideas appeared under more than one discussion topic, the report organizes findings by recurring implementation theme rather than by World Café table. This approach is intended to make the results more useful for policy and program decisions.

III. Cross-Cutting Findings



Finding 1. Position problem gambling within integrated behavioral health care

Participants consistently described problem gambling as relevant to the same clients and treatment goals already being addressed in substance use and mental health services. They emphasized relationships with substance use, mental health conditions, suicide risk, financial instability, and other addictive behaviors. This framing supports treating gambling-related concerns as part of a broader behavioral health assessment rather than as an isolated specialty issue that automatically requires a separate treatment episode.

Partners recommended integrating gambling questions into intake, assessment, individual and group counseling, and treatment for co-occurring conditions when appropriate. Screening was viewed as an entry point for recognizing concerns that might otherwise go undetected, particularly among clients whose primary presenting issue is substance use or mental health.



Implications for the initiative

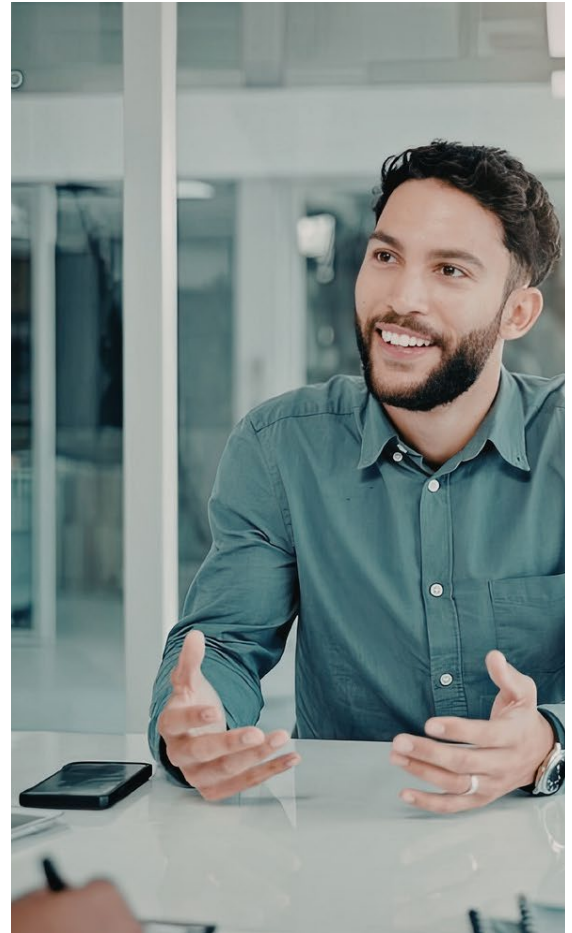
- Use policy and training language that frames problem gambling as a potential co-occurring condition.
- Where feasible, incorporate screening into existing intake and assessment processes rather than creating a separate workflow.
- Include guidance on when gambling-related goals can be addressed within existing treatment and when specialist care is indicated.



Finding 2. Build baseline competency without expecting universal specialization

A recurring concern was that the mental health and addictions workforce has received limited problem gambling education and that only a small number of professionals have gambling-specific specialization. Partners nevertheless did not recommend making every clinician a specialist. Instead, they supported a baseline level of competency across the broader workforce: recognizing gambling-related concerns, discussing gambling comfortably, administering and interpreting a brief screen, understanding key harms and co-occurring risks, and knowing what to do next.

This distinction is important for implementation. Providers repeatedly conveyed that they need “permission to not be an expert on everything.” A workable standard can establish expectations for identification and initial response while preserving clear boundaries around specialized assessment and treatment.



Implications for the initiative

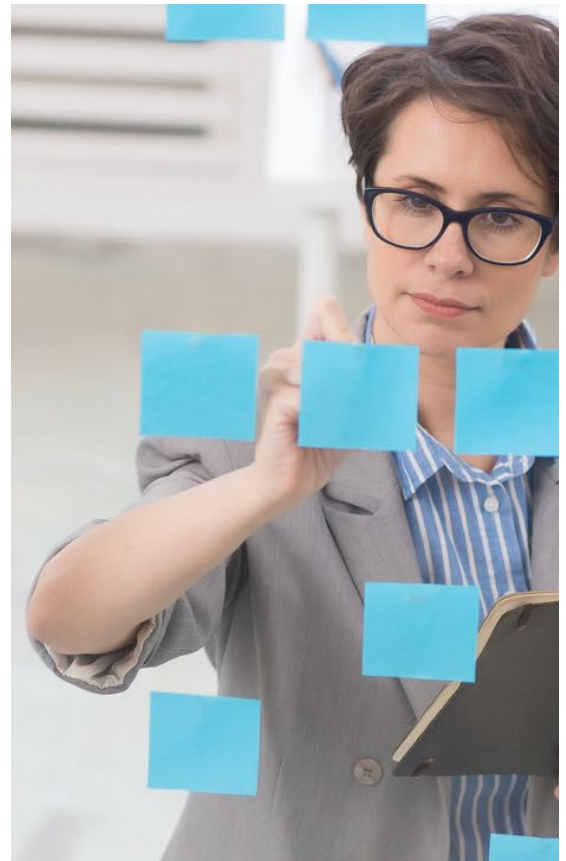
- Define a minimum competency level for providers expected to conduct screening.
- Develop tiered training: basic awareness and screening for the broad workforce; advanced training and supervision for those providing specialized treatment.
- Provide clear professional-development pathways for providers who want gambling-specific endorsement, certification, supervision, or deeper clinical expertise.



Finding 3. Reduce implementation burden by designing around existing clinical workflows

Survey results presented during the workshop identified limited staff training and competing clinical priorities as the most frequently reported barriers, with each selected by 42 percent of respondents. World Café participants expanded on this finding, describing an already understaffed and under-resourced behavioral health system in which new responsibilities can be difficult to absorb.

Partners emphasized that implementation should make it easier, not harder, for providers to address gambling. Recommended approaches included embedding screening into existing processes, providing concise checklists and decision guides, offering agency-based training, and ensuring access to a knowledgeable point person who can answer questions. The goal is to reduce the amount of independent problem-solving required of individual clinicians.



Implications for the initiative

- Keep the required screening and documentation process brief and clearly defined.
- Avoid duplicative forms when gambling questions can be incorporated into existing intake or assessment workflows.
- Design toolkit materials for rapid clinical use, including one-page job aids, decision trees, and referral steps.
- Support agencies with technical assistance during implementation rather than relying on toolkit distribution alone.



Finding 4. Make the response to a positive screen explicit and practical

The most consistent practical question across the discussions was what should happen after a positive screen. Partners called for standardized next steps that distinguish among further assessment, brief discussion or psychoeducation, integration into existing treatment, consultation, and referral to a problem gambling specialist. They also wanted clarity about what falls within the provider's role and when additional training, supervision, or specialist involvement is needed.

This finding addresses a central risk identified in the workshop presentation: screening can create the illusion that gambling has been addressed when, in practice, the client's concern has only been identified. A screening initiative therefore needs a response pathway that is as visible and operational as the screening instrument itself.



Implications for the initiative

- Pair the screening tool with a standardized “what next?” protocol.
- Differentiate responses for negative screens, lowlevel concerns, positive screens, urgent safety concerns, and cases requiring specialist consultation.
- Include prompts for financial harm, suicide risk, affected others, and ~~oc~~occurring substance use or mental health needs when clinically relevant.
- Clarify documentation expectations for follow-up actions and referrals.



Finding 5. Treat referral and consultation resources as core infrastructure

Participants reported that providers often do not know what referral options are available and may only begin searching once a client has an urgent need. They recommended a centralized, comprehensive referral resource that includes state funded and other qualified treatment providers, telehealth, outpatient and higher levels of care, peer support, resources for affected others, financial counseling, and services relevant to specific populations.

Partners also noted that a static directory is not enough if information becomes outdated or if providers need help matching clients to appropriate care. They proposed stronger agency-to-agency relationships, formal referral agreements or MOUs where useful, and access to a consultation or navigation resource that can assist with difficult referrals. These recommendations recognize that screening can only lead to better care when the next step is accessible and reliable.



Implications for the initiative

- Create or designate a centralized referral hub with an explicit maintenance process.
- Include treatment, telehealth, peer support, affected other, and financial recovery resources.
- Develop consultation/navigation support for providers who are uncertain about level of care or specialist referral.
- Encourage stronger interagency referral relationships and streamlined handoffs.



Finding 6. Sustain implementation through training, technical assistance, and evaluation

Partners viewed workforce development as an ongoing infrastructure need rather than a onetime training event. They recommended flexible and accessible professional development, including free or low-cost continuing education, self-paced and weekend options, virtual and in-person formats, agency-based presentations, and training across career stages from interns to supervisors. Participants also supported integrating problem gambling education into academic programs and exploring continuing education expectations for relevant licensed professionals.



The workshop roadmap similarly anticipated support beyond initial toolkit distribution and called for evaluation to inform program improvements. Partner feedback suggests that evaluation should examine not just whether screening occurred, but whether providers felt prepared, whether positive screens resulted in appropriate action, whether referral resources were useful, and whether implementation created unintended workflow burdens.

Implications for the initiative

- Provide implementation training before or concurrent with the effective date of the standard.
- Maintain continuing technical assistance and specialist consultation after launch.
- Use evaluation findings to revise training, referral resources, toolkit content, and operational guidance.
- Track implementation quality and followup, not simply the number or percentage of completed screens.

IV. Recommended Initiative Structure

The partner findings support an initiative built around five mutually reinforcing components. These components are intended to keep the screening requirement operationally manageable while ensuring that identification leads to meaningful clinical action.

1. Screening standard

Define who should be screened, when screening should occur, the approved instrument or questions, how results are interpreted, and the minimum documentation expectations. The standard should encourage integration into existing workflows whenever feasible.

2. Standardized response pathway

Provide a concise decision process for what follows a negative result, an identified concern, a positive screen, an urgent safety concern, or a case requiring consultation or specialist referral.

3. Provider toolkit

Package the screening instrument with practical job aids, gambling background information, examples of emerging and gambling-adjacent activities, scope-of-practice guidance, referral resources, financial harm resources, client-facing materials, training links, and clinician tools.

4. Workforce training and technical assistance

Establish baseline training for the broad workforce, more advanced pathways for specialized providers, agency-based technical assistance, and access to consultation from a problem gambling specialist or designated point person.

5. Referral and evaluation infrastructure

Maintain a current referral hub and navigation supports, strengthen interagency referral relationships, and evaluate implementation quality, follow-up, provider readiness, and barriers over time.

Design principle for DPBH

The initiative can set a meaningful statewide expectation without requiring every agency to build a separate problem gambling treatment program. The key is to establish a reliable continuum from recognition → screening → initial response → consultation/referral → follow-up.

V. Priority Content for the Provider Toolkit

Partners identified a broad set of toolkit needs. To keep the toolkit usable, the content can be organized in layers: a short “start here” implementation guide for routine use, supported by deeper reference materials for providers and agency leadership.

Problem gambling background and education: Definitions, Nevada-specific prevalence and harms, links with substance use and mental health, suicide risk, financial harm, and guidance for discussing gambling with clients.

Emerging and gambling -adjacent activities: Examples such as sports betting, gaming-related activities, social media, crypto or financial market behaviors, and guidance on how these activities may relate to gambling concerns.

Screening tools and instructions: Approved screening form or questions, administration instructions, scoring and interpretation, documentation guidance, and incorporation into existing intake or behavioral health screening.

Positive-screen response guide: Step-by-step next actions, including when to provide education, integrate concerns into current treatment, consult, assess further, or refer.

Referral directory and protocols: Current treatment and telehealth options, state-funded programs, peer supports, services for affected others, population-specific resources, and agency-to-agency referral guidance.

Financial harm and recovery resources: Financial counseling, budgeting and money management support, debt-related resources, recovery planning, and financial case management options.

Scope-of-practice guidance: Role-specific guidance for screening, discussion, integrated support, consultation, and specialized treatment; ideally presented as a decision guide by credential or provider role.

Training and professional development: Free or low-cost CEUs, virtual and in-person training, certification or endorsement pathways, licensing information, and supervision resources.

Clinician and client tools: Conversation prompts, urge or behavior tracking tools, psychoeducation, coping-strategy resources, affected-other materials, and practical followup

VI. Implementation and Evaluation Considerations

The planning process suggests that the manner of implementation will be as important as the final wording of the standard. A phased approach can allow agencies to understand expectations, prepare workflows, identify training needs, and become familiar with referral resources before full implementation.

Suggested implementation sequence



Pre-launch preparation: Finalize the screening standard and response pathway; validate referral information; prepare toolkit materials; identify consultation resources; communicate timeline and expectations.



Agency readiness period: Offer training and technical assistance; encourage agencies to map screening into existing workflows; clarify documentation and scope-of-practice questions; identify local referral relationships.



Initial implementation: Launch the requirement with readily available support; monitor common questions, referral barriers, and workflow problems; rapidly update job aids and FAQs.



Ongoing improvement: Use evaluation findings to refine the screening process, toolkit, training, referral resources, and technical assistance. Maintain a schedule for updating referral information and provider resources.

Evaluation should extend beyond screening completion. Potential measures include provider confidence discussing gambling, percentage of positive screens with documented followup, type of follow-up action taken, referral success, use of consultation resources, agency-reported burden, training participation, and changes in toolkit or referral resource use over time. These measures would better reflect whether the initiative is improving the response to gambling related concerns rather than simply increasing documentation.

VII. Decision Framework: Provider Needs and Possible Initiative Responses

The table below translates the major provider needs into actionable program responses and concrete implementation elements for DPBH consideration.

Provider Need	Recommended Initiative Response	Possible Implementation Element
Providers have limited baseline knowledge of problem gambling.	Establish minimum problem gambling competency across the BHCEN workforce.	Brief foundational training; CEU options; concise background guide; integration into agency orientation and future professional education.
Clinicians face competing priorities and limited time.	Design screening to fit existing workflows and reduce extra steps.	Embed questions into intake/assessment; short job aids; simple documentation expectations; implementation FAQs.
Providers are uncertain what to do after a positive screen.	Create a standardized response pathway.	Decision tree; positive-screen protocol; guidance for brief intervention, further assessment, consultation, urgent risk, and referral.
Providers are unclear about scope of practice.	Clarify role-based expectations and boundaries.	Credential/role decision guide; examples of actions within scope; consultation and specialist-referral thresholds.
Referral information is difficult to find or may be outdated.	Create centralized, actively maintained referral infrastructure.	Online referral hub; state-funded and other qualified providers; telehealth; peer support; affected-other and financial resources; maintenance owner and update schedule.
Some cases require help beyond a static directory.	Provide consultation and navigation support.	Designated specialist or point person; scheduled consultation hours; difficult-referral navigation; agency-to-agency support.
Financial harms can undermine recovery.	Integrate financial recovery resources into the response continuum.	Financial counseling and case-management resources; budgeting/debt supports; gambling-specific financial recovery materials.
Agencies need practical resources, not awareness alone.	Develop a layered implementation toolkit.	Screening form; instructions; checklists; scripts; decision guides; client materials; referral protocols; training links.
Workforce capacity is limited and specialization pathways are unclear.	Use a tiered workforce-development model.	Baseline training for all; advanced endorsement/certification pathways; supervision resources; internships/practicums; agency-based training.
Implementation support must continue after launch.	Build a continuous improvement structure.	Technical assistance; referral-directory maintenance; provider feedback loop; periodic evaluation; toolkit and training updates.

VIII. Conclusion

The 2026 planning process indicates that partners see value in more consistently identifying gambling-related concerns within Nevada's behavioral health system, while also recognizing the limits of a standalone screening mandate. The central implementation challenge is not simply selecting a screening tool; it is creating a practical system that helps providers recognize gambling concerns, respond within their role, and connect clients to additional support when needed.

A successful initiative can therefore balance two goals: establish a clear and consistent expectation that gambling be considered within BHCEN-certified substance use treatment settings, while avoiding the assumption that every provider or agency must become a specialized gambling treatment program. A concise screening standard, a practical response pathway, baseline workforce competency, role clarity, reliable referral and consultation infrastructure, and ongoing technical assistance would provide that balance.

Implemented in this way, the screening requirement can serve as a gateway to more integrated care, helping Nevada identify gambling-related risks earlier, address their interaction with substance use and mental health recovery, and create clearer pathways to specialized services when those services are needed.

