

White
Paper:

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**Key Findings from SEIGMA
Research Activities & Potential
Implications for Strategic
Planners of Problem Gambling
Prevention and Treatment
Services in Massachusetts**

This white paper summarizes descriptive statistics from a large baseline population survey, a descriptive analysis of data from a problem gambling helpline, and key findings from an online focus group that the SEIGMA team recently conducted with a group of mental health and substance abuse treatment providers across the state. It also discusses the potential implications that these findings have for strategic planners of problem gambling prevention and treatment services in Massachusetts.

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Introduction

In November 2011, an [Act Establishing Expanded Gaming in the Commonwealth](#) was passed by the Massachusetts Legislature. This legislation permits casinos and slot parlors to be introduced in Massachusetts for the first time. Section 71 of the Expanded Gaming Act requires the Massachusetts Gaming Commission (MGC) to establish an annual research agenda to understand the impacts of these new venues, including a comprehensive, first-of-its-kind baseline study of problem gambling prevalence and available treatment services before any of the new gaming facilities become operational [1]. In 2012, the MGC selected a research team from the University of Massachusetts Amherst School of Public Health and Health Sciences to carry out the Social and Economic Impacts of Gambling in Massachusetts (SEIGMA) Study to achieve this agenda.

In addition to conducting a large baseline population survey, the SEIGMA research team initiated an evaluation of existing problem gambling prevention and treatment programs with the aim of using these findings to make scientifically-based recommendations to maintain and enhance problem gambling prevention and treatment in Massachusetts. The SEIGMA team identified a number of questions related to treatment-seeking for gambling problems within its original research plan. These questions included:

- How many problem gamblers in Massachusetts desire treatment and how many seek treatment?
- Where do problem gamblers go to receive treatment in Massachusetts?
- What barriers exist to treatment-seeking?
- What problem gambling prevention and treatment services currently exist in Massachusetts?
- How aware is the general public of existing problem gambling prevention initiatives?
- What is known about the effectiveness of existing problem gambling treatment and prevention services in Massachusetts?
- How well do current problem gambling prevention and treatment services in Massachusetts match up to best practices in problem gambling prevention?

In attempting to answer these research questions, the SEIGMA team was unable to identify a single source of data in Massachusetts about the number and characteristics of people who sought treatment for a gambling problem within the past year. In the absence of one clear data source, the SEIGMA team collected information from a variety of sources about service provision and identified additional data sources that might inform its evaluation. These included SEIGMA survey data, data from the Massachusetts Council on Compulsive Gambling's (MCCG) Helpline, and analysis of medical claims data from the Center for Health Information and Analysis (CHIA). The SEIGMA team also elected to supplement these quantitative analyses with qualitative data collected from mental health and substance treatment providers across the state. Analyses of these data are ongoing.

Concurrent with the SEIGMA team's research activities, the Massachusetts Department of Public Health (MA DPH) contracted with the Education Development Center's (EDC) Massachusetts Technical Partnership for Prevention (MasTAPP) to develop a strategic plan for problem gambling services in Massachusetts. The resulting strategic plan will provide an overview of existing problem gambling-related services in Massachusetts as well as recommendations to MA DPH and MGC for how best to utilize the Public Health Trust Fund (PHTF). The PHTF was established in the Expanded Gaming Act and will be endowed by fees assessed from the state's new casino operators and taxes on gross gaming revenues. Resources in the PHTF will be expended on social service and public health programs to mitigate the potentially harmful impacts of gambling expansion, including prevention, intervention, treatment, and recovery support services as well as the MGC's annual research agenda. Through the mechanism of a Memorandum of Understanding, the PHTF is managed by the Secretary of

Health and Human Services in partnership with the MGC. The vision is that the state strategic plan will ultimately be carried out by the MA DPH and the Secretary of Health and Human Services with assistance from the MGC along with other state agencies and community-based organizations.

Because several of the SEIGMA team’s analyses are in process and the state is understandably eager to finalize its strategic plan for problem gambling services, this white paper summarizes findings from three research activities for which full or partial analyses are complete. This white paper summarizes (1) descriptive statistics from a large baseline population survey, (2) a descriptive analysis of data from the Massachusetts Council on Compulsive Gambling’s (MCCG) problem gambling helpline, and (3) key findings from an online focus group that the SEIGMA team recently conducted with a group of mental health and substance abuse treatment providers across the state. This white paper also discusses the potential implications that these findings have for state strategic planners and those responsible for implementing the strategic plan. Because the SEIGMA team’s research activities are ongoing, this will likely be the first in a series of white papers that discuss the possible relevance of our findings for problem gambling prevention and service provision in Massachusetts.

Key Findings from the SEIGMA Baseline Population Survey & Implications for Strategic Planning

In the absence of a single data source about the number and characteristics of individuals with gambling problems who have sought treatment in Massachusetts, the primary data that the SEIGMA team has collected through its surveys is an important source of information about the scope of problem gambling, treatment desire, and treatment-seeking in the Commonwealth.

Overview of Baseline Population Survey Methods

From September 11, 2013 to May 31, 2014, the SEIGMA team conducted a large Baseline Population Survey (BPS) that measured attitudes about gambling, gambling participation, problem gambling prevalence, awareness of problem gambling prevention efforts, treatment desire, and treatment seeking among Massachusetts adults aged 18 and over. The SEIGMA team obtained a probability sample of all Massachusetts adults. Survey respondents could complete the survey online, on paper, or by telephone. The survey had a response rate of 36.6% and achieved a final sample size of 9,578 respondents. Descriptive findings relevant to strategic planning are summarized in the section that follows. A full set of descriptive statistics from the survey is available on the SEIGMA website: <http://www.umass.edu/seigma/reports> [2]. Comparisons described as “higher” or “lower” are based on statistical tests of significance. Please note: The results summarized below do not reflect deeper exploration of the data; the SEIGMA research team will conduct in-depth analyses over time, releasing findings as they become available.

Relevant Findings

Gambling in Massachusetts: Attitudes and Participation

The BPS asked a number of questions about respondents’ attitudes toward gambling and found that generally, respondents had moderate views about gambling. Over half of the adult population of Massachusetts (57%) believes that some forms of gambling should be legal and some should be illegal, with only a third (31%) reporting that all forms should be legal, and a tenth (11%) reporting that all forms should be illegal. Just over 39% of Massachusetts adults perceived the impact of gambling expansion on the state to be beneficial or very beneficial while 41% perceived the impact to be somewhat or very harmful. The remainder perceived the impact on the state to be neutral.

The BPS defined gambling as: *betting money or material goods on an event with an uncertain outcome in the hopes of winning additional money or material goods*. This includes activities such as lottery games, bingo, betting against a friend on a game of skill or chance, and betting on horse racing or sports. Overall, nearly three quarters of Massachusetts adult residents (72%) reported participating in one or more of these gambling activities in the past year. There were significant differences in overall gambling participation associated with gender, age, race/ethnicity, education, employment, income level, and geographic region. Notably, the survey found that men were more likely to gamble than women, middle-aged adults (35-64) were more likely to gamble than both younger adults (<24) and older adults (80+), and Whites were more likely to gamble than Hispanics, Blacks or Asians.

The three most common forms of gambling in which respondents had participated in the past year were lottery (59%), raffles (32%), and casino gambling (22%). Massachusetts residents reported gambling at different frequencies; while a quarter of the population did not gamble, close to 40% gambled yearly, 20% gambled monthly, and 15% gambled weekly. Past-year gamblers in Massachusetts were most likely to identify winning money as the main reason they gambled, followed by excitement/entertainment, socializing with family/friends, and supporting worthy causes. There were significant differences in gambling motivation associated with race/ethnicity and gender. Hispanics and Blacks were significantly more likely than Whites and Asians to say that winning money was the main reason they gambled, suggesting that they approach gambling more as a financial proposition than a social activity. Men were significantly more likely than women to say that winning money was the main reason they gambled, while women were significantly more likely to say that supporting worthy causes was the main reason they gambled.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
MA residents have high rates of gambling participation and moderate attitudes about gambling availability and impacts.	<ul style="list-style-type: none"> This indicates that there is a broad audience of people who may be receptive to prevention messaging about gambling. High rates of lottery, raffle, and casino participation indicate that these may be possible channels for prevention messaging and resource sharing.
Lottery, raffles, and casino gambling are the most common forms of gambling in MA.	<ul style="list-style-type: none"> This may help strategic planners to target messages (i.e., to particular forms of gambling, venues, etc.).
Certain demographic groups have higher rates of gambling participation.	<ul style="list-style-type: none"> This may aid strategic planners in conducting outreach and tailoring messages to specific populations in the Commonwealth (e.g., promoting responsible gambling in recreational venues where men spend time or creating ads that feature men ages 35-64).
Gambling motivation differs among different demographic groups.	<ul style="list-style-type: none"> This may further aid strategic planners in tailoring messages to specific populations in the Commonwealth (e.g., creating prevention messages that incorporate/acknowledge common gambling motivations).

Problem Gambling in Massachusetts

Based on their answers to a standard set of questions, people who gambled in the past year were classified as recreational gamblers, at-risk gamblers, and problem gamblers. Recreational gamblers gamble because they enjoy these activities. At-risk gamblers engage in a range of behaviors such as persistently betting more than planned, spending more time gambling than intended, chasing losses, and borrowing money to gamble that place them at greater risk of experiencing a gambling problem. Problem gamblers are individuals who

experience significant impaired control over their gambling and negative consequences as a result of their impaired control.

Based on the scale used, we determined that the prevalence of problem gambling in Massachusetts was 1.7% of the adult population and that an additional 7.5% of the population were at-risk gamblers. Based on these percentages, we estimate that between 67,000 and 109,000 adult residents are currently problem gamblers and between 353,000 and 426,000 adult residents are at-risk gamblers. Similar to gambling participation, there were significant differences in problem gambling associated with gender, race/ethnicity, and education: Men were 3 times more likely to have a gambling problem than women; Blacks were 4 times more likely to have a gambling problem than Whites; and individuals with only a high school diploma were 2 times more likely to have a gambling problem than individuals with a college degree.

There were other notable distinctions between recreational, at-risk, and problem gamblers. At-risk and problem gamblers in Massachusetts were significantly more likely than recreational gamblers to be male, Black, unemployed, and have an annual household income of less than \$15,000. Initial survey results show that, compared to recreational gamblers, at-risk and problem gamblers were more likely to report poor physical health, serious mental health problems, tobacco use, and consuming large amounts of alcohol at one time.

Additionally, about 1 in 6 Massachusetts adults (17.5%) reported knowing someone who they considered gambled too much. Respondents who said that there was someone in their life who gambled too much were significantly more likely to be at-risk or problem gamblers rather than recreational gamblers. Respondents who knew someone who gambled too much were most likely to report that the person was a family member outside of their household (32%) or a friend (30%). In response to a follow-up question, these respondents were most likely to identify financial issues (financial strife, borrowing money, difficulty covering household expenses) (31%) or emotional issues (emotional pain, neglect, concern, frustration) (19%) as the most important effects of the person’s gambling.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
Population prevalence of problem gambling in MA is just under 2% and prevalence of at-risk gambling in MA is 7.5%.	<ul style="list-style-type: none"> • Prevalence rates provide an estimate of the number of people who may be eligible for intervention, treatment, and recovery support. • The literature indicates that problem gambling prevalence is substantially higher (often double) in communities with large gambling venues compared with communities without such venues [3, 4]; this has implications for conducting outreach and targeting prevention messages.
At-risk and problem gambling prevalence are higher among certain demographic groups.	<ul style="list-style-type: none"> • Strategic planners should consider targeting prevention and intervention efforts at these high-risk groups.
Certain co-occurring conditions are common among problem gamblers.	<ul style="list-style-type: none"> • Successful treatment of problem gambling will generally require broad-based treatment that also addresses these common comorbidities. • Strategic planners should encourage routine screening that encompasses the range of co-occurring conditions that problem gamblers face. Problem gamblers should be routinely screened for mental health comorbidities and people with mental health disorders should be routinely screened for problem gambling.

<p>Just under a fifth of the population knows someone who gambles too much; these respondents were more likely to be at-risk or problem gamblers than recreational gamblers.</p>	<ul style="list-style-type: none"> • This finding provides an estimate of the number of people who may be affected by someone else’s gambling; individuals within this group may be in need of resources and services. Currently the MA DPH Bureau of Substance Abuse Services (BSAS) does reimburse for collateral clients— parents, primary caregivers, partners, spouses, and children of problem gamblers. Close friends of problem gamblers who are classified as “at-risk” are also covered. Strategic planners should investigate utilization of these resources and maintain funding for concerned others. • This segment of the population is also a potential audience for prevention messaging regarding the scope of problem gambling and bystander intervention. • It may be helpful for treatment providers to assess whether gambling problems are common in clients’ support networks, as this could pose a barrier to achieving treatment goals.
<p>Respondents who knew someone who gambled too much were most likely to report that the person was a family member outside of their household or a friend.</p>	<ul style="list-style-type: none"> • This finding may aid strategic planners in tailoring prevention messages to family members and friends of problem gamblers.
<p>Respondents who knew someone who gambled too much were most likely to report financial strife, borrowing money, or difficulty covering household expenses, and emotional pain neglect, concern or frustration as the most important effects of the person’s gambling.</p>	<ul style="list-style-type: none"> • This finding may aid strategic planners in tailoring prevention messages to identify/address these effects. • Because financial issues were commonly reported as an effect of someone else’s gambling, strategic planners should consider how financial tools and resources can be integrated into the problem gambling service system in MA.

Problem Gambling Prevention Awareness and Treatment-Seeking

Awareness of existing problem gambling prevention initiatives in Massachusetts was quite variable. About 4 in 10 Massachusetts adult residents were aware of media campaigns to prevent problem gambling. However, just over 1 in 10 adults were aware of non-media prevention programs in schools and communities around the state. Of these, only 2.3% had participated in such programs. Awareness of media and non-media prevention programs differed significantly based on respondents’ problem gambling status. Awareness of these campaigns and programs was higher among at-risk and problem gamblers than the general population, with just over half of problem (54%) and at-risk gamblers (51%) aware of media campaigns to prevent problem gambling. Similarly, just under a quarter of problem gamblers (24%) and a fifth of at-risk gamblers (20%) were aware of non-media programs in their school, workplace, or community.

A very small number of problem gamblers in the survey indicated that they would like help for a gambling problem or had sought help for such a problem. This contrasts with our earlier estimate that between 67,500 and 109,100 Massachusetts adults currently have a gambling problem. The gap between this estimate and the small number of individuals who reported desiring or seeking treatment highlights a potentially underserved population that may be in need of treatment.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
<p>The majority of the population is not aware of media campaigns and other programs designed to prevent problem gambling.</p>	<ul style="list-style-type: none"> • Successfully preventing problem gambling at the population level depends on widespread awareness of problem gambling and responsible gambling. Strategic planners may use this information to create media campaigns with broader population reach and impact (e.g., via channels that have widespread viewership). • Strategic planners should consider investigating evidence-based and promising programs designed to prevent problem gambling, implementing such programs in settings across the state, and evaluating their effects.
<p>Just over half of at-risk and problem gamblers were aware of media campaigns and just under a quarter were aware of other programs to prevent problem gambling.</p>	<ul style="list-style-type: none"> • Improved data collection about prevention awareness may provide additional information about the particular campaigns and programs that respondents had in mind when they answered these survey questions. • Additional efforts to increase prevention awareness among at-risk and problem gamblers are needed. These populations interact with gambling products at a much higher rate than the general population and are more attuned to gambling-related messaging.
<p>Low numbers of at-risk and problem gamblers report treatment desire and treatment-seeking despite the much larger number affected based on prevalence estimates.</p>	<ul style="list-style-type: none"> • There may be many things driving this gap. Problem gamblers may not be aware of existing resources and services. Additionally, this population is often reluctant to seek treatment because of a number of barriers including perceived stigma, denial, and lack of resources [5-11]. Those barriers may be driving the gap and warrant further study. • In the absence of additional information, outreach efforts to increase awareness of problem gambling and treatment options may play a role in increasing the number of people seeking treatment for gambling problems in MA. • The lack of data regarding the number of individuals who sought treatment for a gambling problem indicates a need to collect data on the number of clients who receive treatment services and support for problem gambling in MA. Currently no streamlined mechanism exists for collecting these data. • It is important to note that the literature indicates a significant portion of problem gamblers deny having a gambling problem and do not seek professional help, often preferring to address their problem with their own resources [12-15]. A portion of these individuals recovers without professional intervention [12, 16]. This suggests a need for increased availability of online self-assessment tools and online self-help materials for this population (such materials are readily available in other jurisdictions).

Strengths and Limitations of the BPS

Two major strengths of the BPS are its sample size and its representativeness. Due to the sampling strategy and strenuous recruitment efforts used, the sample is representative of the broader Massachusetts population. Four potential limitations of the Baseline Survey include a relatively low response rate, exclusion of adults who do not live in households, limited language translation, and small sample sizes of some population subgroups. Taken together, these possible limitations limit the generalizability of the results presented here. It is also worth noting that these results are based on descriptive, univariate statistical analyses. The SEIGMA team plans to conduct deeper analyses using multivariate statistics to better assess relationships between recreational, at-risk, and problem gambling classification and other factors. These deeper analyses will clarify the results presented in this white paper and will aid in identifying possible risk and protective factors related to at-risk and problem gambling that remain predictive after controlling for underlying relationships in the data.

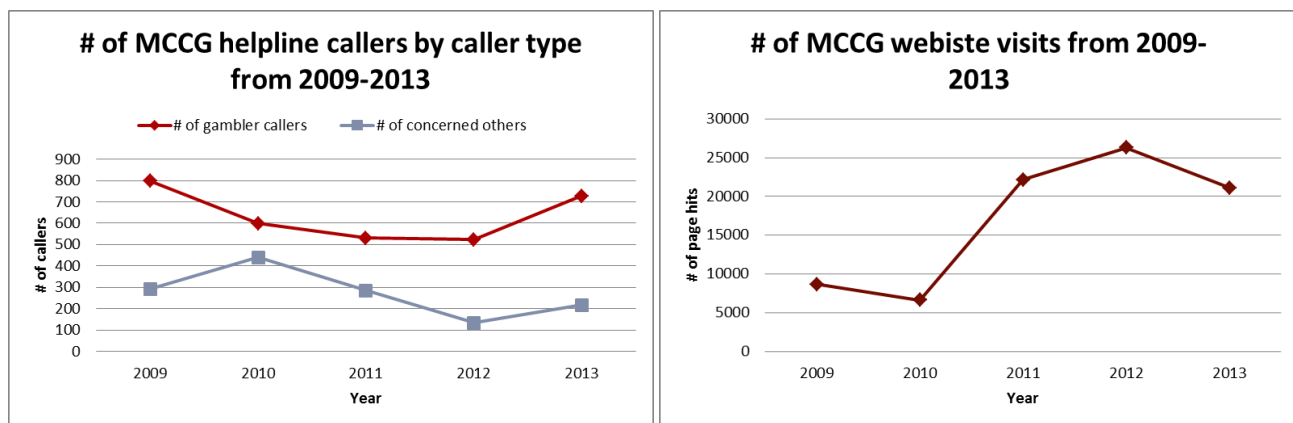
Key Findings from an Analysis of MCCG Helpline Data

Another source of data that the SEIGMA team used to inform its evaluation of problem gambling services was the MCCG Problem Gambling Helpline. MCCG is a private, non-profit agency dedicated to providing leadership to reduce the social, financial, and emotional costs of problem gambling. The organization promotes a continuum of prevention and intervention strategies, including information-sharing, raising public awareness, and providing community education and professional training. One of the vital services provided by the MCCG is a toll free problem gambling helpline, which is available to callers 24 hours a day, 7 days a week.

When a caller dials the helpline, they receive a live and confidential response from a service provider who is trained to respond empathetically to callers. Based on the needs of each caller, helpline responders offer information and referrals for self-help, formal treatment, support groups, and other community resources. While responders do collect data about the calls they receive, *data collection is not their primary goal*. To the extent possible, helpline responders record the time of call, type of caller (e.g., gambler, family member), reason for the call, and referrals made. If possible, helpline responders also collect information on the characteristics of callers, such as socio-demographic information (e.g., gender, age, marital status, ethnicity, employment), residence (e.g., city, state, zip code), primary gambling type, and preferred gambling venue. However, the main goal of helpline responders is to adequately address each caller’s needs, provide them with resources and refer them to professional and self-help treatment services through which they can seek additional help.

Early on in the project and recognizing the dearth of data about problem gamblers in Massachusetts, the SEIGMA team executed a Memorandum of Understanding with MCCG to conduct an analysis of their helpline data. MCCG generously shared 17 years of data with the SEIGMA team. The main dataset contained 31,410 records for fiscal years 1997-2013. Some records were excluded (4,444 calls about lottery winnings, 291 calls from the media, and 100 calls from fiscal year 2014), resulting in 26,575 call records. Due to variations in the completeness of these data from year to year, the SEIGMA team elected to subset and analyze the last five years of the dataset.

From fiscal years 2009-2013, MCCG collected data about 4,574 calls. As shown in the figure on the left, the number of helpline calls generally decreased over the five year period, with a slight rebound in 2013. Compared to the figure on the right, it is clear that hits to the MCCG website generally increased over this period, indicating that help-seekers may increasingly be searching for resources online rather than via telephone.



The majority of callers (3,177; 69%) called about their own gambling behavior; the remaining callers were concerned about someone else’s gambling behavior (most often relatives). Although a great deal of demographic data is missing, the majority of gambler callers were middle-aged men, while the majority of

concerned others were female. The most common reason that callers reported for seeking help were financial problems, emotional health issues, and relationship issues. Within the five year period, MCCG made a number of referrals to state-run treatment centers—619 referrals for problem gamblers and 305 referrals for concerned others. MCCG also made a number of referrals to other sources (e.g., affiliate councils in other states, Gamblers Anonymous, Gam-Anon, private therapists, inpatient treatment, etc.)—1,872 referrals were made to problem gamblers and 773 to concerned others.

Because the needs of each caller are different and responders tailor their responses based on the issues presented, collecting data in a standardized way presents a challenge to helpline responders. Understandably, there is a great deal of missing information within the dataset, making statistical analyses, beyond the basic descriptive results presented here, difficult.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
The MCCG Helpline received approximately 1,000 calls per year from 2009-2013. During this period, the MCCG made over 3500 referrals to treatment or other resources.	<ul style="list-style-type: none"> Individuals in MA are reaching out for help and receiving referrals. What is less clear is whether or not these callers actually sought treatment or help from the other sources to which they were referred. These data illustrate a need for additional information that can tell us more about the profile of help-seekers in MA and how many of them ultimately seek treatment.
Calls to the MCCG Helpline generally decreased from 2009-2013 while visits to the MCCG website generally increased over the same period.	<ul style="list-style-type: none"> Because help-seekers are increasingly seeking resources online rather than via telephone, strategic planners should review existing online resources and if needed, improve web-based content, including adding/improving online self-help resources to ensure that content is both accessible and culturally appropriate.
Helpline callers most often reported financial, emotional, and relationship issues as the reasons for their call.	<ul style="list-style-type: none"> Because the majority of callers had a financial issue, strategic planners should consider how financial tools and resources can be integrated into the problem gambling service system in MA. Strategic planners may also wish to consider how financial professionals and debt counsellors could be informed about problem gambling as a possible challenge for some of their clients.
MCCG Helpline data collection is limited.	<ul style="list-style-type: none"> In the absence of other metrics, the MCCG data are an important source of information about help-seeking among problem gamblers in MA. However, because data collection is not the primary goal of the helpline, these data cannot provide the sole source of information about help-seeking in MA. MA needs a better mechanism for collecting data about help-seeking and treatment. The lack of data about help- and treatment-seeking indicates a possible need to create a standardized data collection process for the state as a part of problem gambling service provision. While data collection will never be the goal of the helpline, it may be possible to improve helpline data collection through additional funding and technical assistance. Possible improvements include: establishing a minimum required dataset that contains minimal information about each caller; creating a more user-friendly data collection tool designed for use on a helpline (e.g., that follows the typical progression of a call); creating a tool that allows users to more easily access and compile data; establishing a process for following up with callers after the call [6, 17-21].

Strengths and Limitations of the MCCG Helpline Data

The MCCG has collected a large amount of data about calls to its problem gambling helpline. In the current service environment, these data are one of the only sources of information about problem gambling help-seekers in Massachusetts. However, because data collection is not the primary goal of the helpline, there are a lot of missing data within the dataset. This makes it difficult to conduct statistical analyses with these data. Because no data source currently captures information about the characteristics of problem gambling treatment-seekers, it is also difficult to determine if this sample of helpline callers is representative of the broader population of help-seekers in Massachusetts.

Key Findings & Themes from an Online Focus Group with Mental Health & Substance Abuse Treatment Providers

Background

While the Baseline Population Survey shed light on some of the research questions posed at the beginning of this document, the SEIGMA team sought more information from treatment providers to more fully investigate treatment practices and effectiveness, including screening practices, perceptions about screening, facilitators and barriers to treating individuals with gambling problems, treatment practices, referral practices, perceptions about the effectiveness of treatment, and perceptions about the barriers and facilitators that clients face in seeking and adhering to treatment. After piloting an online survey to capture information about these topics, the SEIGMA team concluded that a qualitative approach to collecting this information was preferable. To this end, the team contracted with Market Street Research (MSR) to conduct a focus group with treatment providers. In collaboration with MCCG, MA DPH, and MGC, the SEIGMA team developed a focus group moderator guide and sampling strategy. The methods used and key results obtained from the focus group are summarized below. Because these results have not previously been summarized in existing presentations or reports, findings from this initiative are presented in more detail than data presented in previous sections of this white paper.

Methods and Sample

The SEIGMA team contracted with MSR to conduct an online focus group, which took place over three days in late June 2015. Online focus groups allow geographically dispersed groups of people to participate in data collection via an online platform. A moderator is assigned to the online group and poses a series of questions to online focus group participants. Participants respond by typing their answers into a text box. Once participants post answers to the online platform, the moderator can probe for additional information by posting a response within the platform and via e-mail. Likewise, other focus group participants can respond to posted answers.

The SEIGMA team and MSR collaborated with MCCG to develop a sampling strategy for the focus group. MCCG created a list with the names and e-mail addresses of individuals who had completed or were in the process of completing the Massachusetts Problem Gambling Certificate (MAPGS) as well as individuals who had attended one or more of their professional trainings. The resulting list contained 439 names. Visual inspection resulted in some names being scrubbed from the list. For example if an individual had taken a course but was known to not be a treatment provider, s/he was removed from the list. MCCG then sent an e-mail advance letter to every individual on the scrubbed list asking for consent to share their contact information with the SEIGMA and MSR teams. A separate list of 133 consenting individuals was created and shared with the SEIGMA team and MSR.

MSR contacted these individuals to describe the focus group and conduct a brief screener survey. To participate in the focus groups, individuals had to (a) be licensed to provide mental health or substance abuse treatment services in Massachusetts, (b) see a minimum of five clients per week, and (c) practice in at least one Massachusetts County.

Providers who met the inclusion criteria and consented to participate were enrolled in the focus group. A total of 35 providers were enrolled in the study, meeting the recruitment target. Of these, 32 participated in one or more days of the focus group (30 participated all three days; 2 participated for one day). Each participant created a profile and used an anonymous screenname and avatar when posting responses to the group.

The online focus group took place from June 23rd to June 25th, 2015. On each morning of the focus group, the moderator posted a different set of questions and participants had the remainder of the day to provide their answers. Providers received \$50 for each day in which they participated and a total honorarium of \$200 if they participated in all three days of the focus group. Study methods and all materials—advance letter, screener survey, consent forms, moderator guide, and incentives—were approved by the University of Massachusetts Amherst Institutional Review Board.

Each day of the focus group included different questions about treating individuals with gambling problems in Massachusetts. A summary of each day’s content is presented below.

Day 1	Day 2	Day 3
<ul style="list-style-type: none"> • Participant profile • Practice setting • Screening practices • Perceptions re: screening effectiveness 	<ul style="list-style-type: none"> • Professional training rec'd to treat PGs • Treatment practices • Referral practices • Treatment outcomes 	<ul style="list-style-type: none"> • Perceptions of client barriers & facilitators <ul style="list-style-type: none"> • Unmet needs • Perceived effectiveness of practice & treatment system

Focus group data were extracted from the online platform into a Word document, which served as the transcript for the analysis. MSR analysts, trained in qualitative data analysis techniques, reviewed the data, identified key themes and quotes that best illustrated them, and created a set of recommendations based on the key themes. They then compiled a report that summarized the results. The SEIGMA team reviewed the transcript and report with MSR and shared these materials with stakeholders from MCGG, MA DPH, and MGC who had significant expertise in problem gambling treatment. State strategic planners also received a copy of the materials. The SEIGMA team then convened a meeting in which stakeholders discussed the data, clarified the data (e.g., explaining different acronyms that participants used to describe training credentials, screenings tools, etc.), and came to consensus about the key themes and recommendations. The results presented below are reflective of this collaborative process.

Participant Profiles and Screening Practices

As shown above, the first day of the online focus group sought to obtain a profile of participants, both so that participants would better understand each other, and to assist the moderator in posing questions and probes.

The moderator also sought information about the settings in which participants practiced, the screening practices they used in those settings, and their perceptions about the effectiveness of those practices.

The majority of providers who participated in the online focus group were female (19 of 32) and identified as White (25 of 32). A small number of participating providers identified as Hispanic (5 of 32) or Asian (2 of 32). Participants ranged in age from 26-68 years old and practiced in 18 different Massachusetts municipalities across the state. Providers also worked in a variety of practice settings, including large practices with ten or more providers (14 of 32), small practices with less than ten providers (10 of 32), and solo private practices (8 of 32). Within these settings, the volume of clients ranged; 18 providers reported seeing 26 or fewer clients per week and 14 providers reported seeing more than 26 clients per week. Nine providers reported working for a MA DPH Bureau of Substance Abuse Services contracted agency. Within their different practice settings, providers reported accepting a variety of forms of payment, including private/commercial insurance (23 of 32), Medicaid (19 of 32), Medicare (16 of 32), out of pocket payment (18 of 32), payment from the MA DPH (8 of 32), and other unique sources (10 of 32). The majority of participants reported being in practice for ten or more years (19 providers), while others had less experience.

Participating providers reported having an array of licenses and credentials, which ranged from Licensed Alcohol Drug Abuse Counselors, Licensed Mental Health Counselors, Certified Alcohol/Drug Abuse Counselors, to Licensed Independent Clinical Social Workers. All but two participants reported receiving gambling-specific training. Specializations ranged from addiction/substance abuse, depressive disorders, dual diagnoses, PTSD, problem gambling, eating disorders, bipolar disorder, to schizophrenia. Almost half of participants reported treating a client with a gambling problem at some point in their careers (15 of 32).

When asked about the practices they use to screen individuals for gambling-related problems, a majority of participants reported using some type of problem gambling screening tool with their clients. Some providers reported incorporating problem gambling screening within a larger, more comprehensive assessment around substance use and addictive behaviors. Others reported informally asking clients about gambling during an intake interview process. Participants reported using formal screens such as the South Oaks Gambling Screen [22], MCG 4-Question Screening Tool, and the Massachusetts Gambling Screen (MAGS) [23].

Participants expressed mixed feelings about the effectiveness of screening for problem gambling. While the majority perceived screening as somewhat effective, they expressed a number of concerns about current screening processes within their practice. Participants conveyed concern about the lack of education that providers have about problem gambling, its characteristics and symptoms. Participants also acknowledged that clients with gambling problems may be in denial about such problems or may minimize the problems they are experiencing, and that admission of problems often occurs over the course of treatment for another issue. This tendency towards denial or minimization means that clients may not screen positively at intake despite experiencing a problem with their gambling behavior. Similarly, providers shared that gambling problems are often masked by other serious problems—such as substance abuse or mental health issues—which must be managed before dealing with co-presenting issues such as problem gambling. In some cases, the severity of a client’s presenting problems may preclude screening for gambling problems all together.

Despite these concerns, the vast majority of participants felt that screening for gambling problems was advisable, both to raise awareness of the issue and to ensure that they are comprehensively addressing client needs. In addition to general information about screening practices and perceptions of its effectiveness, providers who reported screening clients for gambling problems were asked to describe what happens when a client screens positively. Following a positive screen for a gambling problem, most providers reported collecting more information from their clients both formally through targeted assessment and informally by asking additional questions as part of an interview in order to obtain details about the nature and scope of the problem. Many providers reported incorporating problem gambling within the client’s diagnosis and treatment plan, while others reported referring clients with gambling problems to other sources such as more experienced colleagues, Gamblers Anonymous, the MCCG, and providers with fewer insurance restrictions. Providers commonly reported providing education about gambling addiction to their clients and using behavior change models and techniques such as the Stages of Change Model, motivational interviewing, and Cognitive Behavioral Therapy to begin affecting change.

Illustrative Quote:
We discuss the problem gambling issue with the client and do some education about the disease process of addiction and the chemistry that drives it. We determine the stage of change that the client exhibits and based on the stage of change, work with the client to develop a treatment plan, financial plan, and list of goals. GA [Gamblers Anonymous] attendance and getting a GA sponsor are highly encouraged.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
<p>Providers report using a variety of screening tools in a variety of different ways.</p>	<ul style="list-style-type: none"> • Strategic planners should consider standardizing problem gambling screening to ensure that providers are using a validated problem gambling screening tool. • Strategic planners should consider testing a validated tool within a practice setting and seeking feedback from treatment providers regarding the ease of using the tool and perceived effectiveness of the tool in a clinical setting. Using a validated tool that has been tested and endorsed by treatment providers within a clinical setting may facilitate more widespread adoption of a single standardized screening tool. • If a standardized tool is chosen, strategic planners should ensure that providers are appropriately trained to use the standardized tool within their practices.
<p>The current framework of practice requires that screening occur at the beginning of the treatment process. However, gambling problems often do not emerge until later. Within the current framework of practice, providers are not always permitted to screen or re-screen once treatment has begun.</p>	<ul style="list-style-type: none"> • Strategic planners should consider incorporating screening for gambling-related problems later in the intake/treatment process. For example, the state of Iowa shifted from screening for problem gambling at intake to screening at a later point in the treatment process. • Examine billing and documentation practices in MA to ensure that providers have the ability to update diagnoses and bill for services rendered as clients progress through treatment. Insurance companies often require that providers re-visit and revise treatment plans as clients progress. Perhaps this practice could be adapted for use within the state service system.

Training, Treatment, and Referrals

The second day of the online focus group explored participants’ experiences treating individuals with gambling problems. On Day 2, the moderator collected information about the professional training that participants had received to treat individuals with gambling problems. The moderator also asked about participants’ treatment practices and outcomes.

The providers who took part in the focus group reported participating in a wide variety of trainings, webinars, conferences, and courses to improve their practice. As expected given our sampling strategy, nearly all of the participating providers reported receiving training to treat problem gambling. Most of them obtained this training through the MCCG within the past two years. Most providers found the training they received to be educational and interesting. They reported leaving the training with new information about problem gambling and its similarities and differences with other addictive behaviors.

Providers commonly expressed a desire for trainings that emphasize more practical, real-life treatment methods and examples. Rather than receiving information culled from research studies, providers expressed an interest in learning effective counseling strategies and tools. This desire, for a more practice-focused training that explores the full range of possible client outcomes, was common among participants.

Illustrative Quote:
The best training I could receive would be from a supervisor in the field, discussing both successes and failures of treatment (trainings tend to focus on the best possible outcomes).

As noted earlier, almost half of the participants had experience treating individuals with gambling problems. Providers reported that such clients typically present with other behavioral problems, such as substance abuse or mental health issues, and begin treatment for another issue. Often, gambling problems emerge as clients proceed through treatment. Providers most often attributed its late emergence to denial and a lack of awareness about gambling problems. When asked to describe a typical client with a gambling problem, many participants expressed an unwillingness to typify clients, asserting that clients of any sex, educational level, and background could be problem gamblers. Despite this, many providers acknowledged that some behaviors and issues were common among individuals with gambling problems. These include co-occurring mental health and substance abuse issues (e.g., anxiety, depression, substance abuse, addictive behaviors, compulsive behaviors, etc.), struggles with financial instability as a result of their gambling, and experiencing isolation.

Illustrative Quote:
I always tailor the treatment plan to the specific patient, so I rarely use the same treatment plan twice, but the treatment plan is continually changing as the patient begins to achieve goals, or we realize the treatment plan needs to change to reflect a patient being stuck.

Perhaps because most providers were reluctant to classify a typical client, they commonly reported creating individualized treatment plans. They sought to tailor their particular treatment approach to each client based on his/her diagnoses, needs, and expressed preferences. Similarly, most providers reported modifying a client's treatment plan when additional diagnoses or co-occurring conditions emerged through the course of treatment. While participants did not express a clear orientation towards individual or group treatment therapies, many providers acknowledged using Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and motivational interviewing (MI) with clients.

When asked about treatment goals and outcomes, participants identified the following treatment goals for their clients:

- Reducing or eliminating gambling triggers, such as socializing in places where gambling is offered
- Resolving adverse circumstances resulting from gambling problems, such as reducing debt
- Reducing or eliminating adverse behaviors associated with gambling, such as dishonesty
- Working toward a decrease in addictive behaviors and toward gambling abstinence
- Increasing positive behaviors, such as replacing gambling with other recreational activities

Participants often work with their clients to develop a specific list of measurable goals that they can track as clients progress towards achieving them. Most providers stated that treating and managing addictive behaviors such as problem gambling is a lifelong process, and that they look for evidence of a client’s commitment to overcoming his or her addiction. Most providers acknowledged that relapse was to be expected, but that they hope that over time, their clients will experience shorter periods of relapse and longer periods between relapse episodes. They generally rely on client self-report to chart progress.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
Providers are interested in receiving skills-based clinical training and clinical supervision to provide treatment to individuals with gambling problems.	<ul style="list-style-type: none"> • Strategic planners should examine current models for effectively administering clinical training and supervision for problem gambling treatment, and adapt a chosen model for use in MA. In addition to references already cited, citations 24-34 in the reference list at the end of this document may be a helpful resource for strategic planners as they evaluate existing treatment modalities and service systems [24-34].
Providers set treatment goals with their clients and evaluate treatment outcomes in a variety of different ways. Most of their evaluation efforts are informal, undocumented, and based on self-report.	<ul style="list-style-type: none"> • Standardize documentation of treatment plans and outcome measurement to ensure that providers have an effective mechanism for evaluating clients’ progress. • Ensure that providers are appropriately trained to use the standardized process within their practices. • Strategic planners should consider piloting a treatment evaluation program that follows up with patients after treatment has ended to chart continued progress through treatment goals and outcomes.

Barriers, Unmet Needs, and System Effectiveness

The third day of the online focus group explored participants’ perceptions of client barriers and facilitators for seeking treatment. Participants also discussed their unmet needs and perceptions about how effectively both their practice and the state of Massachusetts administers problem gambling services.

When asked about the barriers that they perceive clients face in seeking treatment, participants identified lack of awareness of gambling addiction, attitudinal barriers, and the availability of trained clinicians as the main barriers clients face in seeking treatment. Many providers stated that there is a lack of widespread awareness about gambling addiction and that this prevents clients from recognizing their own or others’ problematic gambling behavior. This lack of awareness contributes to unfamiliarity about where to seek help for a gambling problem. Several providers noted that the lack of awareness about problem gambling starkly contrasts with the widespread availability of gambling. Several providers perceive gambling to be socially normative and problem gambling as socially stigmatized. Linked to this, many providers shared a perception that attitudes such as shame, denial, stigma, and fear of being caught are barriers their clients face in seeking treatment for a gambling problem. Providers also expressed a common perception that not enough clinicians are trained to recognize and treat gambling addiction, especially clinicians who speak languages other than English and work with clients who do not speak English.

When asked about the barriers that they perceive clients face in achieving treatment goals, participants identified a wide array of barriers. Providers commonly identified self-limiting behaviors and attitudes such as denial, low self-esteem, a lack of desire to quit gambling, feeling pressured to seek treatment, and unrealistic expectations for treatment as barriers that their clients face in achieving treatment goals. Providers also

identified insufficient support structures as significant barriers for their clients. These include a lack of strong support from family and friends, both because family and friends feel alienated due to clients' gambling behavior and because friends who gamble may normalize clients' gambling behavior. Providers also noted a lack of structural support resources such as Gamblers Anonymous and other community support groups. In addition, providers identified the following as barriers:

- High prevalence of gambling opportunities in everyday life
- Co-occurring conditions and comorbidities that complicate treatment
- Limitations on what diagnoses and treatments that insurers cover
- Lack of awareness of options to aid in abstinence, such as self-exclusion from casinos

In addition to identifying a number of perceived barriers that their clients face in seeking and adhering to treatment, participants acknowledged a number of unmet needs. These include a need for additional clinical training and support to treat individuals with gambling problems. Providers commonly expressed a need for more networking and mentoring opportunities, an established referral system, more education around insurance billing, and more education about recreational gambling. Providers expressed an interest in additional training opportunities and obtaining additional real-life experience to supplement these trainings. Providers also expressed a desire for more resources to be allocated to treatment, to create more gambling-specific treatment and support programs across the state. Lastly, providers expressed a strong interest in seeing a public awareness campaign on par with statewide smoking cessation campaigns to raise awareness about gambling problems and resources.

*Illustrative Quote:
A mentoring program would be fantastic. Allowing clinicians to connect and support each other, either in person or online.*

When asked about the effectiveness of their practice at treating individuals with gambling problems, providers commonly felt that their colleagues and supervisors were supportive and that MCCG provides excellent resources and training. However, they expressed a strong interest in connecting with other trained clinicians for support and education. Many acknowledged that their practice lacks clinicians who are experienced in treating individuals with gambling problems and in providing clinical supervision to providers interested in treating this population. Others expressed that while their practice has the necessary infrastructure to treat problem gamblers, they are not getting a large number of these clients. Lastly, some providers expressed an interest in having better technology systems to enable them to track and improve client outcomes over time.

When reflecting on how effectively Massachusetts administers problem gambling services, participants praised the MCCG, the GameSense program, and the voluntary self-exclusion process being implemented in the Commonwealth. However, they advocated for more funding, both to create a public health campaign designed to prevent problem gambling and to fund services and resources to treat problem gambling. They suggested that these efforts be supported by outreach to various populations, including undiagnosed problem gamblers, clinicians, and state policymakers. Once again, participants expressed a strong desire to connect with other clinicians through an online portal that includes educational literature and a database of programs and providers that address problem gambling. Additionally, they expressed a desire for services for problem gamblers to be more easily covered by insurance plans, or for other funds to be made available to compensate clinicians for providing these services.

Possible Implications for Strategic Planning

Key Finding	Possible Implication for Strategic Planning
<p>Participants differed in their opinions regarding treatment goals and outcomes; while some providers identified gambling abstinence as the goal, others identified reductions in gambling-related harms and symptomology as their primary treatment goals.</p>	<ul style="list-style-type: none"> • Differences in treatment goals and outcomes reflect a broader debate in the field regarding abstinence-focused treatment versus other models of care. Individually tailored treatment plans and provider flexibility about treatment goals at the outset of treatment may aid in resolving this issue.
<p>Participants articulated a number of unmet needs including more training opportunities, a desire to be part of a community of practice, a desire to receive clinical supervision, a need for outreach to a variety of audiences to raise awareness about services, the ability to more efficiently track/evaluate/improve client outcomes, and funding to support their work.</p>	<ul style="list-style-type: none"> • These needs may be best met by creating a more integrated problem gambling treatment system in MA. Strategic planners should consider creating a new treatment model based on other jurisdictions that have been successful in implementing a problem gambling treatment system. The <i>2013 National Survey of Problem Gambling Services</i> may be a helpful resource for strategic planners [24] • Participants consistently articulated a need for more clinical supervision, mentorship, and being a part of a community of practice, indicating that strategic planners should incorporate clinical supervision and support into the problem gambling treatment system.

Strengths and Limitations of the Online Focus Group

Online focus groups are a qualitative approach with different standards for sampling and analysis than quantitative approaches. As stated earlier, focus group participants were selected from a list of individuals who had received professional training from the MCCG. Although a diverse array of providers from different backgrounds and practice settings participated in the focus group, they may not fully represent the range of mental health and substance abuse treatment providers in the state. Similarly, their responses may not represent the full range of opinions and needs of mental health and substance abuse treatment providers in the state. Although their responses may not be statistically representative of the population of treatment providers in Massachusetts, these responses provide more detailed information about the experiences and practices of treatment providers in addressing gambling problems than could be obtained in a quantitative survey. Although care was taken to utilize best practices in qualitative analysis, the analyses conducted were subjective in nature and limited to the information provided by this particular group of professionals.

Summary & Conclusion

To complete an evaluation of problem gambling services in Massachusetts, the SEIGMA research team collected information from a variety of sources and planned a number of research activities to better understand service provision for problem gambling in Massachusetts. This white paper summarizes findings from three research activities for which full or partial analyses are complete: (1) descriptive statistics from a large baseline population survey, (2) a descriptive analysis of data from the MCCG problem gambling helpline, and (3) key findings from an online focus group that the SEIGMA team recently conducted with a group of mental health and substance abuse treatment providers across the state.

These analyses have a number of potential implications for state strategic planners as they attempt to finalize and implement their plan for problem gambling services in Massachusetts. The tables within this white paper

summarize key findings and associated implications for strategic planners. Common themes from these tables include:

- Utilizing information about gambling behavior and problems in Massachusetts to tailor prevention messages and target outreach efforts
- Using at-risk and problem gambling prevalence estimates and information about concerned others to estimate treatment volume and plan for treatment-seekers
- A need for improved data collection regarding help- and treatment-seekers in the Commonwealth
- A need for improved problem gambling service administration—clinical supervision, best practices, standardized practices, evaluation, etc.

Based on these themes, we recommend that strategic planners focus on three short-term activities. These include (1) utilizing many of the findings presented in this paper to tailor prevention messages and target outreach efforts; (2) improving data collection about individuals who seek help or treatment for a gambling problem; and (3) collecting additional information to aid in selecting evidence-based and promising practices in problem gambling prevention, intervention and treatment and adapting these practices for use in Massachusetts.

A number of the potential implications presented in this white paper concern using findings from the research activities summarized here to tailor prevention messages and target outreach. For example, knowing the gambling formats in which Massachusetts adults most frequently participate may aid strategic planners in tailoring prevention messages so that they reflect common gambling behaviors. Likewise, knowing common gambling motivations may aid strategic planners in developing prevention messages that reflect these motivations. Demographic differences in gambling participation and problems may aid strategic planners in targeting outreach efforts to vulnerable populations and tailoring messages so that they are culturally appropriate. These are just a few examples. Strategic planners should consider how best to utilize the findings presented into existing prevention messaging efforts (e.g., billboards and public service announcements). MA DPH and agencies such as the MCCG are already expending resources on these efforts, and tailoring messages may increase the reach and impact of their efforts.

A second recommendation is to improve data collection regarding help- and treatment-seekers in the Commonwealth. Although many of the mental health and substance abuse treatment providers who participated in the online focus group summarized here reported having treated one or more individuals with gambling problems in the past year, currently no single data source captures the number of individuals in Massachusetts who have sought treatment for a gambling problem. Numbers of calls to the MCCG Problem Gambling Helpline provide critical insight into the number of help-seekers in the state. Similarly, the number of treatment referrals made by helpline responders aids in estimating the number of individuals who may seek treatment. However, there is currently no mechanism in place to assess whether or not these individuals actually sought treatment after the call. Understanding current needs is critical to maintaining resources for this population in the short term and planning resource and service provision over time.

Lastly, at the present time, only one of the state’s newly licensed gambling venues is operational (Plainridge Park Casino in Plainville, Massachusetts). The state’s larger resort-style casinos will not open their doors until 2018. The lengthy amount of time between licensure and operation provides strategic planners with a window in which they can collect and synthesize additional information and use that information to implement improvements to the problem gambling treatment system in Massachusetts that are based on evidence-based and promising practices. Strategic planners should seek information regarding best practices in problem gambling prevention, state models for administering problem gambling services (including clinical training and

supervision), screening best practices, effective treatments, and evaluating treatment outcomes. Many of the articles referenced in this white paper may be useful to state strategic planners as they embark on this process.

Although working on the three recommendations listed above is possible in the short-term, additional research activities may be necessary to inform decision-making. Most notably, future research is needed to better understand individuals with gambling problems. The literature provides some insight into the broader population of problem gamblers, including the nature of the problems they face, their desire for help, and the barriers they face in help- and treatment-seeking. However, studies of this population are limited in number. While the longitudinal cohort study (the Massachusetts Gambling Impact Cohort Study) currently underway in Massachusetts will shed light on how gambling problems may develop and evolve over time, additional qualitative research may be needed to clarify the lived experiences of Massachusetts residents who are experiencing gambling problems. Such efforts may include focus groups with problem gamblers who have and have not sought help or treatment for a gambling problem. Additionally, key informant interviews with selected providers, patients with gambling problems, and concerned others may enable a deeper understanding of the challenges and barriers that these groups face and may shed light on possible solutions.

Additional research may also be needed to better understand current screening processes and determine how best to standardize problem gambling screening in different practice settings across the Commonwealth. As stated earlier in this white paper, providers report using a wide variety of screening tools in a variety of different ways with their clients. Establishing a standardized screening process will likely be an essential effort to effectively monitor the number of problem gamblers currently in the Massachusetts treatment system. However, more information is needed about providers' comfort using problem gambling screening tools with clients, barriers they face in using such tools, and perceptions about the impact on or effectiveness of these tools within their treatment practices. As strategic planners work to standardize screening practices, they should consider piloting tools with treatment providers to ensure effective implementation and widespread use of standardized tools.

Lastly, strategic planners may benefit from having additional information about support groups such as Gamblers Anonymous and Gam-Anon. The findings presented in this white paper indicate that MCCG and treatment providers are referring clients to these resources. However, very little information is available regarding the number of individuals who attend Gamblers Anonymous meetings in Massachusetts. Understanding this may further clarify help-seeking behaviors in the state.

Over time, the SEIGMA team will conduct additional research activities and analyses, making findings available as these emerge. Findings from these activities and analyses may reveal additional information relevant to strategic planners. We fully anticipate that the SEIGMA team will release additional white papers in the future that summarize findings and identify potential implications for improving problem gambling service provision in Massachusetts.

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