NOTICE of MEETING and AGENDA

Pursuant to the Massachusetts Open Meeting Law, G.L. c. 30A, §§18-25, notice is hereby given of a meeting of the Public Health Trust Fund Executive Committee. The meeting will take place:

Wednesday, January 23, 2019
2:00pm
Massachusetts Department of Public Health
250 Washington Street, 2nd Floor
Public Health Council Room
Boston, MA 02108

1) Call to Order
2) Approval of Minutes for Sept 24, 2018 and Nov 19, 2018 – VOTES
3) Routine Updates
    a. PHTFEC Budget
4) Prevention Programs (Presentation)
5) Treatment Gap Analysis (Presentation)
6) Gaming Research Update
    a. VSE Evaluation (Presentation)
    b. Strategic Plan (Discussion)
    c. SEIGMA Fact Sheets (Presentation)
7) FY 20 Budget Timeline & Process (Discussion)
8) Public Comment
9) Other business – reserved for matters the Chair did not reasonably anticipate at time of posting

I certify that on this date, this Notice was posted as "The Public Health Trust Fund Executive Committee Meeting" at www.massgaming.com and emailed to regs@state.ma.us , melissa.andrade@state.ma.us.

_____ _____
(date) Enrique Zuniga, Co-Chair
Commissioner
Massachusetts Gaming Commission

_____ _____
(date) Lindsey Tucker, Co-Chair
Associate Commissioner
Massachusetts Department of Public Health

Public Health Trust Fund Executive Committee (PHTFEC) Meeting Minutes

Date/Time: September 24, 2018 – 12:30 p.m.

Place: Department of Public Health
250 Washington Street, Boston, MA 02108

Present: **Executive Committee**
Lindsey Tucker, Co-Chair, Associate Commissioner, Massachusetts Department of Public Health
Enrique Zuniga, Co-Chair, Commissioner, Massachusetts Gaming Commission
Jennifer Queally, Undersecretary, Executive Office of Public Safety
Michael Sweeney, Executive Director, Massachusetts State Lottery
Carlene Pavlos, Executive Director, Massachusetts Public Health Association

Attendees
Rebekah Gewirtz, Executive Director of the National Association of Social Workers, MA Chapter
Victor Ortiz, Director of Problem Gambling Services, Massachusetts Department of Public Health
Teresa Fiore, Program Manager of Research and Responsible Gaming, Massachusetts Gaming Commission
Mark Vander Linden, Director of Research and Responsible Gaming, Massachusetts Gaming Commission
Debi LaPlante, Director of Research & Academic Affairs at the Division on Addiction, Cambridge Health Alliance
Heather Gray, Associate Director of Academic Affairs at the Division on Addiction, Cambridge Health Alliance

Call to Order

12:38 p.m. Co-Chair Tucker called to order the Public Health Trust Fund Executive Committee (PHTFEC) Meeting.

Approval of Minutes

12:12 p.m. ***{Insert meeting minute date}:***
*Co-Chair Tucker asked if there were any proposed changes for the **July 11th** meeting minutes.*

Ms. Pavlos noted changes on page 3 and 5. Co-Chair Tucker inquired as to whether they voted on the May 29th minutes at the previous meeting. Co-Chair Zuniga believes that they did.
With no further changes, Co-Chair Tucker asked for a motion to approve the ***July 11th*** *minutes as amended. Ms. Pavlos made the motion and Co-Chair Tucker seconded. All present members approved.*

Research Strategic Plan Presentation
Co-Chair Zuniga invited Mark Vander Linden and Judith Glynn to give an update on the research strategic plan.

Mr. Vander Linden noted beginning in 2020 they will have a research strategic plan that will inform the committee, moving forward.

Ms. Glynn stated that the research strategic plan aims to be a helpful tool for individuals without background in this research.

Co-Chair Tucker asked who the intended audience is.

Ms. Glynn replied that they want to give a presentation to select service providers, policy makers, and program staff in the communities. Eventually, the goal is to provide user friendly information to the community at large.

Ms. Queally arrives at 12:55pm.

Ms. Glynn proceeds with the presentation.

Ms. Pavlos asked what the data source is for the physical and psychological data under population health.

Rachel Volberg, UMass, replied that the information comes from various subject sources from towns and cities. Secondary data is also from BRFSS.

Ms. Pavlos requested use of the word crash instead of accident under the section that discusses traffic.

Ms. Glynn also noted that they are looking at the economic and fiscal impacts, specifically looking at things like employment.

Ms. Pavlos noted her concerns with how benefits may accrue to one group but harm another. Ms. Pavlos also suggested not using the word vulnerable and instead marginalized/ oppressed communities.

Ms. Gewirtz suggested that they look at employment and the cannibalization of jobs and how other outside jobs have collapsed.

Ms. Volberg informed her that they are looking at employment conditions, net employment, as well as business starts and failures.

Mr. Crosby noted that Plainville has already started research on employment.

Co-Chair Tucker raised a concern regarding tracking home care employees and other business that may not necessarily leave an obvious gap in business services.

Ms. Queally also noted that they should look at the change in salary.

Mr. Vander Linden informed the group that the new employee survey discusses many of these things. Employees can check off whether they've left previous employment for an increase in benefits, more pay etc.

Ms. Fiore also informed them that tips were an option as well on the survey.

Ms. Glynn went on to discuss the research and strategic planning process along with the purpose of research strategy.

Ms. Pavlos stated that she was concerned about accessibility and usefulness. She feels like there are two sub-research agendas and it is not articulated that way. One sub-research agenda is problem gambling and what are the risk factors and how it is being addressed. The second would be how casino gaming is impacting the Commonwealth and what are the larger trends in population health. She suggested that this be explicitly stated.

Ms. Glynn agreed.

Ms. Pavlos also suggested that it is helpful to have differential language that everyone is aware of, e.g., gaming defined as industry and gambling defined as the individual.

Ms. Volberg stated that gaming is the term that the industry prefers to use.

Ms. Pavlos replied that to know what framework they're discussing it is important that they are distinguished.

Ms. Queally agreed and stated that problem gambling (individual) can be looked at as one of the effects of casino gaming where economic impacts are analyzed.

Co-Chair Tucker also stated that they are distinct and both could impact a community in different ways.

Co-Chair Zuniga asked what the next steps are for this research.

Mr. Vander Linden replied that they believe they will have a draft in November.

Ms. Queally asked if they are engaging any public safety stakeholders.

Mr. Vander Linden informed her that they are on the list of those they plan to speak with.

Co-Chair Tucker asked if they can circulate a stakeholder list to the group.

With no further questions or comments they proceeded with the GameSense Evaluation Presentation.

GameSense Evaluation Presentation

Following Mr. Land's presentation the group was invited to ask questions or comment.

Ms. Pavlos stated that it was helpful and thinks it re-contextualizes the summary that was provided, rather a synthesis of the compendium than a summary.

Mr. Land replied that he knows things should be explicitly laid out.

Ms. Pavlos stated that she would like to see a logic model of how they will be a theory of change.

Ms. Sweeney asked would they characterize it as an independent evaluation of GameSense.

Mr. Land said that he would, although it is not an attempt to conduct a narrative but a conversation in an attempt to capture underlying truths to the extent that they exist.

Mr. Sweeney asked if he was asserting that the Cambridge Health Alliance study was flawed.

Mr. Vander Linden stated that any evaluation that we do has limitations.

Co-Chair Zuniga stated that he wouldn't call it flawed.

Mr. Sweeney noted that the presentation seems more like a criticism of CHA rather than a transfer of knowledge or dissemination of knowledge.

Mr. Land stated that the comment that was received from all reviewers was that evaluation was too difficult for this body to digest in this timeframe.

Mr. Sweeney asked are the memo and the presentation companion documents.

Mr. Land replied that they are and he would view them as companion documents framing GameSense.

Mr. Sweeney asked what the scope of the project was.

Mr. Land replied that it was to write a 3 page summary of compendium and prepare slides that could be presented to this group on this day. Mr. Land also stated that there is more positive information collectively rather than negative and that he would have appreciated a broader view of the program itself.

Mr. Sweeney stated that he would like to have more information on staffing and whether it should be expanded.

Mr. Land replied that more information is needed.

Mr. Sweeney asked why they did not receive a full breakdown from CHA prior to this presentation.

Mr. Crosby stated they he could see from the timing and the process how committee members might interpret the knowledge translation work as whitewashing the results, but that was not the intent. He thinks it's important that the conversation of knowledge transfer, the process that they've gone through with CHA reports, is extensive. He noted that it is the same process that is undertaken with UMASS and SEIGMA. They try to synthesize and put their narrative on it; it is not an attempt to whitewash the material but an attempt to synthesize the information.

Mr. Sweeney stated that he is seeking clarification on the knowledge transfer because it sounds like a reanalysis. He commended CHA for the integrity in their work.

Ms. Queally asked when GameSense advisors are engaging people within the casino what information are they providing with respect to treatment.

Mr. Vander Linden stated that they have information on treatment resources and it can take on many different directions. The advisors have training to assist with providing information.

Ms. Queally stated that most people who think they have a problem with gambling, typically do. She asked if individuals seeking help are being given something in hand that they can bring home to review when they are vulnerable.

Mr. Vander Linden replied that there is a package of information with provider information that they receive.

Ms. Queally asked if there was thought to putting treatment personnel in the casino rather than just referrals.

Mr. Vander Linden informed her that there was not.

Co-Chair Tucker stated that it was included in the statutory language.

Mr. Vander Linden stated that on that topic he believes there is more work to be done regarding handoffs and how to warm transfer and connect people to resources. He also discussed doing more voluntary self-exclusions outside of casinos.

Ms. Queally asked if they are doing anything to measure follow up treatment.

Mr. Vander Linden replied that the closest would be the VSE and if they received any follow-up services.

Co-Chair Zuniga stated they are trying to reach all gamblers. He discussed the quality of the interactions and how it takes a number of "hellos" to get into a more meaningful discussion about gambling habits. He noted that a lot of work needs to be done such as training for employees.

Ms. Pavlos stated that she thinks there are some process missteps that are making it difficult to evaluate what information is being given. She requested that when GameSense comes before the group again, she'd like to see a logic model for the program.

With no further questions or comments from the group from the committee, the Co-Chairs opened the floor to public comment.

Public Comment

Ms. LaPlante stated that she believes this was a missed opportunity to align thinking and that information was received late for DoA's input of knowledge transfer. She also suggested that work that is supposed to an independent evaluation has a different peer review given that MGC is acting as a supporter and reviewer. She also suggested that independent evaluation is different from research.

Ms. Gray stated that she personally would suggest a cost/benefit analysis of the program. Additionally, she would like the work to be represented accurately and noted that they were not at the table for this process and if they were it would be have been more true to the findings.

Mr. Sweeney agreed and stated that GameSense needs to be evaluated in a non-emotional way. He urged for it be reassessed without placing blame and to determine the best way to spend public dollars. He continued by saying that a significant change needs to occur and issues should be discussed frankly and openly.

Co-Chair Zuniga asked if he thinks that as a binary choice or as in a way the program can be changed. He stated that this is a unique opportunity to have a resource in the casinos.

Mr. Sweeney stated that he believes it is an opportunity to analyze both and discuss the cost effectiveness and ongoing impact of the program. He noted that this program is costly given the limited group of people reached. He is willing to discuss if this body should fund the cost or if the casinos should.

Co-Chair Zuniga stated that it is an effort worth pursuing.

Co-Chair Tucker noted the time and that they will send what they can via email for items that were not discussed. The needs assessment will also be sent and she requested that members send items they would like to address in future meetings.

With no further comments Co-Chair Tucker asked for a motion to adjourn. Michael Sweeney made the motion and Jennifer Queally seconded it. All present members approved and the meeting adjourned at 3:34pm.

Public Health Trust Fund Executive Committee (PHTFEC) Meeting Minutes

Date/Time: November 19, 2018 – 2:00 p.m.

Place: Department of Public Health
250 Washington Street, Boston, MA 02108

Present: **Executive Committee**
Lindsey Tucker, Co-Chair, Associate Commissioner, Massachusetts Department of Public Health
Enrique Zuniga, Co-Chair, Commissioner, Massachusetts Gaming Commission
Jennifer Queally, Undersecretary, Executive Office of Public Safety
Michael Sweeney, Executive Director, Massachusetts State Lottery
Carlene Pavlos, Executive Director, Massachusetts Public Health Association

Attendees
Victor Ortiz, Director of Problem Gambling Services, Massachusetts Department of Public Health
Teresa Fiore, Program Manager of Research and Responsible Gaming, Massachusetts Gaming Commission
Mark Vander Linden, Director of Research and Responsible Gaming, Massachusetts Gaming Commission
Gayle Cameron, Interim Chairperson, Massachusetts Gaming Commission

Call to Order

2:13 p.m. Co-Chair Tucker called to order the Public Health Trust Fund Executive Committee (PHTFEC) Meeting.

Approval of Minutes

2:15 p.m. *September 24, 2018 minutes:*
Co-Chair Tucker noted that the previous meeting minutes were mistakenly not sent in advance and proposed postponing the vote until the following meeting to allow time to review.

MGC Updates

Co-Chair Zuniga introduced Gayle Cameron, MGC Interim Chairperson.

GameSense Program Objectives:

Co-Chair Zuniga discussed the potential of a logic model that Ms. Pavlos discussed at the previous meeting. He informed the committee that a summary had been provided discussing GameSense and the responsible gaming framework. Co-Chair Zuniga then noted that GameSense fits into the statute and that it is a unique opportunity to have a program related to public health and responsible gaming in the casinos. The summary highlights various principles: informed decision making for those who gamble and informed player's choice. Three responsible gaming strategies within the confines of informed decision making are included in the summary. He also informed the committee that a key strategy articulated in the summary paper is that GameSense is a point of sale intervention. Fundamentally, this is an opportunity to receive feedback, provide information and offer voluntary self-exclusion.

Ms. Pavlos thanked Co-Chair Zuniga for his summary. She noted that her previously request for a logic model was to assure there was an opportunity to have process and outcome measures. The summary that Co-Chair Zuniga provided was helpful.

Mr. Vander Linden added that while he hoped the logic model would be ready in time for this meeting, he believe the summary is sufficient. He also discussed the hours of GameSense and that they have shifted over time based off utilization and believes that it is something that they should continue to evaluate.

Ms. Queally asked what the hours are now.

Ms. Fiore informed her that they are 9-1pm currently.

PHTFEC Budget Update

Co-Chair Zuniga stated that revenue coming in from MGM from Aug 24th to Oct 31st $58 million gross, and taxed at 25% are equivalent to $14.6 millions. The 5% of the taxed amount that comes to the trust amounts to $733,000. He further stated that the projections give them a reason to be optimistic about reaching the budget. For the next meeting, they are working on the budget for the next 6 months and expenditure.

Co-Chair Tucker stated that this should be a regular item on the agenda.

Co-Chair Zuniga agreed.

Co-Chair Tucker then asked if the group can consider adding the opening of Encore to the agenda.

Co-Chair Zuniga informed her that they can add that to the agenda. The $3M that he mentioned didn't involve any projections from Encore. Encore is scheduled to open at the end of June which is the end of the fiscal year.

Gaming Research Update

a. Baseline analysis of crime, call-for-service, and collision data in the communities near MGM

Mr. Vander Linden stated that the full report was released on October 25th. It is a baseline report so there are no significant findings. There will be a follow up report in a few months. This is required from the statue, to produce a baseline study to determine crime in cities where casinos have been opened. Christopher Bruce did this study. Mr. Bruce goes to each individual police department and downloads their data particularly looking at Springfield and Ludlow. Mr. Bruce will go back those communities in the future and see what has changed in the 3 months since the casino has opened. From there, a 3 month update, 6 month update and hopefully a yearly update will be conducted. This will allow police to formulate a strategy regarding the impact of casinos in their communities. The primary audience are police departments and they hope the information can be used as a tool. He then discussed that crime analysts and police chiefs will receive qualitative reports as well. Interim Chairperson Cameron is leading this effort.

Ms. Cameron informed the group that this began with an MOU. She thanked Ms. Queally for her efforts. She stated that she appreciates that it is real time information and allows chiefs from various areas to discuss common issues, therefore allowing things to be addressed immediately if there is an impact.

Mr. Vander Linden discussed human trafficking in casinos and how the current public safety study captures human trafficking in casinos. He informed the group that Mr. Bruce noted that the information isn't captured well due to the fact that any arrests would happen after an extensive investigation and therefore captured overtime.

Ms. Cameron noted that prostitution is probably easier to track instead of trafficking. In the next police chief meeting, she noted that they can ask them to track it and include a training process so that they can make sure the data is captured. She also noted that Plainridge Casino doesn't have hotels so that changes the landscape.

Ms. Pavlos informed the group that Springfield can capture children trafficking as well due to the Children Advocacy Center located there.

Ms. Queally noted that state police has a child trafficking unit as it relates to Massachusetts, however there is very little information even nationwide.

Ms. Cameron suggested having Ms. Queally join the next meeting with the police chiefs.

Ms. Queally agreed and stated that she would bring individuals from her team to discuss potential strategy and training.

Mr. Sweeney noted that this type of crime has shifted into the cyber arena at least for initial engagement. He encouraged either study to track frequency of websites targeting Springfield and Everett area. He noted that it would be helpful to receive a list of offenses under most serious list and if they would take into account individual precincts emphasis on certain campaigns. The data would be impacted if the precincts are cracking down on particular crimes.

Ms. Cameron stated that was an excellent point and that it is considered. They have discussions with the chiefs that allows this information to be added.

Mr. Sweeney stated that he objects to the definition of statutory rape on page 66. He doesn't believe it is an appropriate definition.

Mr. Sweeney noted that on page 69, sexual assault is categorized as a violent crime but it is categorized as a non-violent crime elsewhere.

Ms. Pavlos stated that the definition suggests a framing as interpreting data that we would not like to associate with.

Ms. Cameron replied that it was an excellent point.

Co-Chair Tucker stated that the definition of prostitution should also be altered.

Ms. Pavlos stated that she is happy to provide them with edits to the definitions.

Mr. Ortiz stated that it is great to see and hear collaborative work around human trafficking and is equally important to look at the community level to see how folks are working together as being proactive around these issues. He noted that he had an opportunity to speak with community members and they raised the concern of limited funding for these efforts. He noted that as we look at things on a macro level , it is important to determine if there is an opportunity to assist in funding for work at the community level.

Casino Gambling in MA: African American Perspective, Rudy Vega

Mr. Vega discussed how the existing theories do not shed light on how features of the life context of people of color impact gambling behavior. All 5 focus groups were either at risk or problem gamblers and were mostly women. There was difficulty finding men to participate. Participants described their communities as impoverished and needing social services. When asked why they gamble, they noted that gambling was not for recreation but mostly for financial need.

Ms. Pavlos thanked him for the presentation. She then asked if different things were learned due the gender of the population.

Mr. Vega replied that the limitation of the study was pointed out by reviewers. He believes that regardless of the gender, the same theme would emerge.

Ms. Queally asked about stigma and what stigma the participants were referring to and if there are cooccurring disorders.

Mr. Vega replied that the stigma is similar to mental health.

Ms. Pavlos noted that the discussion of gambling for financial need is interesting and commented that that it appears to be a group of sophisticated thinkers.

Mr. Sweeney noted that mental health keeps coming up regardless of the study and the importance of community based intervention.

Screening for Gambling Disorder in VA Primary Care Behavioral Health: A pilot study, Shane Kraus

Mr. Kraus noted that Veterans have been found to have elevated rates of problem gamblers compared to non-Veterans. He then discussed what questions can be asked to encourage self-disclosure.

Ms. Queally asked what the sample size was.

Mr. Kraus replied that it was 260.

Ms. Queally asked if lottery was not included, would it alter the results.

Mr. Kraus stated that it wouldn't but he would be interested in how individuals endorse items. Mr. Kraus also noted that there are lot of veterans who are spending a great deal of money on gambling but did not endorse any of the BBGS items.

Co-Chair Tucker asked if they were all on fixed incomes.

Mr. Kraus stated that he looked at disability to determine if they were receiving benefits.

Mr. Vander Linden stated that there is possibly a disconnect with money spent and endorsement.

Mr. Ortiz asked if he thought that had to do with the level of gambling and disclosure.

Mr. Kraus stated that there are concerns on reporting gambling as people may not disclose.

Mr. Sweeney asked if the gambling practiced began while they were serving in the military.

Mr. Kraus replied that the data suggests that it does.

Co-Chair Tucker asked how the BBGS was picked and why.

Mr. Kraus replied that it was 3 questions, other measures are longer and setting plays a role.

Co-Chair Tucker asked if there was a difference between the veterans that go to the VA and those that do not.

Mr. Kraus replied that those who go to the VA usually have more medical or psychological problems and receive care due to their service connection. Those who do not, typically do

not go to the VA. He stated that this is one study in a very small pilot that gives an opportunity to set a plan for the Commonwealth.

Targeted Population/Community Driven Research Update and Discussion

Mr. Vander Linden provides a presentation on community driven research. He discusses data management, knowledge translation, and community driven research as being 3 specific areas in the research strategic plan.

Mr. Vander Linden went on to say that using a slightly different term, Community Based Research, it more deeply understands and addresses impact of casinos in the communities. It is responsive to community demands and needs. The limitations are willingness to participate. The focus is the host and surrounding communities: youth, seniors, parents.

It was discussed that in the procurement letters of support not only include community members but also endorse that they saw the proposal and the budget.

Ms. Judith Glynn noted that there have been some awards already given for small projects. The rationale is to get the shape of the program as early as possible and try to develop a program that is set up for success.

Ms. Queally stated that she would like to see more research findings put into practice.

Co-Chair Tucker added that she hopes that community concerns would be interjected more and that local research versus people's voice in broader research are incorporated into the overall strategy.

Mr. Vander Linden agreed.

Ms. Pavlos added that we tend to select community driven research to support as we develop the agenda; however, as we are investing it should realign research agenda as we learn more from participatory studies.

Ms. Glynn discussed SIEGMA and MAGIC research.

Co-Chair Zuniga noted that Ms. Pavlos' point is now the essence of strategic planning.

Mr. Ortiz advised the group to rethink using the term academic research that in itself implies many things, including that only academics conduct research . Academic researchers go into communities, produce papers and leave. He asked how can we redesign that process.

Ms. Pavlos replied that we could build accountability into the procurement process for ourselves.

Mr. Sweeney stated it is not appropriate to send people into neighborhoods and only put programs into the casinos. The resources bypass the actual communities and the dollars need to show the public that those funds are in those communities.

DPH Listening Sessions – update and discussion

Due to timing, Victor Ortiz gave a brief update on the DPH stakeholder listening session conducted in Springfield. DPH is utilizing the stakeholder listening sessions to maintain accountability and inform work relating to cultural competency as outlined in the PHTF strategic plan. Last year, there were 32 people in the two sessions held, one in Boston and one in Springfield. This year, one session was conducted in Springfield and DPH is planning another session in January. Victor, encouraged the group to provide names of community groups and members that should attend. The goal is to take the information gathered and put it into a report to see the pulse and priorities of the community.

Co-Chair Tucker noted that there is nice synergy between community based research and what comes out of the listening session.

Mr. Ortiz stated that people are concerned about the CORI issues. He noted that Co-Chair Zuniga attended a session to explain the actions being taken regarding CORIs and that that was helpful and effective.

Co-Chair Zuniga added that he believes they should be doing more of these sessions and that he is willing to participate. He inquired about the number of 800 engagements.

Mr. Ortiz stated that all of their work conducted has a principle and function of community engagement that has resulted in over 800 engagements to inform the work

Public Comment

Carolyn Wong, UMASS Boston thanked the presenters and discussed the synergy in Mr. Vega's report, the proposal for CDR, and Mr. Ortiz's report. She noted that the potential for synergy has to be realized and that it needs to be a launching point. She suggested involving agencies and people who helped with the research to help write the report and if possible, interpret the findings.

Chien Chi Wong, Asian Women for Health noted that language matters and she was surprised to hear the term healthy gambling used. She cautioned against the use of the term so that the public doesn't think that gambling can somehow better their health. She noted that she was interested in what the drivers are that cause veterans to gamble and suggested that listening sessions be promoted by ethnic media. She also asked how many grants will be awarded and what is the criteria and the cap. She stated that it takes time to build relationships and that community questions should be included in the RFP and help with the design, implementation and dissemination of the study. She also agreed with Ms. Queally that research can help us decide how we can allocate funds.

Mr. Kraus noted that it is important to focus on treatment and research needs to be applied.

Ms. Wong added that it is not just intervention of the individual but also the family.

Ms. Queally stated that in most SUD treatment programs there is a family component.

Mr. Sweeney noted that family members or peers do not accompany the family member to the casino and it is important that they help engage the gambler or develop exit strategies for them to use.

Co-Chair Zuniga stated that the notion of safe levels of gambling can be misconstrued with healthy levels of gambling.

Co-Chair Tucker added that if there were particular agenda items that they would like to see in future meetings to please let them know.

With no further comments Co-Chair Tucker asked for a motion to adjourn. The meeting adjourned at 4:49pm.

MA Department of Public Health/MA Gaming Commission
Public Health Trust Fund

	FY19 Projection	FY19 to Date	Projected at end FY19 *
Revenues	**8,000,000**	**5,018,540**	**7,994,026**
PHTF - Category 1 Region B	3,000,000	1,268,540	2,994,026
FY19 MGC Assessment	5,000,000	3,750,000	5,000,000

* Projection is based on average full month for Category 1 (prior four months - Sept thru Dec 2018 or $287,581/month)

Expenditures/Commitments	FY19 Approved	Committed / Expended	Projected at end FY19	Difference / Uncommited
A. Personnel	**874,448**	**499,637**	**756,227**	**118,221**
MGC (inclusive of all expenses except indirect)	311,981	140,812	310,000	1,981
MDPH (inclusive of all costs, including indirect)	562,467	358,825	446,227	116,240
B. Prevention and Health Promotion	**2,478,552**	**2,111,620**	**2,398,000**	**80,552**
MGC Initiatives	1,748,552	1,556,620	1,650,000	98,552
MDPH Initiatives	730,000	555,000	748,000	(18,000)
C. Infrastructure, Development and Capacity	**1,408,000**	**723,000**	**471,100**	**936,900**
MGC Initiatives	0	0	0	0
MDPH Initiatives	1,408,000	723,000	471,100	936,900
D. Research	**2,609,000**	**2,422,915**	**2,490,756**	**118,244**
MGC Initiatives	2,549,000	2,328,159	2,414,000	135,000
MDPH Initiatives	60,000	94,756	76,756	(16,756)
E. Marketing and Communication	**600,000**	**446,246**	**731,372**	**(131,372)**
MGC Initiatives	200,000	200,000	230,000	(30,000)
MDPH Initiatives	400,000	246,246	501,372	(101,372)
F. Strategic Planning	**30,000**	**9,323**	**45,000**	**(15,000)**
MGC Gaming Research Strategic Planning	30,000	9,323	45,000	(15,000)
Total	**8,000,000**	**6,212,741**	**6,892,455**	**1,107,545**

MEMO:

To: Victor Ortiz, Director of Problem Gambling Services
From: Rebecca Bishop, Program Manager & TA Lead
Date: December 19, 2018
Re: Updates on prevention projects: MA Photovoice and MA Ambassador Projects

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Introduction: In FY18 Social Science Research & Evaluation (SSRE) conducted site visits for both photovoice and ambassador projects, the outcomes of the site visit are the following:

- A need for materials to implement the project s
- Clarification of goals and objectives

SSRE, DPH and EDC met to review outcomes of site visits in order to address these concerns. SSRE and EDC met between August and October 2018 to collaborate and redefine:

  - Project goals and objectives
  - Theory of Change
  - Specify target populations
  - The overall activities in each strategy

Between October and December 2018, MassTAPP created materials consistent with the redefined information.

Photovoice

1. Products

   - A **youth curriculum** that is made up of 16 lesson plans that grantees can use to train youth. The overview of the training includes: an overview of the project (*Lessons 1A–1C*), content to build skills in advocacy (*Lessons 1D–1F*) and photography (*Lessons 2A–2D*), and underage gambling education (*Lessons 3A–3D*). The last two lessons (*Lessons 4A–4B*) guide youth through researching an issue that impacts their community and thinking about how to describe it in photographs.

   - An **implementation guide** as a resource for youth-serving organizations funded by the Office of Problem Gambling Services on how to prepare for and execute the MA Photovoice Project.

2. Changes to the model

- Goals and Objectives

  Goals

  - Prevent or reduce underage gambling among youth and high risk populations
  - Help youth and develop and maintain the healthy lifestyles needed to ensure that they won't develop problems with gambling

  Objectives

  - Support healthy youth lifestyles that are incompatible with underage gambling
  - Focus on communities experiencing racial and ethnic health disparities
  - Empower youth to encourage healthy behaviors that are incompatible with problem or underage gambling throughout their community

- Caregivers must agree to participate in the project by having regular discussions with their child (about the project), and attend the education session and a recreational event.

- This project will now be youth-led in the following ways:
  - Youth will develop their own captions
  - Youth will develop a call to action to ensure that there is an advocacy component to the cycle.
  - Youth will play key planning and implementation roles at the exhibition.
  - Youth will participate in disseminating the photography and Call to Action.

- The length of one cycle of the MA Photovoice Project went from 8 weeks to 16 weeks.
  - MA Photovoice Model:
    - Staff Training: 1 day
    - Youth Recruitment: 2 weeks
    - Youth Training: 8 weeks
    - Photography and Discussions: 3 weeks
    - Captions and Call to Action: 1 week
    - Caregiver Education and Recreational Session: 1 day
    - Community Exhibition: 1 day
    - Message Dissemination

Ambassador

1. Products:

   - An **ambassador curriculum** that is made up of 14 lesson plans that recovery center directors and technical assistance providers can use to train ambassadors. The overview of the training includes gambling and problem gambling (*Lessons 1A–1B*), the relationship between substance use disorders and gambling (*Lessons 2A–2C*), disparities and building equity (*Lessons 3A–3C*), individual and group interventions (*Lessons 4A–4D*), and workforce development (*Lessons 4A–4D*).

- An **implementation guide** as a resource for recovery centers funded by the Office of Problem Gambling Services on how to prepare for and execute the MA Ambassadors Project.

2. Changes to the Model

    - Goals and Objectives

      <u>Goals</u>
        - Prevent or reduce problem gambling among high risk populations
        - Help at-risk populations develop and maintain the healthy lifestyles needed to ensure that they won't develop problems with gambling

      <u>Objectives</u>
        - Recruit and retain ambassadors from communities that experience racial and ethnic health disparities and have a history of substance misuse
        - Improve ambassadors' workforce skills through training, professional development and supervisory support
        - Ambassadors establish relationships with community organizations in order to conduct groups and have individual conversations their peers in high risk populations

    - The MA Ambassador Model has been re organized into three phases that support the ambassadors in workforce development and peer recovery supports, while also supporting the organization to build capacity to address problem gambling prevention on an ongoing basis.
        - **Phase 1: Overview and Orientation:** Staff and Ambassadors are oriented to the goals and objectives of the grant, evaluation design and requirements, and the Ambassador model.
        - **Phase 2: Training and Intervention Planning:** Ambassadors receive training and begin outreach and relationship-building with local partners to deliver groups, and implement workforce development activities.
        - **Phase 3: Implementation:** Ambassadors deliver Individual level peer education, facilitate peer groups at partner organizations, and participate in community-level events and distribute program materials.

Memorandum

To: Office of Problem Gambling Services, Department of Public Health

From: Division on Addiction, Cambridge Health Alliance, a Harvard Medical School teaching hospital

Date: May 18, 2018

RE: Considering Gambling-related Treatment Need in Massachusetts: From Construct to Care

Purpose: Our FY18 scope of services required the Division on Addiction (Division) to commence a gap analysis to better understand treatment demand in Massachusetts. The Division is taking a multi-pronged approach to this gap analysis; focusing on (1) capability caps, (2) current state of services, and (3) need fulfillment. This document concerns **need fulfillment (i.e.,** the gap between individual needs and the met need or *fulfillment* of those needs).

Deliverables: Identify and evaluate available data to assess gap. If possible, estimate number of Massachusetts residents in need of gambling treatment and estimate the proportion of those in need who receive services. Provide recommendations for resource allocation, future data collection, and gap identification.

Recommendations: Based upon our review of the literature and assessment of available data in the Commonwealth, we suggest that available datasets of gambling participation and problems among Massachusetts residents have limitations that currently prevent nuanced estimation of the population's gambling treatment need. We recommend the following actions to estimate treatment need in Massachusetts:

1. When appropriate data are available, apply the described Partially Adjusted or Fully Adjusted Algorithm to assess treatment need in Massachusetts.

2. Enhance planned data collection activities (i.e., Follow-up Gambling Prevalence Survey and Follow-up Online Prevalence Survey) by adding variables that are necessary to apply the recommended algorithms:
    a. Measure functional impairment;
    b. Among treatment seekers, measure treatment participation;
    c. Among treatment participants, measure perceived need for treatment and inquire about sources of treatment participation;
    d. Measure motivation for change;
    e. Measure general awareness of local resources, such as mutual help, helplines, and self-help materials.
3. Adopt a universally applicable, non-pejorative labeling system for describing individuals' gambling-related problems by severity.
4. Commission focused studies of other at-risk populations that might have unique treatment need experiences, including these groups:
    a. Adolescents
    b. Casino employees
    c. Individuals dealing with homelessness
    d. Incarcerated individuals
    e. Individuals involved with domestic and/or partner violence
5. Convene researchers who have experience studying gambling participation and problems among Massachusetts residents to discuss the state of currently available data and evaluate these recommendations and other possible approaches to generating a needs fulfillment gap analysis.

Considering Gambling-related Treatment Need in Massachusetts: From Construct to Care

Prepared for the Office of Problem Gambling Services
Massachusetts Department of Public Health

by the Division on Addiction

May 18, 2018

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Considering Gambling-related Treatment Need in Massachusetts: From Construct to Care

During the current period of gambling expansion and beyond, the Commonwealth of Massachusetts is using the Substance Abuse and Mental Health Service Administration's five-step planning process (Substance Abuse and Mental Health Services Administration, 2017) to guide its prevention and intervention activities (MassTAPP, 2016). The first step in this planning process is assessment: systematically gathering and examining relevant data from a variety of sources to ensure that the Commonwealth is using its prevention and intervention resources effectively. Gaps between services provided and services needed can exist at every stage of the Continuum of Services, from prevention and health promotion, to screening and referral, to treatment, to recovery support (MassTAPP, 2016). This document concerns the potential treatment gap, or an estimate of the difference between the number of people who need treatment services and the number of people who receive them (Shepard et al., 2005). Public health officials can use treatment gap estimates to make informed decisions about deploying specific resources for treatment services, which in Massachusetts are delivered by psychologists, psychiatrists, social workers, and mental health, and substance abuse counselors (MassTAPP, 2016). Consequently, how well Massachusetts public health officials estimate treatment need can affect the quality of these resource deployment decisions.

Treatment need is an elusive construct with important ramifications. Underestimating need risks prolonging the suffering of people who would benefit from treatment that is unavailable; overestimating treatment need risks misapplying valuable resources. Thus, an essential first step to minimize harm and allocate resources appropriately is to identify a nuanced approach to estimating treatment need. This work is especially important for the Commonwealth of Massachusetts, where residents currently are experiencing an expansion of legal gambling opportunities with potential incident gambling-related problems[1] adding to existing gambling-related problems. To progress toward such an estimate of treatment need, this document presents for consideration

[1] Terminology in this field has been inconsistent over time and across authors. We use the term "gambling-related problems" to refer to the full scope of such problems, apart from any particular diagnostic framework. We use the formal term "Gambling Disorder" to refer to the condition characterized in the DSM-5, and we use the term "sub-clinical Gambling Disorder" to refer to the condition of meeting 1-3 diagnostic criteria for DSM-5 Gambling Disorder.

two models for estimating treatment needs: (1) a partially adjusted algorithm, and (2) a fully adjusted algorithm. Following this, we evaluate the available data from the Commonwealth of Massachusetts with respect to these algorithms. Finally, we conclude by identifying data needs for existing Commonwealth of Massachusetts research programs to fulfill the requirements of these algorithms.

A Partially Adjusted Algorithm

One potential approach to estimating gambling treatment need within a given community involves administering diagnostic criteria checklists to a survey sample representative of the Commonwealth estimating the prevalence of gambling-related problems and using that prevalence estimate as a proxy for treatment need. Though this approach is appealing in its simplicity, it is problematic, in part, because diagnostic criteria were developed for clinical decision making, not public health decision making. Psychiatric epidemiologists caution against conflating "presence of a disorder" with "need for treatment" (Pincus, Zarin, & First, 1998; Spitzer, 1998). Moreover, this simplistic approach is insufficient because a gross prevalence rate fails to control for known aspects of treatment need and demand. Therefore, algorithms generated to estimate treatment need should attempt to address such known aspects.

This document provides two algorithms that differ in the extent to which they recommend controlling for known aspects of treatment need. The first algorithm represents a relatively uncomplicated approach to estimating treatment need via representative population surveys. This approach requires two basic sets of survey questions: (1) questions assessing gambling-related problems, ideally using a validated mental health assessment tool derived from an accepted classification system such as the DSM-5 (American Psychiatric Association, 2013) and (2) questions assessing treatment seeking. More specifically, this approach requires evaluators to use an accepted and psychometrically validated symptom checklist, such as the DSM-5, to assess gambling-related problems. We suggest using a current (i.e., past-year) timeframe for the presence of symptoms. Assessing gambling involvement with questions about gambling frequency or money spent gambling (e.g., "How often do you

gamble?" "How much money do you spend?") is helpful to address a number of research questions, but insufficient to estimate treatment need.

This approach also requires evaluators to use appropriate treatment seeking questions among respondents who endorse a minimum number of symptoms (e.g., 1 DSM-5 criteria), such as the following questions:

1. In the past year, have you *sought* professional help for your gambling? By "professional help," we mean a psychiatrist or other medical doctor (e.g., primary care provider), psychologist, other mental health professional (e.g., counselor, therapist, social worker), or religious advisor (Picco et al., 2018).
2. If yes: In the past year, have you *participated* in professional help for your gambling?[2]
3. If yes: Do you continue to need professional help for your gambling?

We consider seeking treatment to be distinct from participating in treatment. Because treatment might be unavailable or unaffordable, someone who has sought help for gambling might not have received it, for example. We also suggest using a broad definition of professional help when assessing treatment seeking and participation because, in Massachusetts, gambling treatment services occur in a variety of settings. According to the Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts (MassTAPP, 2016, p. 15), the majority of gambling-related treatment occurs "…within independent practices or outpatient services."

This sequence of treatment-seeking questions is beneficial because it enables researchers to classify respondents who report gambling-related problems according to four mutually exclusive treatment status categories:

1. Respondents who report that they have sought, received, and feel they no longer require professional treatment represent **Met Demand** (Brownsberger, Love, Doherty, & Shaffer, 2004).
2. Respondents who report that they have sought and received but still require professional treatment represent **Enduring Demand**.

[2] We recommend following up with a question asking respondents to indicate the source of professional help (e.g., psychiatrist, psychologist, other mental health provider). This question will be useful for resource allocation but is not essential for categorizing respondents according to treatment-seeking status.

3. Respondents who report that they sought but did not receive treatment represent **Unmet Demand** (McAuliffe et al., 1994).
4. Respondents who report that they did not seek – and therefore did not receive – treatment represent **Absent Demand**.

Together, respondents in the Enduring Demand, Unmet Demand, and Absent Demand represent the extent of potential **Unmet Need**. We also can consider this group to represent **treatment potential**.

As indicated in Figure 1, analytically, this relatively uncomplicated approach involves four steps. The first step involves estimating the prevalence of gambling-related problems within a given jurisdiction. This step yields an Initial Estimate of Gambling-related Problems. The second step is to use responses to treatment-seeking questions to categorize respondents with gambling-related problems, yielding Estimates of Met, Enduring, Unmet, and Absent Demand. The third step is to remove the sub-set of respondents who represent Met Demand. This step yields estimate of Enduring Demand, Unmet Demand, and Absent Demand (i.e., treatment potential). Fourth and finally, within each of these three treatment-seeking categories (i.e., Enduring, Unmet, and Absent Demand), researchers can separate respondents according to the severity of gambling-related problems (e.g., Gambling Disorder or sub-clinical Gambling Disorder, if using an assessment derived from the DSM-5), which would yield estimates of Enduring Demand, Met Demand, and Absent Demand for Gambling Disorder and sub-clinical Gambling Disorder.

We intentionally retain people experiencing sub-clinical Gambling Disorder in this algorithm because research indicates that some of them experience psychosocial distress to the extent that they might benefit from professional or paraprofessional treatment. To illustrate, Weinstock, April, and Kallmi (2017) examined psychosocial functioning among people reporting 2-3 Gambling Disorder criteria (i.e., sub-clinical gamblers). They also examined people with mild severity *substance use disorder* (i.e., those who met 2–3 SUD criteria) and individuals with no psychopathology. They observed that sub-clinical gamblers reported significantly poorer psychosocial functioning compared to those endorsing no current psychopathology; moreover, in terms of psychosocial functioning, sub-clinical gamblers were equivalent to individuals with mild severity SUD. Among individuals with sub-

clinical gambling disorder, psychosocial impairment took the form of lower marital satisfaction, happiness, life satisfaction, family functioning, and social support; more stressful life events; and increased levels of overall stress.

Epidemiological evidence suggests that sub-clinical Gambling Disorder is more prevalent than diagnostic-level Gambling Disorder. To illustrate, using a meta-analytic approach, Shaffer, Hall and Vander Bilt (1999) reported that lifetime sub-clinical gamblers compose about 3.85 percent of the adult population compared to pathological gamblers, who compose about 1.6 percent of the population. To estimate the potential treatment needs of a population, if the target population includes 1,000,000 people and only people who meet diagnostic criteria are taken into account (i.e., 1.6%), then the prevalence estimate will be 16,000; however, an additional 38,500 (i.e. 3.85%) people will be ignored despite have some level of gambling-related problems and concomitant suffering. Therefore, estimates based just on those who reach a diagnostic threshold can underestimate treatment need by failing to include those who are experiencing adverse gambling-related events.

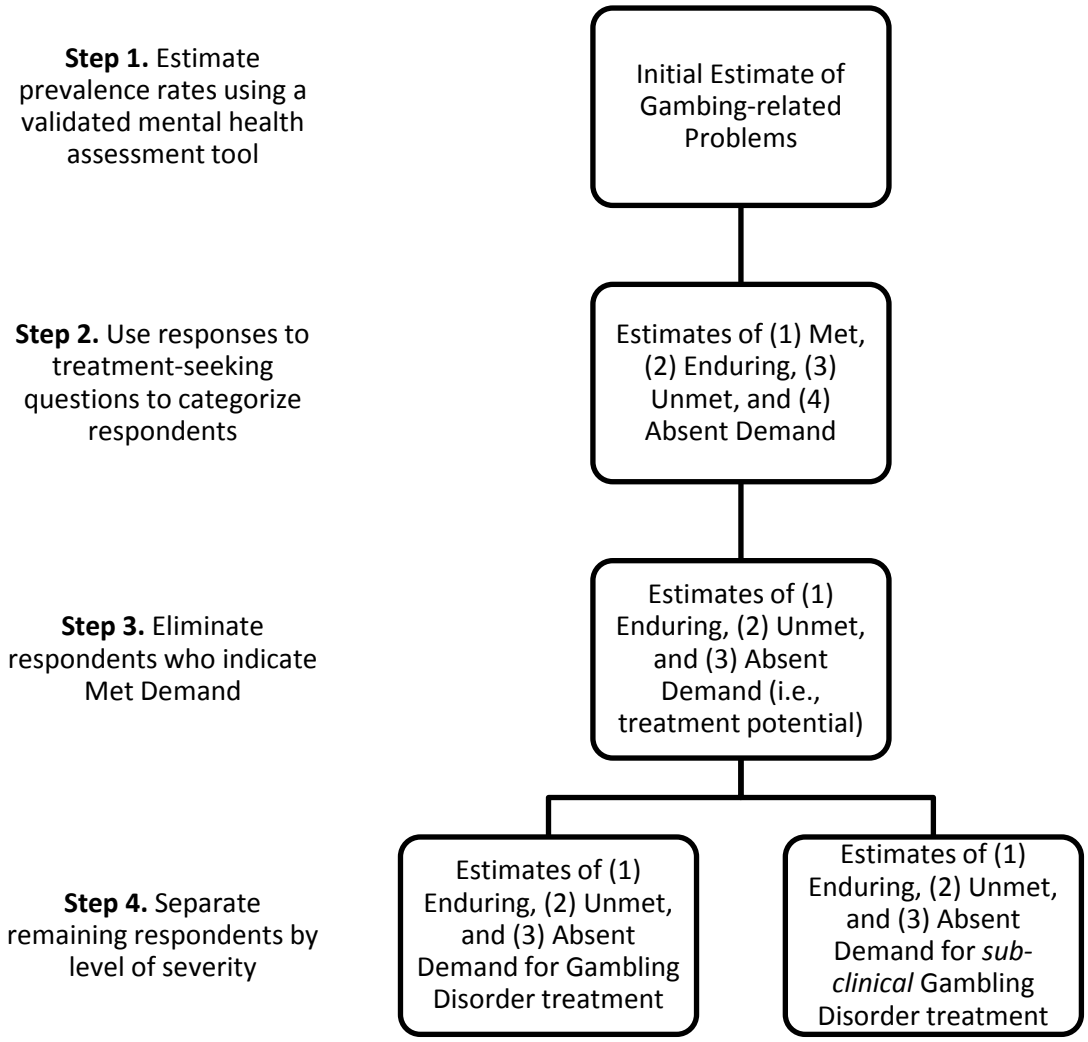

Figure 1: Partially Adjusted Algorithm

The Partially Adjusted Algorithm provides a total of six estimates of treatment need: Enduring, Unmet, and Absent Demand for Gambling Disorder and sub-clinical Gambling Disorder. Generating fine-grained estimates would allow the Commonwealth to distribute limited secondary and tertiary treatment resources in a more informed way. For instance, a high rate of Absent Demand could indicate need for greater awareness among MA residents of the nature, consequences, and potential treatment of gambling-related problems. A high rate of Unmet Demand, on the other hand, could indicate that residents are aware of their gambling-related problems and the potential for effective treatment, but are experiencing that such treatment is unavailable or unaffordable. Finally, a high rate of Enduring Demand indicates high engagement with the treatment system and continuing need.

In addition, with regard to the severity of gambling-related problems, we recommend matching addiction treatment settings, interventions, and services to an individual's particular needs (Albanese & Shaffer, 2003; National Institute on Drug Abuse, 2018; Norcross & Wampold, 2011). Broadly speaking, individuals with Gambling Disorder likely need relatively intense treatment options, such as intensive outpatient treatment. Many of those with sub-clinical Gambling Disorder might need less intensive treatment. For instance, they might benefit from brief interventions delivered by healthcare providers, including primary care providers or providers managing co-occurring substance use or mental health conditions (Petry, Weinstock, Ledgerwood, & Morasco, 2008). The Commonwealth could monitor changes in these six indices over time to examine, for instance, whether attempts to make treatment more available and affordable are reducing the rate of Enduring, Unmet, and Absent Demand.

Complicating Factors for Estimating Treatment Need: Fully Adjusting the Algorithm

A more expansive approach recognizes the true complexity of treatment need as a multifactorial concept (Aoun, Pennebaker, & Wood, 2004). At least three primary factors might necessitate additional adjustments to the treatment need algorithm, beyond Steps 1-3 of the Partially Adjusted Algorithm. These factors are (1) natural recovery, (2) treatment for co-occurring disorders, and (3) use of self-help resources. In the following, first we describe these primary factors and their individual adjustments, then we describe how those factors might be incorporated into a fully adjusted treatment need algorithm.

Natural Recovery

In the broader addiction and mental health field, recovery has been defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2012). Natural recovery occurs when a person accomplishes this state without professional treatment (Chiauzzi & Liljegren, 1993; Shaffer & Jones, 1989). Natural recovery is well documented within the substance use disorder research (Shaffer, 2007; Shaffer & Jones, 1989; Smart, 1975-1976; Sobell, Ellingstad, & Sobell, 2000; Waldorf & Biernacki, 1979, 1981, 1982). These studies report high abstinence or low-risk use of a variety of substances (e.g., alcohol, cigarettes, opiates), a find-

ing that contradicts the commonly held belief that all people with substance use disorders experience persistent, lifetime harm.

Similarly, Gambling Disorder symptom patterns vary considerably over time and present in different ways depending on the number of and type of symptoms present (Nelson, Gebauer, Labrie, & Shaffer, 2009; Slutske, Jackson, & Sher, 2003). Slutske and her colleagues reported that between 33-36% of individuals with gambling-related problems recovered naturally, as indicated by the absence of symptoms in the previous year without treatment-seeking for gambling (Slutske, 2006). Though most individuals who experience natural recovery report abstinence from gambling, others report recent (i.e., past year) gambling in the absence of gambling disorder symptoms (Slutske, Piasecki, Blaszczynski, & Martin, 2010).

Natural recovery findings demonstrate that a meaningful portion of the population who meet diagnostic criteria for Gambling Disorder will decrease their gambling behavior without any professional or paraprofessional treatment. The observation of natural recovery has important implications for estimating gambling treatment need: professional or paraprofessional treatment is not requisite for all individuals experiencing gambling-related problems. Therefore, estimates of gambling treatment need must anticipate natural recovery. Failing to account for the likelihood of natural recovery might result in an overestimation of treatment need.

Accounting for Natural Recovery

Leading psychiatric epidemiologists have accounted for natural recovery from substance use and mental health conditions by applying clinical significance criteria (Frances, 1998; Narrow, Rae, Robins, & Regier, 2002; Ustun, Chatterji, & Rehm, 1998). They reason that survey respondents who indicate that they are experiencing mild or transient disorders--in other words, those who do not meet clinical significance criteria-- will be more likely to recover on their own without treatment (Albanese & Shaffer, 2003; Narrow et al., 2002; Shepard et al., 2005).

To illustrate, two large epidemiologic studies—the National Institute of Mental Health's Epidemiologic Catchment Area Program (ECA; conducted between 1980 and 1985) and the National Comorbidity Survey (NCS; conducted 1990-1992)—took this approach by including clinical significance questions. One commonly used clin-

ical significance question is *functional impairment* (i.e., "Did your symptom(s) interfere with your life or activities a lot?"). Examining NCS and ECA data for a variety of substance use/mental health conditions, Narrow et al. (2002) observed that prevalence rates dropped substantially when the clinical significance questions were applied. For example, in the NCS, the prevalence of any substance use disorder was 11.5% before the clinical significance questions were applied and 7.6% after these questions were applied. In the ECA, the prevalence of any drug use disorder was 4.0% before the clinical significance questions were applied and 1.5% after the questions were applied. These reductions indicate that a meaningful number of respondents who met DSM-III symptom criteria did not meet clinical significance criteria; in other words, they were experiencing more mild and transient symptoms.

Even modest changes in estimates of treatment need can meaningfully impact the planning of mental health service systems. For example, according to Narrow et al.'s (2002) estimates, the overall drop in ECA and NCS prevalence rates corresponds to a decrease of over 13 million Americans who need professional mental health or substance use services.

Narrow et al. (2002, p. 116-117) note that, although "clinical significance has been a part of the DSM definition of mental disorder starting with DSM-III," there is "no consensus as to how it should be defined or operationalized." In the DSM-5, clinical significance of Gambling Disorder appears in the introduction to the symptom description and is *assumed* to be present if individuals report at least four symptoms; functional impairment is not listed *per se* in the diagnostic criteria. False positives—people whose symptoms satisfy DSM criteria but are so mild as to not cause harm or require treatment—therefore might result (Spitzer & Wakefield, 1999). Therefore, we recommend that researchers reduce their estimates of treatment need by eliminating respondents who report no functional impairment.

Treatment for Co-occurring Disorders

Second, comorbid disorders, such as mood disorders or other expressions of addiction, can contribute to the course and ultimate outcome of treatment for gambling-related problems. Comorbidity is common among people experiencing gambling-related problems (Lorains, Cowlishaw, & Thomas, 2011). Using a representative

national sample, Kessler et al. (2008) reported that approximately 96% of people with Gambling Disorder (then known as Pathological Gambling) also qualified for a lifetime diagnosis of one or more other disorders (e.g., substance use disorder, anxiety disorder; see also, Afifi, Nicholson, Martins, & Sareen, 2016). More recently, Rodriguez-Monguio, Errea, and Volberg (2017) analyzed the diagnostic history and treatment-seeking patterns of commercially-insured, treatment-seeking Massachusetts adults with a diagnosis of Pathological Gambling. They observed a high burden of co-occurring disorders, particularly anxiety disorders (evident in 28% of the Pathological Gambling sample), mood disorders (26%), and substance use disorders (18%).

Further, these co-occurring disorders often are the reason people struggling with gambling-related problems first enter the mental health/substance use treatment system (Kessler et al., 2008). In their analysis of Massachusetts claims data, Rodriguez-Monguio et al. (2017, p.413) observed that treatment-seeking patients "did not seek care from family physicians for their gambling problems as their main clinical condition but as a bundle involving multiple disorders and conditions." Primary care providers and behavioral health providers who are trained to screen and provide brief interventions for gambling-related problems are positioned to reduce the need for specialist gambling treatment. Indeed, effective brief interventions for gambling-related problems can be delivered with substance use disorder treatment without a great deal of additional provider or client burden (Petry et al., 2008). For researchers and public health officials, the implication of these findings is that we must consider the potential for recovery from gambling-related problems following treatment for comorbid conditions alone. Failing to consider favorable gambling treatment outcomes from care focusing on other disorders will result in overestimates of treatment need.

Accounting for Treatment for Co-occurring Disorders

Accounting for treatment for co-occurring disorders requires gathering additional information. More specifically, researchers will need to assess whether respondents are currently participating in treatment for a substance use disorder or other mental health condition using a question such as, "Are you participating in professional help for a concern about your mental health or substance use?" By "professional help," we mean a psychiatrist or other medical doctor (e.g., primary care provider), psychologist, other mental health professional

(e.g., counselor, therapist, social worker), or religious advisor. We recommend that researchers reduce their treatment need estimates by eliminating respondents who indicate that they are receiving professional help for co-occurring mental health or substance use concerns.

Self-Help/Mutual Help

Third, self-help resources also hold the potential to reduce gambling-related problems, without professional treatment. Gamblers interested in self-help strategies can find these resources online or in hard copy formats (e.g., Blaszczynski, 2017; Shaffer, Martin, Kleschinsky, & Neporent, 2012). Self-help activities aim to reduce a problematic behavior via structured application of psychotherapy principles, often cognitive behavioral therapy. Guided self-help tools combine self-help material with brief therapeutic encounters, either in-person, by telephone, or online.

Self-help strategies are appealing for those experiencing gambling-related problems and other health conditions for a variety of reasons. Experiencing these problems is often stigmatizing (Gainsbury, Hing, & Suhonen, 2014; Horch & Hodgins, 2008; Suurvali, Cordingley, Hodgins, & Cunningham, 2009), and self-help strategies are one way to avoid the stigma that comes with identifying as someone in need of professional treatment. Self-help strategies hold additional benefits: they are low (or no cost) to individuals and ideally are readily accessible, such as through online portals or written materials freely available at health clinics, libraries, and other locations.

Researchers have proposed seven categories of gambling self-help strategies: (1) information seeking; (2) self-assessment and monitoring; (3) alternative activities; (4) cash control and financial management; (5) stimulus control; (6) cognitive strategies; and (7) social strategies (Lubman et al., 2013). Those who have studied the effectiveness of these resources generally find greater improvement among respondents who receive a self-help guide *plus* a brief intervention; however, a meaningful proportion of those who receive a stand-alone self-help guide report improvements. For example, Hodgins, Currie, and el-Guebaly (2001) studied respondents with gambling problems who completed a self-help workbook based on the cognitive-behavioral model of problem gambling (Blaszczynski & Silove, 1995). They also followed respondents who completed the workbook *plus* a

motivational enhancement interview with a clinician, and a final group of respondents who remained on a wait-list. All three groups reported improvement during the first month of the study. Only respondents who completed the motivational enhancement interview plus the workbook reported more improvement than the waitlist control group; however, 61% of the workbook only group, and 44% of the waitlist control group, improved their gambling problems or quit gambling altogether during that month. At 12 months post treatment, 79% of respondents who completed the workbook alone reported either improving their gambling or abstaining from gambling. At a 2-year follow-up, 63% of the workbook alone condition reported either improvement or abstinence.

Other researchers have identified similar success using self-help strategies. For example, LaBrie et al. (2012) evaluated a toolkit, *Your First Step to Change: Gambling (1st edition)*, as a brief self-help intervention for gambling-related problems. Respondents either (1) received the toolkit alone, (2) received the toolkit *and* received guidance about it by telephone from a member of the research team, or (3) remained on a waitlist. Results indicated that toolkit recipients were more likely than waitlist respondents to report recent abstinence from gambling; at the 1-month follow-up, 41-49% of respondents who received the toolkit alone (depending on study site) reported abstinence, and these rates rose to 56-67% at the 3-month follow-up.

Table 1 provides rates of gambling improvement/abstinence among respondents provided with a stand-alone self-help guide (workbook or toolkit) across all the studies we have identified as part of a recent DPH-funded research synthesis (LaPLante, Wiley, Gray, & Shaffer, 2018). Together, these findings provide evidence that stand-alone self-help resources can assist remediating gambling-related problems among gamblers who do not engage in formal treatment. In doing so, they confirm that using straightforward prevalence rates as a proxy for Gambling Disorder treatment need might overestimate treatment need.

Table 1: Percent of respondents who reported improvement in gambling problems or abstinence from gambling at follow-up

Study	% improved / abstinent at 1-month follow-up	% improved/ abstinent at 3-month follow-up	% improved/ abstinent at 1-year follow-up	% improved/ abstinent at > 1-year follow-up
Hodgins et al. (2001/2004)	61	75	79	63
Hodgins et al. (2009)	64	65	76	
LaBrie et al. (2012)	41[1]	67[1]		
	49[2]	56[2]		

Notes: [1] Las Vegas, NV sample; [2] Massachusetts sample. Campos et al. (2016) and Oei, Raylu, and Lai (2017) additionally studied workbook-only conditions; however, they did not report % improved/abstinent. In both of these studies, those assigned to workbook-only conditions reported, on average, problem gambling symptom improvement over time.

However, we encourage readers to consider three essential caveats. First, all respondents in these studies were concerned enough about their gambling to reach out to the study teams recruiting them. Their initial motivation to control their gambling was likely a key ingredient in their success, regardless of their condition assignment (Babor, 1994). This situation helps explain why researchers often observe improvement over time among respondents in a waitlist condition. Indeed, self-help strategies are most effective when paired with motivational enhancement strategies (Boudreault et al., 2017; Hodgins, Currie, el-Guebaly, & Peden, 2004; Hodgins et al., 2001). Self-help resources likely will be effective only for highly motivated community members experiencing gambling-related problems. Second, though some respondents in both studies did not receive formal intervention aside from a workbook or toolkit, they still had contact with research team members and completed repeated assessments. This context might have contributed to their improvement, as the process of assessment likely communicated that other people recognized the importance of their problems and prompted them to recognize of the extent of their disordered behavior. Third, respondents who were unsatisfied with, or felt overwhelmed by, the self-help resources might have been more likely than others to drop out of these studies, re-

sulting in systematic attrition. As a result of these three limitations, self-help strategies might not produce widespread or dramatic improvement in the general population.

There is comparatively less evidence about the effectiveness of mutual aid for gambling-related problems, including Gamblers Anonymous and SMART Recovery. Although many former gamblers anecdotally report that these programs were crucial in their recovery, a recent systematic review of the available literature revealed that the evidence is inconsistent (Schuler et al., 2016). A large-scale randomized controlled trial is necessary for determining effectiveness of mutual aid and the mechanisms through which mutual aid might work. Therefore, we restrict our discussion to empirically supported self-help resources, such as toolkits and workbooks.

Accounting for Self-help

We recommend a conservative adjustment for use of self-help and mutual help. Recall our three caveats regarding the existing literature in this area: (1) respondents were motivated enough to reach out for help, (2) respondents likely benefitted from contact with research team members that would be unavailable outside the context of a study, and (3) respondents who were unsatisfied with self-help resources might have dropped out of studies selectively. Such a conservative approach will help researchers avoid over-correcting for the potential benefits of self-help resources.

First, we recommend that researchers consider only respondents with sub-clinical Gambling Disorder— not diagnostic-threshold Gambling Disorder— to be potentially responsive to stand-alone self-help resources. We make this recommendation because the former group's problems are likely more amenable to change outside the professional treatment context. Second, although some gambling self-help resources, like the *Your First Step to Change* toolkit, are designed to reduce resistance to change (Labrie et al., 2012; Shaffer & Simoneau, 2001), we recommend that researchers consider only respondents who are already contemplating changing their gambling to be responsive to stand-alone self-help resources. This nuanced approach to accounting for self-help resources requires assessing respondents' stage of change (Prochaska & DiClemente, 1986).

One validated measure of stage of change is the Gambling Readiness to Change Scale (GRTC; Neighbors, Lostutter, Larimer, & Takushi, 2002), a nine-item questionnaire modeled after the alcohol Readiness to Change questionnaire (Rollnick, Heather, Gold, & Hall, 1992). The GRTC measures three stages: pre-contemplation (e.g., "It's a waste of time thinking about my gambling"), contemplation (e.g., "Sometimes I think I should cut down on my gambling"), and action (e.g., "Anyone can talk about wanting to do something about gambling, but I am actually doing something about it"). Researchers using this instrument can generate an overall composite of readiness to change or use the scale to categorize individuals as pre-contemplators, contemplators, or in the action stage. A briefer option is a Readiness Ruler (LaBrie, Quinlan, Schiffman, & Earleywine, 2005) modified for Gambling Disorder, with anchors at the pre-contemplation stage (e.g., "I never think about my gambling") and the maintenance stage (e.g., "I changed my gambling; I now do not gamble, or gamble less than before").

In a recent large naturalistic study, Johansson et al. (2017) observed that respondents who scored higher on such a readiness inventory at baseline were more likely to report clinically significant changes to a lower level of alcohol use after using a Web-based drinking self-help program. Interestingly, respondents who had contact with a professional about their drinking or used pharmacological treatment since registering for the self-help program showed the opposite pattern; they were *less* likely to report a clinically significant change to a lower level of alcohol use. This finding suggests that making contact with a health professional is not a valid proxy of motivation to change one's behavior.

Not all individuals in the contemplation stage or higher will respond to stand-alone self-help treatment; recall that in our review of the relevant literature (Table 1), we observed one rate of improvement/abstinence as low as 41%. One possible option for accounting for the use of self-help resources is to remove 41% of respondents with sub-clinical Gambling Disorder who are at the contemplation stage or higher, assuming that they will all benefit from stand-alone self-help resources. However, there is a potential overlap between this group and the group who already participate in professional help for a mental health/substance use concern, who we also recommend eliminating from a Fully Adjusted Algorithm. We must anticipate and account for such overlap to avoid over-correcting for either factor. Therefore, regarding respondents with sub-clinical Gambling Disorder,

we recommend removing no more than 10% of respondents who are at the contemplation stage or higher, after removing individuals who report participating in treatment for another mental health/substance use condition.

A Fully Adjusted Algorithm

Figure 2 illustrates one approach to a Fully Adjusted Algorithm. Other approaches are possible, and we need additional research to move this algorithm from concept to practice. As we mentioned earlier, the Fully Adjusted Algorithm approach builds upon the Partially Adjusted Algorithm approach; the first three steps are identical (i.e., Step 1: Estimate prevalence rates using a validated mental health assessment tool, such as the DSM-5; Step 2: Use responses to treatment-seeking questions to categorize respondents; Step 3: Eliminate respondents who indicate Met Demand). As we mentioned, Step 4 expands these adjustments by accounting for natural recovery, via elimination of those who do not report functional impairment. Next, at Step 5 of the Fully Adjusted Algorithm, researchers need to separate the remaining respondents by level of severity, yielding adjusted rates of Enduring, Unmet, and Absent Demand for Gambling Disorder and Enduring, Unmet, and Absent Demand for sub-clinical Gambling Disorder. We recommend making this separation at this step because the final two recommended adjustments apply only to respondents who report sub-clinical Gambling Disorder.

Finally, Step 6 of the Fully Adjusted Algorithm begins with eliminating from estimates those respondents with sub-clinical Gambling Disorder who report that they currently are participating in treatment for a co-occurring mental health/substance use concern. The second part of this step includes removal of individuals who might benefit from stand-alone self-help treatment. We operationalize this group as people with sub-clinical Gambling Disorder who are motivated to change (i.e., at the Contemplation stage or above). As indicated above, based on our review of the self-help literature, we conclude that up to 41% of these individuals might reduce or eliminate their gambling after completing stand-alone self-help guides. Consequently, one option is to remove 41% of these individuals at this stage. However, it is likely that many respondents with sub-clinical Gambling Disorder who already are participating in treatment for a co-occurring disorder are motivated to change their gambling. We must consider the overlap between these two groups, which is likely sizable. Therefore, we recommend that, at Step 6, after eliminating respondents who already are participating in treatment for a co-

occurring condition, researchers eliminate no more than 10% of respondents who are at the contemplation state or higher regarding their gambling. Implementation of all these steps yields what we refer to as the Fully Adjusted Algorithm for estimating treatment need.

Step 1. Estimate prevalence rates using a validated mental health assessment tool

Step 2. Use responses to treatment-seeking questions to categorize respondents

Step 3. Eliminate respondents who indicate Met Demand

Step 4. Eliminate respondents who report no functional impairment

Step 5. Separate remaining respondents by level of severity

Step 6. Remove those who are engaged in professional help for a co-occurring condition and 10% of those who are at the contemplation stage or higher

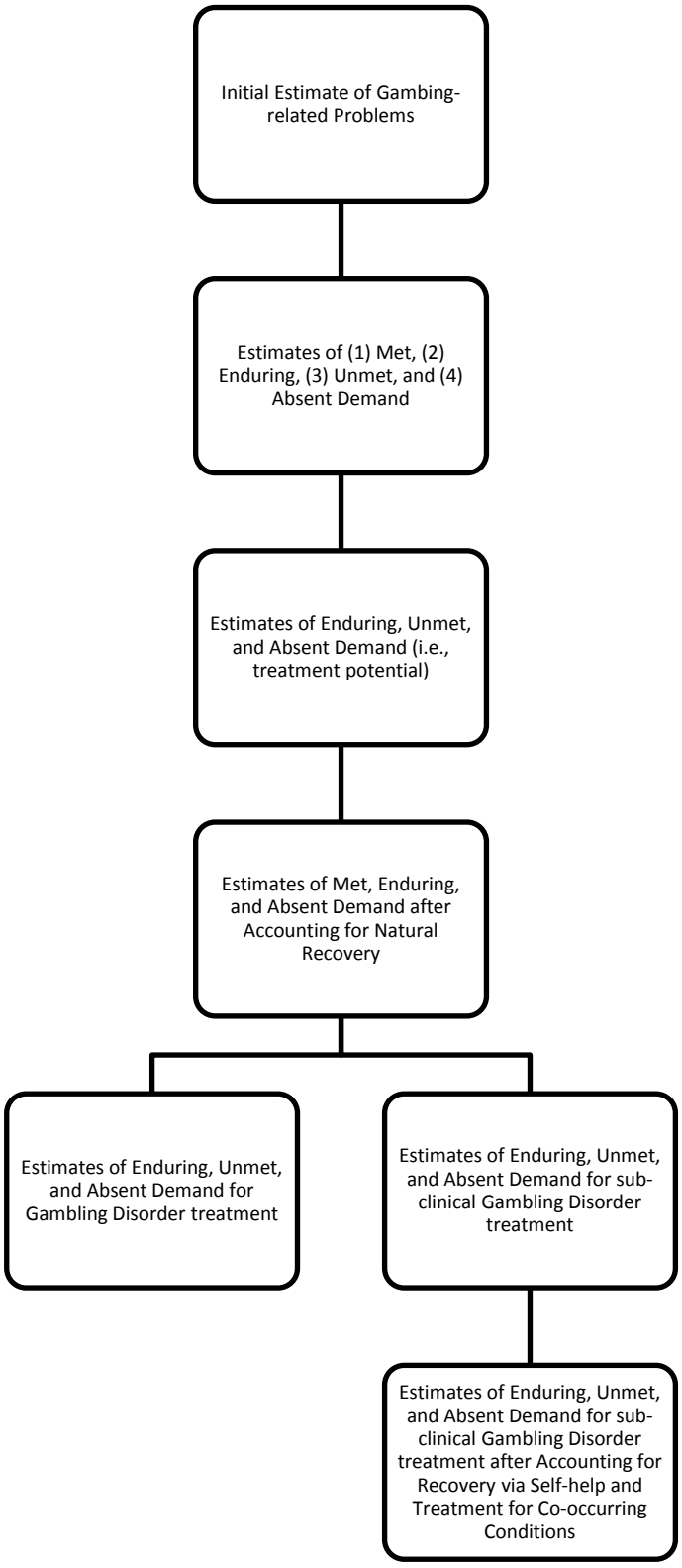

Figure 2: Fully Adjusted Algorithm

Assessing Available Massachusetts Data for Estimating Treatment Need

According to the most recent estimate, there are 6.86 million Massachusetts residents, 5.49 million of whom are adults 18 and older (U.S. Census Bureau, 2017). As described below, several researchers have attempted to estimate the extent of gambling-related problems within this population. Concerns about the incidence and prevalence of gambling-related problems have arisen largely in response to legalization of casinos in 2011. This expansion presents a unique opportunity to establish baseline estimates gambling behaviors and gambling-related problems and measure, over time, how such estimates change with the addition of new gambling venues. We have identified five relevant independent studies, all of which were published within the past five years:

1. An Internet panel survey conducted by the Division on Addiction at Cambridge Health Alliance (Nelson, Kleschinsky, LaPlante, Gray, & Shaffer, 2013)
2. The Massachusetts Statewide Gambling Behavior, Opinions, and Needs Assessment, conducted by the Massachusetts Council on Compulsive Gambling (Massachusetts Council on Compulsive Gambling, 2013);
3. Data derived from the 2013 Massachusetts Behavioral Risk Factor Surveillance System (Okunna, Rodriguez-Monguio, Smelson, Poudel, & Volberg, 2016) ;
4. The Social and Economic Impacts of Gambling in Massachusetts Baseline General Population Survey (Volberg et al., 2015); and
5. The Social and Economic Impacts of Gambling in Massachusetts Baseline Online Panel Survey (Williams et al., 2016).

The SEIGMA team established its Massachusetts Gambling Impact Cohort (MAGIC) Study from a stratified sample of respondents who completed the Baseline General Population Survey (Volberg et al., 2015). Therefore, it does not represent an independent sample, and we do not include it in our review.[3]

We review these five studies in chronological order with a focus on their ability to provide a nuanced estimate of the extent of need for gambling treatment services among Massachusetts residents. We do not provide a full summary of each study's methodological features (e.g., response rate, sample source, sample representativeness, weighting) because we consider such a summary outside the scope of this document; interested readers can find such a summary in Volberg et al. (2015). We note that four out of five of these studies collected data that investigators can use to complete Step 1 of the Partially/Fully Adjusted Algorithms; however, none of these five studies collected the data required to complete Steps 2 or 3. Consequently, because the algorithms in this project proceed in a sequence of steps, investigators cannot use any of the current studies to complete subsequent steps. Nonetheless, to provide a complete description of the currently available data, we describe data within these five studies that are relevant to later stages of the algorithm (i.e., functional impairment, motivation to change, treatment for co-occurring conditions). Doing so allows us to highlight adequacies that should be maintained and variable gaps that need to be filled if the Commonwealth wants to use a study's approach to estimate treatment need gap.

Nelson et al. (2013)

Nelson et al. studied gambling patterns among MA residents before gambling expansion occurred. During December 2012, they recruited from a standing GfK Knowledge Panel. This is an online survey panel of Massachusetts adults recruited through Random Digit Dial and Address-Based Sampling (ABS). ABS is intended to reduce sampling bias and yield a more representative sample; however, Nelson et al. (2013) note that the household recruitment rate to the Massachusetts arm of the Knowledge Panel was 16.7%. Of the 725 respond-

[3] MAGIC included five new questions not originally included in BGPS and BOPS. These questions concerned the respondent's internet connection and use, gambling at "underground" casinos/slot parlors, and gambling at Plainridge Park Casino. None of the new questions address our recommendations, which are provided in detail below.

ents in this panel invited to participate in the December 2012 gambling study, 511 agreed and completed the study (i.e., a 70.5% participation rate). In addition to the comprehensive 2013 report that we reference here, a peer-reviewed publication (Nelson, LaPlante, Gray, Tom, Kleschinsky, & Shaffer, 2017) provided selected findings from this survey.

In accordance with Step 1 of the Partially and Fully Adjusted Algorithms, respondents reported past-year gambling-related problems on the Alcohol Use Disorder and Associated Disabilities Interview Schedule IV (AUDADIS; Grant et al., 2003). The AUDADIS-IV is a 16-item inventory assessing for Pathological Gambling criteria based on the 10 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 2000). Nelson et al. (2013) observed that one respondent (0.2% of the entire sample) endorsed 5+ DSM-IV Pathological Gambling criteria within the past year, as Table 2 shows:

Table 2: Prevalence estimates in Nelson et al. (2013)

AUDADIS-IV classification	**Observed rate**
Non-gambler	46.4%
0-2 DSM-IV criteria	52.3%
3-4 DSM-IV criteria	1.2%
5+ DSM-IV criteria	0.2%

Nelson et al. (2013) noted that the National Epidemiological Survey of Alcohol and Related Conditions (Grant et al., 2003), which also used the AUDADIS-IV, reported that 0.2% of the sample qualified for past-year Pathological Gambling. It is noteworthy that the rate of clinically disordered gambling among a Massachusetts online panel was identical to a national estimate.

Nelson et al. asked several treatment-seeking questions. They asked respondents who endorsed at least one Pathological Gambling criterion, "In your life, did you ever talk to a medical doctor or other professional about your problems with gambling? By other professional we mean psychologists, counselors, spiritual advisors, and other healing professionals." Respondents who answered affirmatively also reported the first time they sought this kind of help and whether they had done so within the past 12 months.[4] Researchers can use these answers to classify respondents according to whether they received treatment for the current episode of

[4] Respondents also reported their experience with Gamblers Anonymous and gambling helplines.

gambling-related problems. However, because Nelson et al. did not ask about seeking treatment separately from participating in treatment, these data cannot be used to distinguish between Unmet Demand (i.e., respondents who sought but did not receive treatment) and Absent Demand (i.e., respondents who did not seek treatment) as recommended in Step 2 of the Partially or Fully Adjusted Algorithms. Additionally, Step 3 is not possible because there is no estimate of Met Demand. It should be noted, however, that Nelson and colleagues observed that none of the 36 respondents who endorsed at least one past-year Pathological Gambling criterion reported having ever spoken to a medical doctor or other professional about their problems,[5] suggesting a possible high rate of Unmet Need among this sub-set of participants. This finding is consistent with Kessler et al.'s (2008) finding that none of the national sample who met diagnostic criteria for Pathological Gambling reported getting treatment for their gambling, though about half were in treatment for other conditions. Nelson and colleagues did not assess functional impairment, stage of change, or engagement in professional help for a co-occurring condition (necessary for Steps 4 and 6 of the Fully Adjusted Algorithm).

MCCG (2013)

The Massachusetts Council on Compulsive Gambling assessed gambling-related problems with the Massachusetts Statewide Gambling Behavior, Opinions and Needs Assessment. During January, 2013, the MCCG conducted a web-based survey of 1,054 Massachusetts adults aged 18+ recruited from an online survey panel. The researchers generated 12 demographics cells defined by age groups, gender, and race and used screening questions during the recruitment process in an attempt to achieve a representative sample. In accordance with Step 1 of the Partially and Fully Adjusted Algorithms, respondents who reported any past year gambling responded to the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987), a 20-item questionnaire based on DSM-III criteria for Pathological Gambling. Respondents were categorized as Probable pathological gamblers (i.e., a SOGS score of 5+), Problem gambler (i.e., a SOGS score of 3-4), Social gambler (i.e., a SOGS score of 0-2),

[5] One respondent had attended a mutual-help meeting (e.g., Gamblers' Anonymous), but not during the past year. None of the 36 respondents had ever called a gambling helpline.

or Non-gambler (i.e., a respondent who was not assessed with SOGS because they did not report gambling behaviors in the past 12 months). The MCCG observed the following:

Table 3: Prevalence estimates in the Massachusetts Statewide Gambling Behavior, Opinions and Needs Assessment

SOGS classification	Observed rate
Non-gambler	15.3%
Social gambler	74.8%
Problem gambler	4.9%
Probable pathological gambler	5.0%

To our knowledge, the MCCG did not ask respondents about seeking help for gambling-related problems. Therefore, it is impossible to complete Steps 2 or 3 of the Partially/Fully Adjusted Algorithms. The MCCG did not assess functional impairment or stage of change, necessary for Steps 4 and 6 of the Fully Adjusted Algorithm. However, respondents did indicate whether they had sought treatment for substance use problems – if they acknowledged such problems. The MCCG observed that 65% of respondents who acknowledged an alcohol problem reported that they had ever sought treatment for that problem. Similarly, 64% of respondents who acknowledged a drug problem reported seeking treatment for that problem. Rates of seeking treatment for a behavioral addiction (i.e., sex addition or stealing/shoplifting) were considerably lower.

Okunna et al. (2016)

Okunna and colleagues (2016) analyzed data from the Behavioral Risk Factor Surveillance System, a national telephone survey representative of state populations. To establish baseline (i.e., pre-gambling expansion) rates of gambling participation and gambling problems, in 2013 Massachusetts added a gambling module to the Behavioral Risk Factor Surveillance System (BRFSS). Investigators administered this module to one-third of the 2013 Massachusetts BRFSS sample, or 3,318 of 15,072 respondents.[6] The gambling module included three gambling participation questions and the Brief Biosocial Gambling Screen (Gebauer, Labrie, & Shaffer, 2010), derived

[6] Volberg et al. (2015) note an important caveat: only landline users were administered the gambling module. Based on their demographic characteristics, landline-only users are likely report lower levels of gambling participation and gambling-related problems compared to the general population.

from the DSM-IV criteria for Pathological Gambling. Among these 3,318 respondents, past-year gambling prevalence was 57% (95% confidence interval: 54.1%-60.7%). Gambling prevalence varied by state region, with the highest prevalence identified within Central Massachusetts (67%). As reported by Volberg et al. (2015), 1.2% of the 2013 Massachusetts BRFSS gambling module sub-sample endorsed the withdrawal criterion of the BBGS, 1.1% endorsed the lying criterion, and 0.1% endorsed the financial trouble/financial bailout criterion. Data about the percent of respondents who screened positive for gambling-related problems (i.e., by endorsing at least one BBGS criterion) are unavailable. More importantly, the BBGS is a screening instrument, not a complete evaluation of Gambling Disorder symptoms. When comprehensively evaluated, about two-thirds of individuals who screen positive on the BBGS will not meet full diagnostic criteria (i.e., the Positive Predictive Value is 0.36; Gebauer et al., 2010). As a result, it is impossible to complete Step 1 of the Partially/Fully Adjusted Algorithms.

To our knowledge, these researchers did not assess treatment seeking, functional impairment, motivation to change, or treatment for co-occurring conditions. Therefore, these data do not address any steps of the proposed algorithms.

The Social and Economic Impacts of Gambling in Massachusetts Baseline General Population Survey (Volberg et al., 2015)

SEIGMA BGPS assessed baseline gambling participation and knowledge and use of gambling services from September, 2013-May, 2014. These researchers used Address Based Sampling to generate probability sampling. The researchers over-sampled Western Massachusetts to increase the precision of their problem gambling prevalence estimates in this part of the Commonwealth. Respondents included 9,581 respondents age 18 and older. Respondents responded to questions on the Canadian Problem Gambling Index (CPGI; Ferris & Wynne, 2001) and the Problem and Pathological Gambling Measure (PPGM; Williams & Volberg, 2010; 2014). Because the PPGM is a relatively new instrument, we describe it in detail here. It includes three sections: (1) Problems (i.e., financial, mental health, health, relationship, work/school, legal), (2) Impaired Control (e.g., "In the past 12 months, have you made any attempts to either cut down, control or stop your gambling?"), and (3)

Other Issues (i.e., questions designed to assess preoccupation, withdrawal, and tolerance) within a past-year timeframe. It generates five categories of gambling activity:[7]

- Non-gambler (has not gambled within the past year)
- Recreational (has gambled within the past year but scores zero on the PPGM)
- At-Risk (endorsement of an item from the Problems *or* the Impaired Control section)
- Problem (endorsement of 1 or more items from the Problems section *and* 1 or more items from the Impaired Control section)[8]
- Pathological (endorsement of several items from the Problems section *and* several items from the Impaired Control section)

Volberg et al. (2015) elected to combine respondents in the PPGM "problem" and "pathological" groups and refer to this combined group as "problem gamblers." Because combining these groups can reduce the acuity of any measure and limit the value of the results for estimating treatment need, particularly when severity is a proxy for need, we used estimates provided in an Appendix to Volberg et al. (2015) to generate separate prevalence estimates for the "problem" and "pathological" groups.[9] We present these separate estimates in Table 4, along with other estimates provided by Volberg et al. (2015):

Table 4: Weighted prevalence estimates in the Baseline General Population Survey

CPGI category	**CPGI observed rate**	**PPGM category**	**PPGM observed rate**
Non-gambler	26.9%	Non-gambler	26.6%
Non-problem gambler	61.2%	Recreational gambler	62.9%
At-risk gambler	9.8%	At-risk gambler	8.4%
Problem gambler	2.2%	Problem gambler	1.2%
		Pathological gambler	0.8%

[7] Responses to gambling frequency and expenditure questions, and total scores on the PPGM, additionally factor into these classifications, but for ease of presentation we have simplified the classification scheme.

[8] Additionally, the PPGM uses gambling involvement questions to identify respondents who have not acknowledged they have a problem but whose "gambling expenditure and frequency are equal to those of unambiguously identified problem gamblers" (Volberg et al., 2015, p. 257)

[9] Volberg et al. (2015) report that 2.0% of their sample (unweighted n = 129; weighted n = 5,211,381) met the criteria for their *combined* PPGM "problem gambler" category. In Table 73 of Appendix E, they specify that of these 129 individuals, 75 respondents met the criteria for their original "problem gambler" category and 54 met the criteria for their "pathological gambler" category. We used unweighted sample sizes (i.e., 75 and 54) to estimate separate prevalence rates for the "problem gambler" and "pathological gambler" categories, which Volberg et al. (2015) do not provide. Because we did not have access to weighted n's for these categories, our estimates might differ slightly from Volberg et al.'s.

These estimates fulfill Step 1 of the Partially/Fully Adjusted Algorithms. With regard to Step 2, SEIGMA asked the following treatment-seeking questions among respondents who, according to the CPGI, were problem gamblers:

1. Have you wanted help for gambling problems in the past 12 months?
2. If yes:
    a. Have you sought help for gambling problems in the past 12 months?
    b. Where did you seek help from? (open-ended)
    c. How helpful was this? (on a scale from "very helpful" to "not at all helpful")

Volberg et al. (2015) did not include a question explicitly assessing treatment participation (e.g., "Have you participated in treatment for gambling problems in the past 12 months?"). Therefore, although it is possible to categorize respondents according to whether they sought treatment, it is not possible to categorize them further (i.e., Step 2) or eliminate respondents with Met Demand (i.e., Step 3).[10] Moreover, because the subset of respondents classified as problem/pathological gamblers according to the PPGM included only 129 individuals, Volberg et al. (2015) did not include results from the treatment-seeking questions.

With regard to later steps of the Fully Adjusted Algorithm, Volberg et al. (2015) did include indicators of functional impairment within the CPGI/PPGM. For example, one question asks if someone besides the respondent would say that the respondent's gambling has caused significant problems. The BGPS embedded these functional impairment questions within the symptom checklist rather than presenting them separately for respondents who endorse a minimum number of symptoms, as we recommend above; however, eliminating respondents who reported no functional impairment is presumably possible with available data (i.e., Step 4 of the Fully Adjusted Algorithm). Finally, with regard to Step 6 of the Fully Adjusted Algorithm, the BPGS did not include a

[10] Volberg et al. (2015) use published estimates of treatment-seeking trends in other U.S. jurisdictions to estimate that between 2,500 and 4,050 Massachusetts residents (i.e., 3% of the 83,152 - 135,122 residents who were estimated to experience problem/pathological gambling) might seek treatment for gambling-related problems annually. Volberg and colleagues speculate that this rate of treatment-seeking—3%, based on published estimates—might double as a result of increased availability and awareness of treatment resources.

measure of respondents' motivation to change their gambling behavior. It did ask about respondents' history of substance use and other mental health conditions but not about treatment for such conditions. Consistent with the literature review we provided above, at-risk and problem gamblers were significantly more likely than recreational gamblers to report serious problems with depression, anxiety, or other mental health problems and were more likely to acknowledge tobacco use and binge drinking in the past 30 days. Therefore, accounting for other behavioral treatment appears to be warranted.

The SEIGMA Baseline Online Panel Survey (Williams et al., 2017)

The SEIGMA team designed the BOPS to supplement the BGPS. They sought to assemble a larger sample of individuals with gambling-related problems who would, presumably, yield more reliable estimates of treatment-seeking. Based on evidence indicating that online panel surveys report relatively high rates of mental health disorders broadly, the researchers contracted with Ipsos Public Affairs to survey Ipsos' standing Massachusetts panel, composed of approximately 17,000 individuals.

Respondents included 5,046 individuals who were contacted between October 2013 and March 2014, coincident with the BGPS. The researchers assessed gambling-related problems and treatment seeking, as well as mental health and substance use status, using the same instruments as the BGPS. As expected, BOPS respondents were different demographically; compared to the BGPS sample, they were "younger, more likely to be White, born in the US, never married, less educated, unemployed, have a lower household income, and to be from Greater Boston" (Williams et al., 2017, p. 8). Also, as expected, they were more likely to report poor health including higher levels of tobacco use, binge drinking, mental health problems, and gambling-related problems.

Williams et al. (2017) did not intend for the BOPS sample to be representative of the general MA population in terms of their gambling-related problems. More specifically, the prevalence of problem/pathological gambling was 6.4% (95% Confidence Interval = 5.7%-7.1%). Williams et al. (2017) achieved their goal of obtaining a larger sample of people experiencing gambling-related problems (i.e., 317 in the BOPS vs. 129 in the BGPS). Williams and colleagues described the treatment-seeking behavior of these 317 individuals. They observed that

25.4% wanted help for problems and 16.1% sought help for these problems. The SEIGMA team plans a follow-up online panel (FOPS) in 2020 to examine changes from baseline.

The BOPS overlaps with the BGPS in terms of its utility for completing the steps described in the Partially and Fully Adjusted Algorithms. As with the BGPS, this study included two measures of problem gambling symptoms, including questions that tap functional impairment embedded within a symptom checklist. Researchers can use these data to achieve Step 1 of the Partially/Fully Adjusted Algorithms. As in the BGPS, Williams et al. asked about treatment seeking but not whether respondents had *received* treatment.[11] This makes it impossible to complete Steps 2 and 3. Finally, this study did not include a measure of respondents' motivation to change their gambling behavior or treatment for co-occurring substance use/other mental health conditions (necessary for Step 6).

Summary of the Sufficiency of Available Massachusetts Data

As we described in the preceding discussion, none of the existing studies assessed the DSM-5 diagnostic criteria for Gambling Disorder. However, four of them (i.e., all except Okunna et al., 2016) used an internationally recognized instrument for estimating the prevalence of gambling-related problems. Estimating prevalence is necessary to complete Step 1 of the Partially or Fully Adjusted Algorithms. Responses to these questions could be used to separate respondents according to their level of severity (i.e., Step 4 of the Partially Adjusted Algorithm and Step 5 of the Fully Adjusted Algorithm). None of the available studies assessed treatment seeking as would be required to complete Steps 2 and 3 of both algorithms. Hence, none of the studies can complete the Partially Adjusted Algorithm. The studies are mixed regarding their contributions to Steps 4 and 6 of the Fully Adjusted Algorithm. Table 5 summarizes the extent to which the five currently available studies provide data relevant to completing the recommended steps of the Fully Adjusted Algorithm.

Table 5: Sufficiency of available data with regard to the Fully Adjusted Algorithm

[11] It is noteworthy that more than 16% of respondents with gambling-related problems reported that they had sought help for these problems, which is substantially higher than the 3% estimate derived from past research.

	Step 1: Estimate prevalence rates	***Step 2: Categorize respondents according to treatment-seeking status***	***Step 3: Eliminate respondents who represent Met Demand***	***Step 4: Eliminate respondents who report no functional impairment***	***Step 5: Separate remaining respondents according to severity***	***Step 6: Eliminate respondents with sub-clinical Gambling Disorder who are engaged in professional help for a mental health/substance use concern and 10% of those who are at the contemplation stage or higher***
Nelson et al., 2013	*Yes*	*No*[12]	*No*[12]	*No*	*Yes*	*No*
MCCG, 2013	*Yes*	*No*	*No*	*No*	*Yes*	*No*
Okunna et al., 2016	*No*	*No*	*No*	*No*	*No*	*No*
Volberg et al., 2015	*Yes*	*No*[12]	*No*[12]	*Yes*	*Yes*	*No*
Williams et al., 2017	*Yes*	*No*[12]	*No*[12]	*Yes*	*Yes*	*No*

Recommendations

The Commonwealth of Massachusetts has embarked on an ambitious program of research designed to monitor potential societal and economic impacts of expanded gambling opportunities. This research agenda has yielded two independent estimates of gambling-related problems among MA residents (Volberg et al., 2015; Williams et al., 2017). Researchers working outside this research agenda have additionally provided estimates of gambling participation and gambling-related problems during the pre-expansion period (Nelson et al., 2013; MCCG, 2013; Okunna et al., 2016). These five studies comprise all of the independent estimates of Massachusetts' gambling participation and gambling-related problems within the past five years. We make the following recommendations for expanding this evidence base moving forward, so that the Commonwealth can make informed decisions about expanding gambling treatment services.

First, in the short term, we recommend applying the Partially Adjust Algorithm when appropriate data is available. In the long term, we recommend additional assessment and development of the Fully Adjusted Algorithm, and subsequently, application of that algorithm when appropriate data is available. Using such approach-

[12] The report provides some treatment-seeking information, but this information is not sufficiently detailed to complete the steps as recommended.

es should avoid some of the mishaps that can occur with simplistic estimates that rely on prevalence estimates alone and increase the precision with which stakeholders can make treatment need decisions.

Next, the Massachusetts Gaming Commission has committed to funding the SEIGMA team to complete a follow-up General Population Survey and a follow-up Online Panel Survey, both expected to be in the field during 2020. Both follow-ups will examine changes from the baseline versions of these surveys. These planned studies represent an opportunity to collect additional data needed to complete the steps described above. More specifically, we encourage the SEIGMA team to consider supplementing their existing survey instruments with the following questions, to be administered at least to respondents in the "at-risk" or "problem gambler" categories:

1. A question formally designed to measure functional impairment caused by gambling (i.e., "In the past year, have you suffered significant vocational or social distress due to gambling?" (Przybylski, Weinstein, & Murayama, 2017)).
2. For those who indicate that they have sought treatment for their gambling, a question formally designed to measure treatment participation (e.g., "In the past year, have you participated professional help for your gambling? By "professional help," we mean a psychiatrist or other medical doctor (e.g., primary care provider), psychologist, other mental health professional (e.g., counselor, therapist, social worker), or religious advisor.").
3. For those who indicate that they have received treatment for their gambling, a question formally designed to assess their perceptions of continued treatment need (i.e., "Do you continue to need professional help for your gambling?").
4. A question (or set of questions) designed to measure respondents' motivation to change their gambling (e.g., the Gambling Readiness to Change Scale, the Readiness Ruler).

Studying treatment-seeking and treatment-participation behaviors in detail will be essential in the coming years because, ideally, the Commonwealth and other stakeholders will make efforts to make treatment options more appealing and available to MA residents. For instance, through dozens of partner agencies, the Divi-

sion on Addiction promotes screening for Gambling Disorder every March. We are also building capacity among providers through DPH-sponsored training webinars and through continuing medical education courses. These and other capacity building efforts could meaningfully expand the pool of providers who are trained to screen and provide brief interventions for gambling-related problems, including non-gambling specialist providers (e.g., primary care providers, BSAS providers). Making screening and brief intervention more accessible could reduce the need for professional (i.e., specialist) treatment, and the Commonwealth will need to continually monitor these kinds of trends over time.

Relatedly, we recommend supplementing the planned follow-up studies. First, the research team should consider asking specifically about respondents' awareness and use of mutual-help groups (e.g., GA, SMART Recovery), the MA or national gambling helpline, and self-help materials. These questions would supplement the BGPS and BOPS questions about awareness of media campaigns and programs offered at schools, workplaces, and elsewhere in the community. Respondents' responses will indicate whether, for MA residents in need, lack of awareness contributes to lack of use of these resources. For example, in our 2012 survey, we observed that only 31% of the sample had heard of the Massachusetts Council on Compulsive Gambling and only 37% had heard of their associated helpline (Nelson et al., 2013). These new questions, combined with the current open-ended question, "Where did you seek help?" will provide a detailed picture of residents' help-seeking preferences and behavior.

Importantly, accounting for the use of self-help strategies rests on the assumption that residents in need will find these strategies appealing and easily accessible. To that end, we recommend that the Department of Public Health take a multi-pronged approach to raising awareness of these resources, as needed, and making them freely accessible. Researchers have recommended making self-help guides available within primary care settings for use by individuals with relatively less severe gambling problems, high motivation and insight, and less comorbid issues (Oei et al., 2017; Petry, Rash, & Alessi, 2016). Further, such resources should be freely available online and within mental health/substance use disorder treatment settings for use by people experiencing these conditions.

Additionally, even if the SEIGMA team continues to use the CPGI and PPGM rather than a symptom checklist derived from the DSM-5, we recommend that they should consider using a labeling system that is not pejorative (Shaffer, Freed, & Healea, 2002; Shaffer & Hall, 1996) and does not inadvertently imply a worsening trajectory.[13] We illustrated below how a non-pejorative labelling system could replace the existing CPGI labels:

Table 6: Suggested labelling system

CPGI label	**Suggested label**
Non-gambler	Level 0
Recreational gambler	Level 1
At-risk gambler	Level 2
Problem gambler	Level 3

Not all community residents are at equal risk for developing gambling-related problems. Recognizing this fact, authors of these five studies examined rates of gambling participation and gambling-related problems within specific demographic segments. Additionally, the SEIGMA team has studied how other respondent characteristics, such as physical and mental health, preferred gambling activity, and reasons for gambling relate to gambling participation and gambling-related problems. Presumably, they will continue to explore these correlates in their follow-up studies. The Massachusetts Gaming Commission has contracted with investigators for studies of gambling participation and problems among MA veterans, Boston-area Asian Americans, and Boston-area African Americans (Massachusetts Gaming Commission, 2017). In addition to these studies, we recommend that the Commonwealth study at-risk populations who are not typically represented, or not adequately represented, in general population surveys. These populations include adolescents (Shaffer et al., 1999; Welte, Barnes, Tidwell, & Hoffman, 2008), casino employees (Shaffer & Hall, 2002; Shaffer, Vander Bilt, & Hall, 1999), individuals experiencing homelessness (Nower, Eyrich-Garg, Pollio, & North, 2015; Howard J. Shaffer et al., 2002), individuals involved with domestic and/or partner violence (Dowling et al., 2016) and individuals who are incarcerated (Abbott, McKenna, & Giles, 2005; Riley, Larsen, Battersby, & Harvey, 2017). Little is known about the treatment needs and preferences among these vulnerable and high-risk population segments.

[13] The at-risk label can be construed to suggest that individuals are on the path toward worsened gambling-related problems, when, in fact, a meaningful number of these individuals might be improving their gambling-related problems or have a static experience.

Finally, prior to SEIGMA's 2020 follow-up studies, the Commonwealth should consider convening researchers who have experience studying gambling participation and problems among MA residents, either independently or within the Gaming Research and Advisory Committee framework. Individual research teams are likely uninformed about the full scope of each other's work. Collectively, we might have more evidence than we realize. Coming together to discuss existing research and recommendations for future research, including the recommendations provided in this document, can help the Commonwealth make more informed decisions about the Commonwealth's potential treatment gap and how to fill it.

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Memorandum

To: Office of Problem Gambling Services, Department of Public Health

From: Division on Addiction, Cambridge Health Alliance, a Harvard Medical School teaching hospital

Date: September 6, 2018

RE: Current State of BSAS Gambling-Related Services in Massachusetts – Gap Analysis

Purpose: Our FY18 scope of services required the Division on Addiction (Division) to commence a gap analysis to better understand treatment demand in Massachusetts. The Division is taking a multi-pronged approach to this gap analysis, focusing on three primary areas: (1) capability gaps, (2) current state of services, and (3) needs fulfillment. This document describes the **current state of gambling-related services in Massachusetts**.

Deliverables: Identify and describe BSAS-affiliated programs currently providing gambling treatment services in Massachusetts. Identify entry points into Massachusetts gambling treatment services for providers and clients. Identify available data collection mechanisms and linkages between these services and the greater BSAS system.

Recommendations: Based on our review of the current state of gambling treatment services in Massachusetts, we provide recommendations in the following three areas: (1) Distribution and provision of gambling treatment services; (2) Client entry points to gambling treatment services; (3) Data systems and communication related to gambling treatment services. The justification for these recommendations is provided within the body of the report and in the Recommendations section at the end of the report.

1. Distribution and provision of gambling treatment services:
    a. We recommend that BSAS focus any gambling treatment expansion efforts on Cape Cod, southeastern Massachusetts, and Worcester and its southern suburbs.
    b. We recommend that BSAS provide information and recommendations about validated gambling assessments to all BSAS-affiliated substance use programs. One means of doing this might be through expanding the Practice Guidelines for gambling treatment web resource to cover screens, assessment, and diagnostic instruments.
    c. We recommend that BSAS continue to update and publicize its Practice Guidelines for gambling treatment and, where possible, disseminate resources related to the most promising approaches.
2. Client entry points to gambling treatment services:
    a. We recommend that the Gambling Helpline, when making referrals, make information available about the full range of gambling treatment services in a caller's area.
    b. We recommend that the Gambling Helpline adopt a warm handoff approach to referrals, communicating directly with the caller's potential treatment provider, as well as the caller.
    c. We recommend that BSAS adopt the use of a single validated screening instrument to screen all clients in substance use treatment programs for gambling-related problems.
3. Data systems and communication related to gambling treatment services:
    a. We recommend that BSAS collect and compile for review the following information from the programs it licenses and/or with which it contracts:
        i. For all programs – in a given month or quarter
            1. # of clients screened for gambling-related problems
            2. # of clients who screened positive for gambling-related problems
            3. # of clients referred to other programs for gambling treatment services and where they were referred
        ii. For programs that provide gambling treatment services – in a given month or quarter
            1. # of clients to whom the program provided gambling treatment services
            2. # of referrals received for gambling treatment services and how many of those referrals commenced treatment
            3. # of clients discontinuing gambling treatment, identified as drop-out, transfer, or completion

b. We recommend that BSAS, through OPGS, develop and maintain an information exchange system and database of organizations that provide gambling treatment services in Massachusetts, as well as the locations at which they deliver these services and the MA-PGS certified providers who work at these organizations.

c. We recommend that OPGS implement a data system for the state Helpline(s) through which it collects information from treatment providers and programs about whether Helpline referrals are fulfilled and how quickly the clients who are referred enter treatment.

The Current State of Gambling Services in Massachusetts

Prepared for the Office of Problem Gambling Services
Massachusetts Department of Public Health

by the Division on Addiction

September 6, 2018

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The Current State of Gambling Treatment Services in Massachusetts

The state of services assessment is one component of a comprehensive gap analysis that examines problem gambling treatment services across Massachusetts. Figure 1 illustrates the three components of this comprehensive gap analysis. The purpose of the needs fulfillment gap component is to position Massachusetts to identify the extent of gambling treatment needs and the extent to which the treatment system is satisfying those needs. The purpose of the capability gap component is to determine how well positioned the Massachusetts treatment system is to satisfy gambling treatment needs. The purpose of the state of services component is to provide comprehensive documentation of the Massachusetts gambling treatment system infrastructure to identify potential areas for new development, support, and/or growth.

Figure 1: Visual Summary of Gap Analysis

In this document, we first describe three primary goals that compose our state of service assessment. Then, we describe the data sources that inform our goals. Following this, we describe data informed observations by goal. We conclude this document by providing some overarching suggestions and recommendations.

Current State of Gambling Treatment Services in Massachusetts: Goals

As just mentioned, observations related to three primary goals compose this component of the gap analysis: first, *identify the gambling treatment services currently available in Massachusetts and their relationships to each other*; second, *identify the client entry points to gambling treatment services*; and third, *assess current state of data systems & interagency communication*. The sections immediately following provide additional detail for each of these goals.

(1) Identify the gambling treatment services currently available in Massachusetts and their relationships to each other.

Gambling treatment services in Massachusetts occur in a variety of settings. According to the *Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts* (Massachusetts Technical Assistance Partnership for Prevention [MassTAPP], 2016), the majority of treatment occurs "within independent practices or outpatient services." In addition, that plan indicates that at the time of the report, in April 2016, Massachusetts had certified 140 service providers as Massachusetts Problem Gambling Specialists (MA-PGS) to provide gambling treatment services. Related information available from the Strategic Plan, through the Massachusetts Council on Compulsive Gambling (MCCG), and via the Bureau of Substance Abuse Services (BSAS) varies somewhat in its terminology and the content provided. Therefore, an initial goal of this Current State of Services portion of the Gap Analysis was to *identify the gambling treatment services currently available in Massachusetts and their relationships to each other*.

To achieve this goal, we integrated data available from BSAS, the Office of Problem Gambling Services (OPGS), and MCCG, as well as responses to e-surveys with OPGS and MCCG to generate a comprehensive list of (a) BSAS-contracted gambling treatment providers in the state, (b) BSAS-contracted treatment providers that also are used as referrals for MCCG, (c) any other gambling treatment providers listed as resources by MCCG, and (d) all MA-PGS trained providers in the state. In this document, we describe the relationships between these groups, as well as the geographic distribution of these services, and the training requirements for organizations and providers wishing to provide gambling treatment services. In addition, as part of the survey of program directors, which we describe later, we included questions for gambling program treatment directors about the gambling treatment services their programs provide and the number of clients who engage in treatment. This document, therefore, also provides a description of the types of services provided within gambling treatment programs in Massachusetts.

(2) Identify the client entry points for gambling treatment services.

Given that gambling treatment services represent a small proportion of services licensed by BSAS, a key element to understanding the current state of gambling treatment services is understanding how these gambling treatment services are nested within the larger BSAS system. Therefore, the second key goal of this analysis was to identify the client entry points for gambling treatment services.

To achieve this goal, we integrated the list of gambling treatment services, described above, with a database of all BSAS-licensed service programs and the services those programs provide. This integration allowed for an examination of the geographic availability of gambling treatment services throughout the state compared to other BSAS services, as well as gambling opportunities. In addition, as we describe later, we surveyed all BSAS-affiliated program directors about screening and referral practices for gambling disorder at their organizations. Finally, through a structured e-interview, follow-up conversations, and Helpline data from MCCG, we documented current MCCG practices for referring clients with gambling problems to services.

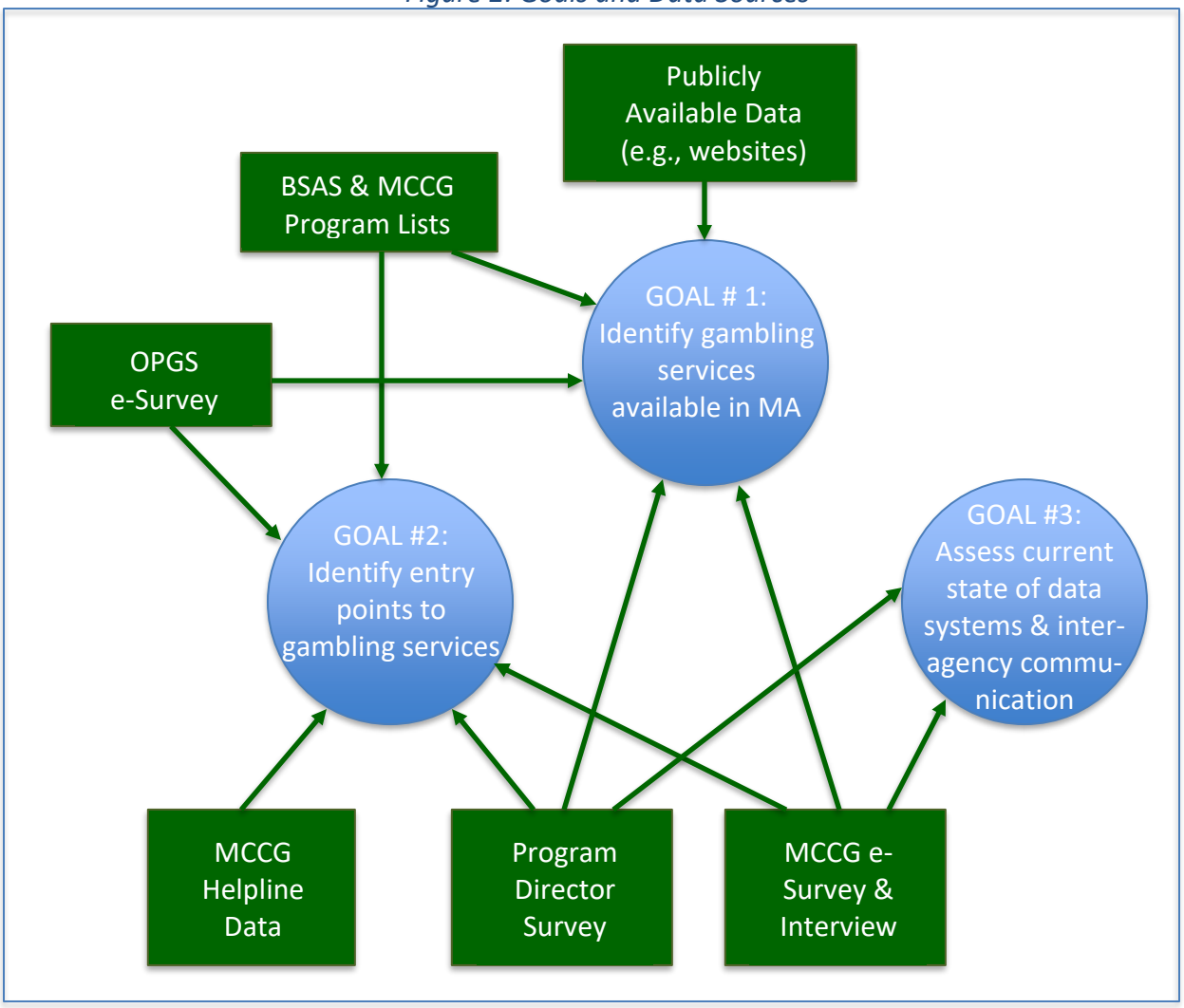
(3) Assess the current state of data collection and sharing systems, referral processes, and inter-agency communications as they relate to gambling treatment services.

One important tool for improving the availability and visibility of gambling treatment services is the set of data systems and processes connecting those services to each other and to other agencies and systems that might offer service entry points. Therefore, the third goal of this analysis was to document the current state of data collection and sharing systems, referral processes, and interagency communications as they relate to gambling treatment services.

To achieve this goal, we included questions within our survey of program directors inquiring about referral practices, data sharing, and existing databases. We also interviewed MCCG staff about the current referral and data collection systems in place for the Gambling Helpline.

Figure 2 depicts which data sources we used to inform each of the three goals of this report.

Figure 2: Goals and Data Sources



Current State of Gambling Treatment Services in Massachusetts: Data Sources

Publicly Available Data

Publicly available data helped to inform our understanding, description, and further inquiry about the state of gambling treatment services in Massachusetts. Specifically, we accessed resources available from the OPGS website (https://www.mass.gov/orgs/office-of-problem-gambling-services), as well as resources available from the MCCG website (https://masscompulsivegambling.org/). Available on the OPGS website, the *Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts* (Massachusetts Technical Assistance Partnership for Prevention [MassTAPP], 2016) provides general information about the state of gambling treatment services as of April 2016, including BSAS-contracted services and MA-PGS certified service providers. Likewise, the MCCG website includes a link to "Outpatient Treatment Centers;" this list identifies 16 BSAS-contracted treatment centers that provide services to people with gambling problems, and three "other" treatment centers. This list can be accessed at two different locations on the website: one at https://masscompulsivegambling.org/get-help/outpatient-treatment-centers/ and one at https://masscompulsivegambling.org/resources/outpatient-treatment-centers/. These lists are identical, and each also links to a PDF version of the list that differs slightly from the list provided on the website. The PDF version is dated 12/7/16 and includes 17 organizations instead of 16. The website also includes a list of 16 private practice clinicians who have received their MA-PGS certificate to provide gambling treatment. This webpage has two links to PDFs listing private practice clinicians. The link at the top of the page provides the 2016 list of 14 private practice clinicians, and the link at the bottom provides the 2016-2017 list of 15 private practice clinicians. We combined the information on the lists available from the MCCG website to create a list of 17 BSAS-contracted outpatient treatment centers, 3 "other" treatment centers, and 17 private practice clinicians referenced by the MCCG website. Later, we incorporated an updated, not publicly available, 2018 private practice list shared with us via e-mail to this list, which increased the number of private practice clinicians from 17 to 21.

OPGS and MCCG e-Surveys and Interviews

To provide a review of the current state of gambling treatment services in Massachusetts, we first had to define the scope of that review and define the universe of service providers who will be the target of this MA gambling treatment services gap analysis. In addition, information available through the OPGS and MCCG websites varies somewhat in its terminology and the content provided. Therefore, we conducted a structured e-survey with OPGS to clarify the gambling treatment services to be reviewed as part of this analysis and their relationships to each other. OPGS completed the e-survey on December 26th, 2017. In addition, a meeting with BSAS on December 21st, prior to OPGS completing the survey, provided additional responses to some of these questions. The e-survey and the OPGS responses are attached as Appendix A.

Responses OPGS provided to the survey suggested that some questions were better answered by MCCG. Therefore, we created a similar e-survey for MCCG to complete. That survey and MCCG's responses are attached as Appendix B. MCCG responded to the survey on February 15th, 2018 and followed up with telephone conversations on July 10th and August 9th to clarify their responses.

MCCG Helpline Data

To inform our investigation of entry points to MA gambling treatment services, we worked with MCCG to obtain information about the Gambling Helpline, particularly procedures for making referrals and information about how many referrals the Helpline makes, and to where. We conducted a telephone interview with MCCG to capture information about the Helpline generally, and more specifically about the referral procedures. We also requested and received MCCG's most recent report to OPGS about the Gambling

Helpline, *Massachusetts Council on Compulsive Gambling FY'18 Annual Helpline Report* (Massachusetts Council on Compulsive Gambling, 2018). This report included information about number of Helpline calls, geographic location of those calls, and number of referrals made by the Helpline.

BSAS & MCCG Program Lists

In addition to the lists of outpatient treatment centers and private practice clinicians available from the MCCG website, we requested and obtained information about agencies providing BSAS-licensed substance use services, including address, type of service, and whether that service was BSAS-contracted. BSAS also provided us with its list of agencies contracted with BSAS to provide outpatient gambling treatment services. The lists provided were current as of December 1st, 2017. MCCG supplemented these lists by providing us with a database of providers who have received their MA-PGS certification, including date of certification and affiliated agency. We used these lists to create a master database of programs organized both at the level of the organization and individual site, and sortable by service type provided. We identified 137 organizations and 395 service sites. Twenty-nine of those organizations and 45 of those sites were listed by either BSAS or MCCG as providing gambling treatment services.[1] An additional organization was listed by MCCG as providing gambling treatment services at one location but this site was not affiliated with BSAS. Appendix C provides a consort diagram of organizations and sites and a list of organizations providing gambling treatment services at one or more sites.

Program Director Survey

To learn more about the gambling treatment services provided by gambling treatment agencies, as well as the procedures in place at BSAS-licensed substance use service agencies for identifying and referring individuals with gambling problems to appropriate services, we developed a survey to be sent to BSAS-licensed program directors throughout the state. The survey, included as Appendix D, had subsections for all BSAS-licensed programs, for programs that also provide gambling treatment services, and for programs that do not provide gambling treatment services. All program directors answered questions about the populations their programs serve, the number of providers at their program, data-sharing practices, and what BSAS could do to help them be better prepared to help individuals with gambling problems. Program directors at programs that do not provide direct gambling treatment services answered questions about their screening and referral practices for clients with gambling problems. Program directors at agencies that provide gambling treatment services answered questions about how their programs screen and assess for gambling disorder, how many clients their programs see, services their programs provide, and how their programs receive referrals.

To distribute the survey, we sent OPGS a copy of the master database of programs (n=396) we created, organized by site. We requested email contact information for the program directors at each site. OPGS provided us with contact information for program directors at 292 sites, 33 of which were listed by either OPGS or MCCG as providing gambling treatment services. We sent an email inviting these 292 directors to complete the survey by clicking on a link. Eighteen of the email addresses provided came back as undeliverable, yielding a final pool of 274 program directors who were invited to complete the survey. OPGS sent a reminder email in the middle of June. We also called all program directors at programs that provided gambling treatment services to encourage them to complete the survey. After cleaning the data and removing duplicate and blank surveys, our final sample for the program director survey included 180 program directors (66% of the 274). Twenty-five of these 180 respondents were program directors at

[1] As indicated in our list of recommendations, we encourage the OPGS proactively maintain this integrated master database for gambling services in Massachusetts, and the MCCG use this database as its primary source for referrals moving forward.

programs listed by BSAS or MCCG as providing gambling treatment services (76% of the 33 for which OPGS provided contact information). An additional 19 reported that their programs were licensed by BSAS to provide gambling treatment services even though they did not appear on the original gambling service list provided by BSAS. Appendix C provides a consort diagram of these programs.

We matched the survey responses to the programs in our database to combine information obtained from the survey with information we already had about the program. There were some ambiguities in this matching process because program directors did not always identify their programs using the same program names we had in the database and the survey was otherwise anonymous. Appendix E includes a document detailing the procedures we used to match the data. Appendix F includes information about the distribution of responses to the survey and the subsamples we used for analysis.

Current State of Gambling Treatment Services in Massachusetts: Observations

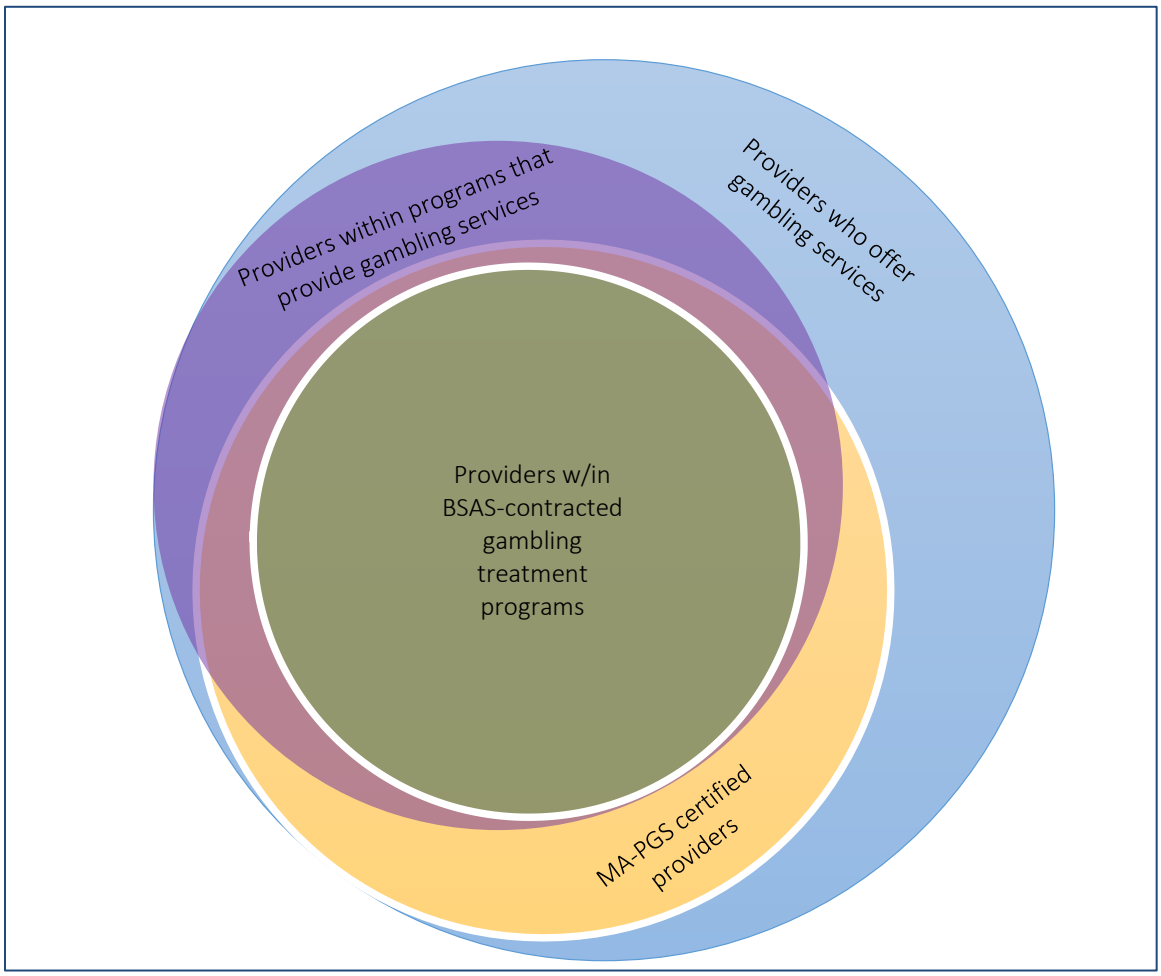
Identifying Gambling Treatment Services Currently Available in Massachusetts

According to the *Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts* (Massachusetts Technical Assistance Partnership for Prevention [MassTAPP], 2016), the majority of gambling treatment within Massachusetts occurs "within independent practices or outpatient services." The current report addresses both groups, relying on information from OPGS and MCCG to identify agencies that provide outpatient gambling treatment services, and information from MCCG about private practice clinicians who have been certified via the MA-PGS to provide gambling treatment services. Missing from this analysis are private practice clinicians who do not have MA-PGS certification but nonetheless provide gambling treatment services. Also missing are substance use and mental health programs, clinicians, and counselors who do not provide dedicated gambling treatment services but address gambling problems as part of the counseling and therapy they provide. To illustrate what the current analysis does and does not cover, Figure 3 provides a theoretical diagram of dedicated gambling treatment services in Massachusetts, with white borders outlining the scope of the current assessment.

The exact number and composition of BSAS-contracted gambling treatment programs is unclear. The director of the OPGS reported in the e-survey that, as of December 2017, there were 39 BSAS-licensed outpatient centers that had been awarded contracts to provide gambling treatment services. However, the list of BSAS-contracted gambling treatment services provided to the Division as of December 2017 indicated that only 27 organizations provided BSAS-contracted gambling treatment services at a total of 43 sites. (As the Figure and Table in Appendix C show, the overlap between organizations and sites might account for the differences in counts.)

For BSAS-contracted centers, a funding source known as the "gambling blanket" allows the Massachusetts Department of Public Health (DPH) to serve the payer of last resort for gambling treatment services. To provide gambling treatment services within these organizations or in private practice, providers receive a Massachusetts Problem Gambling Specialist certificate once they have attended a training program provided by MCCG. To keep their certification active, they must complete training every two years.

Figure 3: Scope of Current Assessment of Gambling Treatment Services in MA. (White outlines demarcate targets of the current analysis.)



Note. Not pictured: providers and organizations who address gambling problems as part of more general substance use or mental health counseling or therapy.

Provider Certification: Massachusetts Problem Gambling Specialist (MA-PGS) Training

To receive a BSAS contract to provide gambling treatment services, treatment programs must have at least one provider who has received MA-PGS certification.[2] However, this certification is not required to

[2] MCCG-provided training to receive a MA-PGS certification occurs each year during MCCG's Training Institute, a four-week program that meets twice a week for 4 hours each session. According to the MCCG, the 32-hour course includes training in: introduction to problem gambling; working with special populations; gambling disorder assessment and diagnosis; co-occurring disorders; evidence-based treatments for gambling disorder; recovery supports; and problem gambling prevention. At the completion of the 32-hour course, individuals meet the requirements for a MA-PGS certificate and can be listed in the MCCG referral database. Alternatively, providers can submit proof of 30 CEU hours of gambling-specific training outside of MCCG's training program to qualify for a MA-PGS certificate. To maintain their MA-PGS certificate, providers must complete 15 hours of training once every 2 years. This can be completed by attending trainings at MCCG's annual conference, any of MCCG's 1-day regional trainings that occur throughout the year, or 15 hours of any other gambling-specific CEUs. In addition, for both initial certification and renewal, providers must provide documentation of clinical supervision specific to gambling or addiction.

offer gambling treatment in private practice or at organizations not contracted by BSAS to provide gambling treatment services. The exact number of MA-PGS certified practitioners is unclear and appears to be changing. As of 2016, according to the *Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts* (MassTAPP, 2016), there were 140 service providers in Massachusetts who had been MA-PGS certified. As of spring of 2018, MCCG databases indicated that there were 166 service providers who had received an MA-PGS. As of June 2018, MCCG recognizes 134 providers in Massachusetts with a current MA-PGS certificate (personal communication, Yvonne Andrews, July 2018). According to the MCCG, much of this change is likely related to clinicians who have moved away from the New England region (personal communication, Yvonne Andrews, July 2018).

The majority of providers with a MA-PGS certificate are affiliated with outpatient treatment centers (n=114, 85%); only 20 (15%) are in private practice. At the time of this report, the MCCG website does not yet include this updated list of 20 private practice providers.

Geographic Distribution of Gambling Treatment Services

Plotting the distribution of gambling treatment services can help identify regional gaps in services. In the section that follows, we refer to Figures 4-8, which plot these services with respect to BSAS-affiliated substance use programs, gambling venues, lottery sales, and enrollments in the MA Voluntary Self Exclusion Program. Because of the size of these figures, we have grouped them together at the end of this section. Table C1, in Appendix C, also provides a list of organizations providing the gambling treatment services, including (1) organizations that have contracts with BSAS to provide gambling treatment services, and (2) organizations that do not have BSAS contracts, but are listed by MCCG as providing gambling treatment services. In addition to the organizations listed in Appendix C, Figures 4-8 also include private practice providers who have MA-PGS certification.[3]

Geographic Dispersion of Gambling Treatment Sites and Gambling Venues

As can be seen by the purple markers in Figure 4, these gambling treatment services are distributed throughout the state. This Figure also includes all BSAS-affiliated substance use programs, represented by yellow markers. There are obviously more substance use programs than gambling treatment programs, but, in general, the distribution of gambling treatment services across the state is similar to the distribution of BSAS-affiliated substance use services. However, there are several clear exceptions to this pattern, particularly in the distribution of services on the Cape and in southeastern Massachusetts, northeastern Massachusetts, north and South of the Massachusetts Turnpike near Interstate 495, and along the Massachusetts Turnpike corridor between Worcester and Springfield. In these areas, gambling treatment services appear scarcer than substance use services.

As Figure 4 also shows, there are 18 gambling venues in Massachusetts and neighboring states. In Massachusetts there are two horse tracks with off-track betting and one proposed horse track in North Lancaster, one category 2 slots-parlor with a racetrack in Plainville, and two resort casinos, MGM Springfield, which just opened on August 24th, 2018, and Encore Boston Harbor scheduled to open during the summer of 2019. In surrounding states there is one casino in Rhode Island, two casinos in Connecticut, six poker room casinos and three poker rooms in New Hampshire. The distribution of gambling treatment sites (i.e., purple markers) in relation to these gambling venues suggests that there are multiple gambling treatment programs available near the sites of the two resort casinos that will open in Springfield and Everett. There

[3] Figures 4-8 include 101 sites and private practice offices that provide gambling treatment services, whereas the table in Appendix C includes 57 organizations, some of which oversee multiple gambling treatment service sites. The numbers are different because a single organization can oversee multiple sites and because the table does not include private practice offices.

are fewer gambling treatment programs available in southeastern Massachusetts and northeastern Massachusetts near out-of-state gambling venues and Plainridge Park casino in Plainville, representing a potential treatment gap with respect to gambling venue availability.

Geographic Dispersion of Outpatient Programs and Private Practice

Figure 5 shows the breakdown of private practice gambling treatment services and outpatient gambling treatment service sites in Massachusetts. There is not much variability in the distribution of these two types of gambling treatment in the eastern half of Massachusetts. The distributions vary somewhat elsewhere. Specifically, there are no outpatient treatment programs within Cape Cod, and no private practice providers in north central and western Massachusetts. This represents a second potential treatment gap with respect to private practice providers, which are the primary referrals made by the Gambling Helpline.

Geographic Dispersion by Lottery Sales

MCCG's FY'18 Helpline Report (Massachusetts Council on Compulsive Gambling, 2018) indicates that among first-time callers, gambling on the lottery is a significant problem. Figure 6 displays total spending on the Massachusetts lottery in 2017 by individual cities and towns mapped alongside available gambling treatment services. As this map shows, total lottery sales are highest (indicated by purple and red on the map) mostly in large urban centers where there is significant coverage by treatment providers. The one exception is Worcester, where there are only two gambling treatment providers, but very high lottery sales. There are smaller clusters of moderately high spending (indicated by orange on the map) in smaller urban areas in Fall River, and New Bedford, Brockton, Haverhill and Lawrence, and Revere. Here potential treatment gaps exist in northern Massachusetts, Worcester, and southeastern Massachusetts with respect to lottery sales activity. Previous research by LaBrie and colleagues has shown that rates of voluntary self-exclusion are a good indicator of the prevalence of gambling problems in a region (LaBrie et al., 2007).

Geographic Dispersion by Voluntary Self Exclusion

In Figure 7, we present the distribution of Massachusetts Voluntary Self Exclusion Program enrollments in Massachusetts between the summer of 2015 and fall of 2017 mapped alongside available gambling treatment services. Cities and towns with no sign-ups are not colored. The range of sign-ups by town of residence ranged from 1 to 11. The map shows most Voluntary Self Exclusion enrollees residing in two areas: major urban centers, and in the region surrounding Plainridge Park Casino. A treatment gap with respect to enrollment location appears to exist along southeastern Massachusetts in Norfolk, Bristol, and Plymouth counties, as well as south of Worcester.

Geographic Dispersion Summary

A full analysis of geographic dispersion is beyond the scope of this document. An extended analysis might include other factors, such as population, income levels, crime, and other risk factors for addiction-related problems. Analyses that take such factors into consideration, or others, might identify different regions. In this preliminary examination, we identified risk areas by examining the availability of gambling treatment services in relation to (1) the distribution of BSAS-affiliated substance use treatment programs,[4] (2) the availability of gambling venues, (3) lottery sales, and (4) Voluntary Self Exclusion enrollment rates to identify areas that might benefit from increased training and services related to gambling. The blue circles in Figure 8 highlight regions of the state, in a 50-mile radius, where BSAS might consider increasing the availability of gambling treatment services (e.g., through targeted recruitment of existing BSAS-affiliated

[4] We consider the availability of substance use programs in a region as a proxy for addiction-related problems in that region. This assumption presumes that BSAS-affiliated substance services represent an established infrastructure that reflects treatment need in an area.

substance use treatment sites). Table 1 presents our assessment of the characteristics of each circled region.

Table 1. Potential Regional Gaps in Gambling Treatment Services

Region Circled in Figure 8	Availability of Gambling Services in Relation to Substance Use Services	Proximity to Gambling Venues	Lottery Sales	Voluntary Self Exclusion Enrol-lees
Cape Cod	Very low	Moderate	Moderate	Low
Southeastern MA	Somewhat low	High	Somewhat high	Moderate
Region surrounding Plainridge Park Casino	Somewhat low	Very high	Moderate	High
Worcester & southern suburbs	Low	Moderate	High	High
Northeast MA	Low	Moderate	Somewhat high	Low
North Central MA	Low	Moderate	Somewhat high	Low

Figure 4: BSAS-affiliated Substance Use Programs and Gambling Treatment Programs in MA

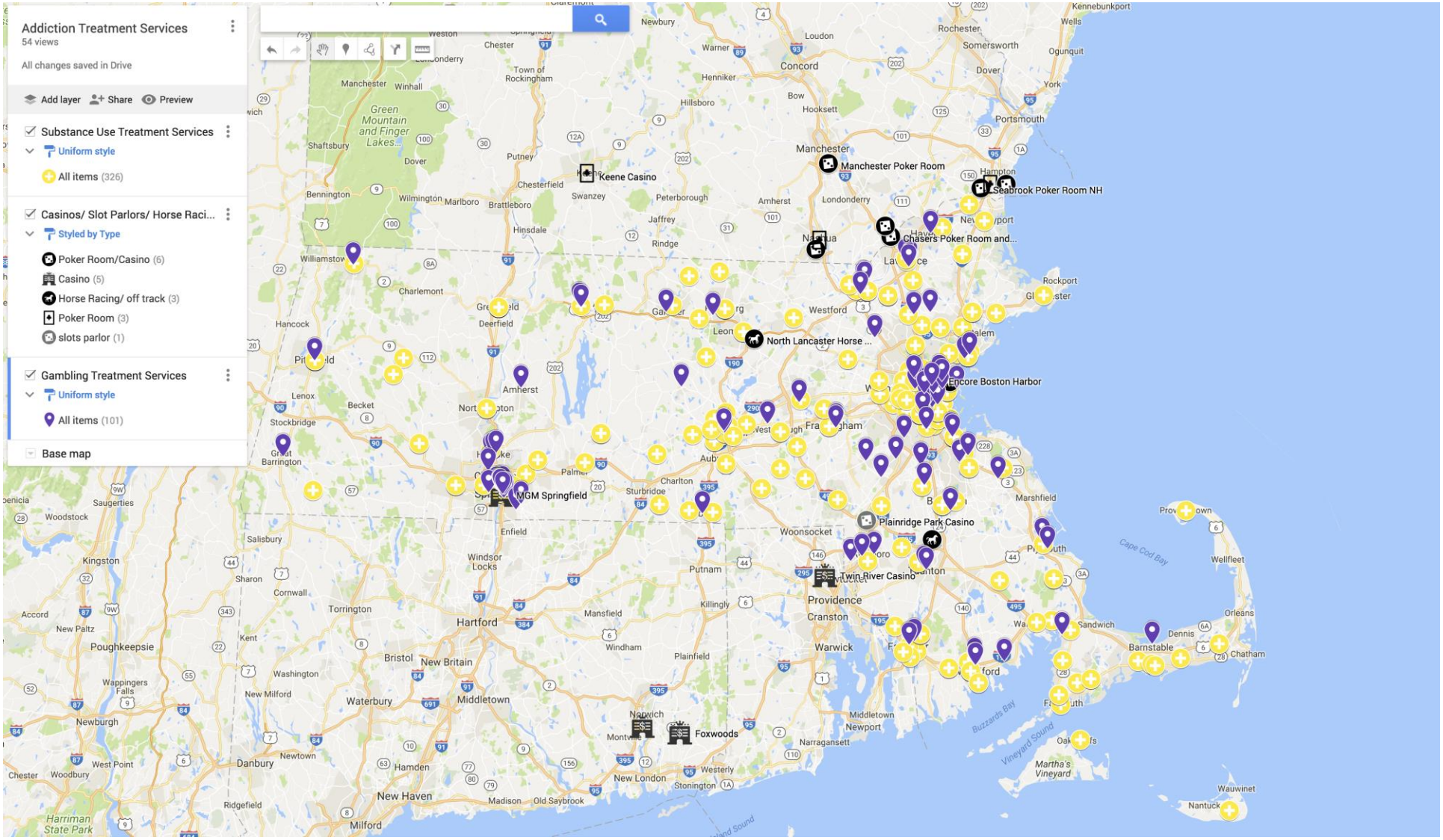


Figure 5: Gambling Treatment Services in MA by Type of Service

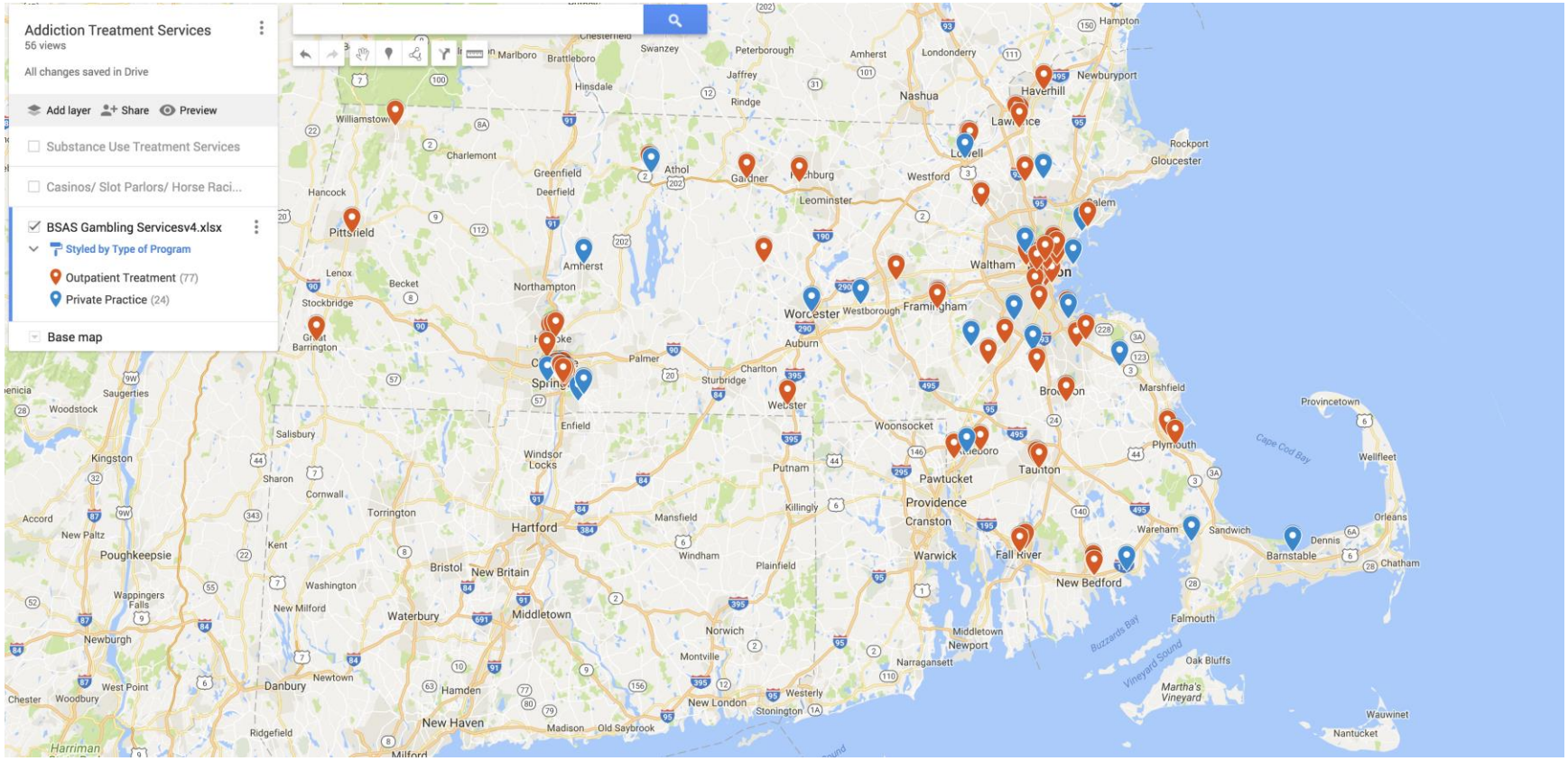
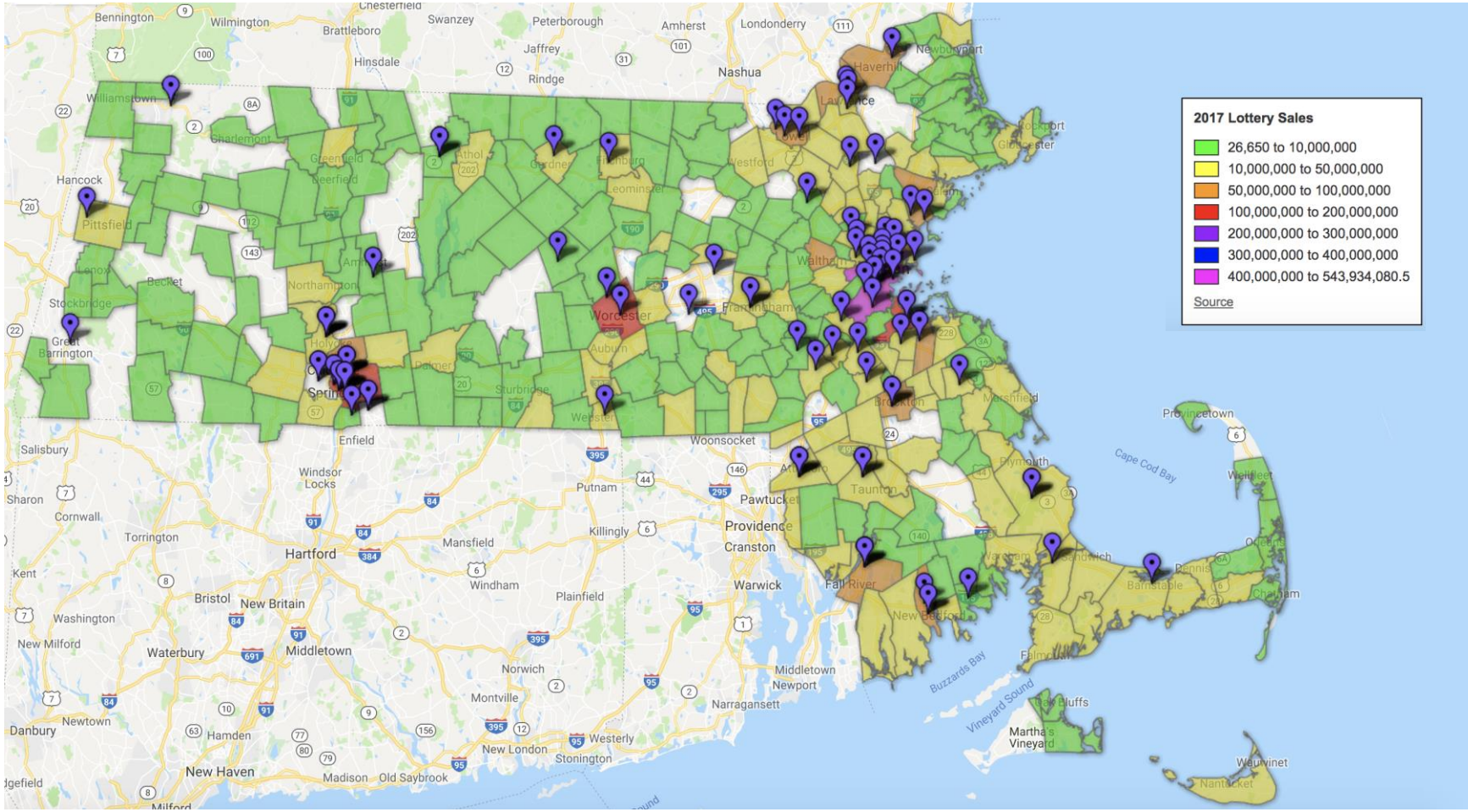
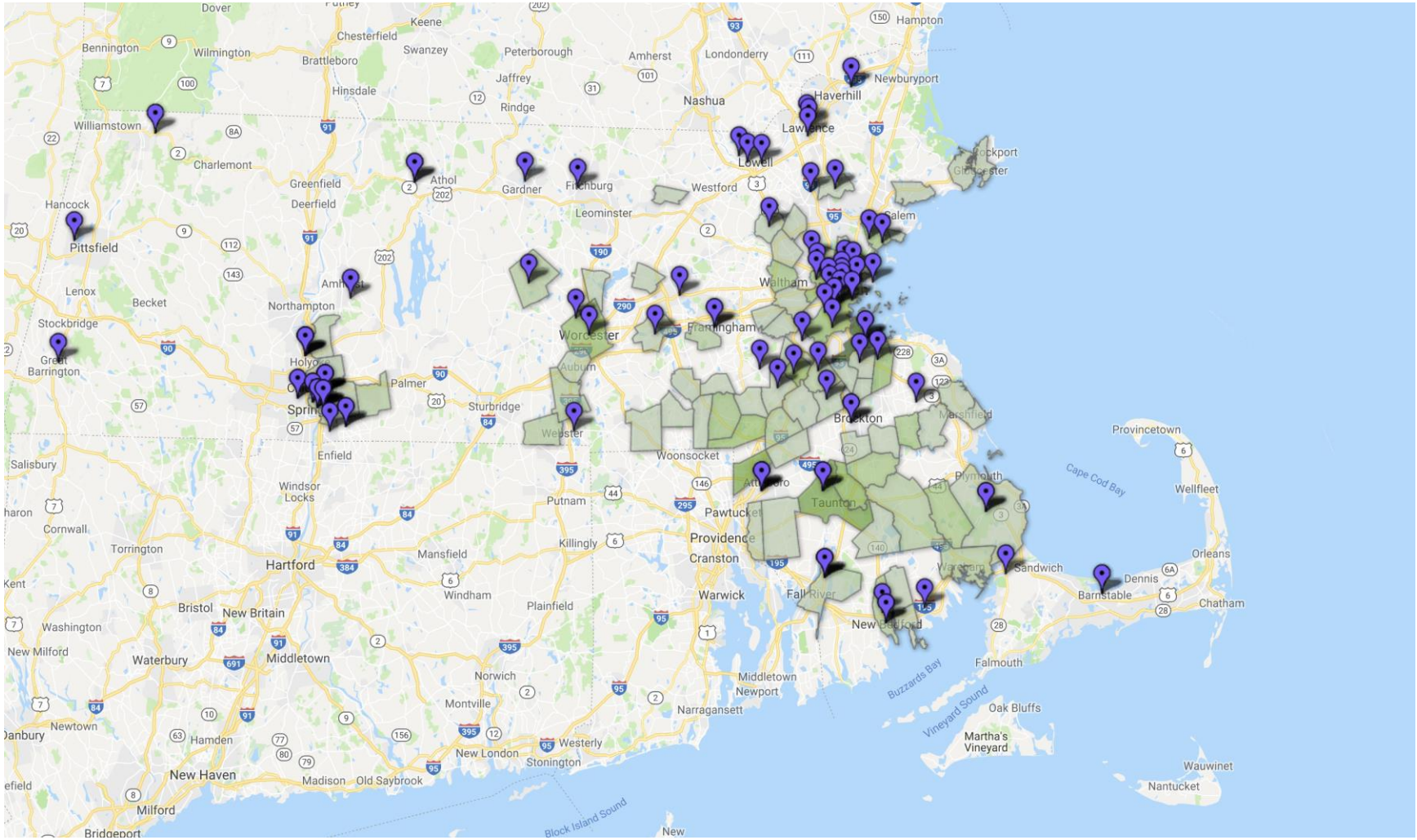


Figure 6: Gambling Treatment Services in MA and 2017 Lottery Spending (Total Dollars)



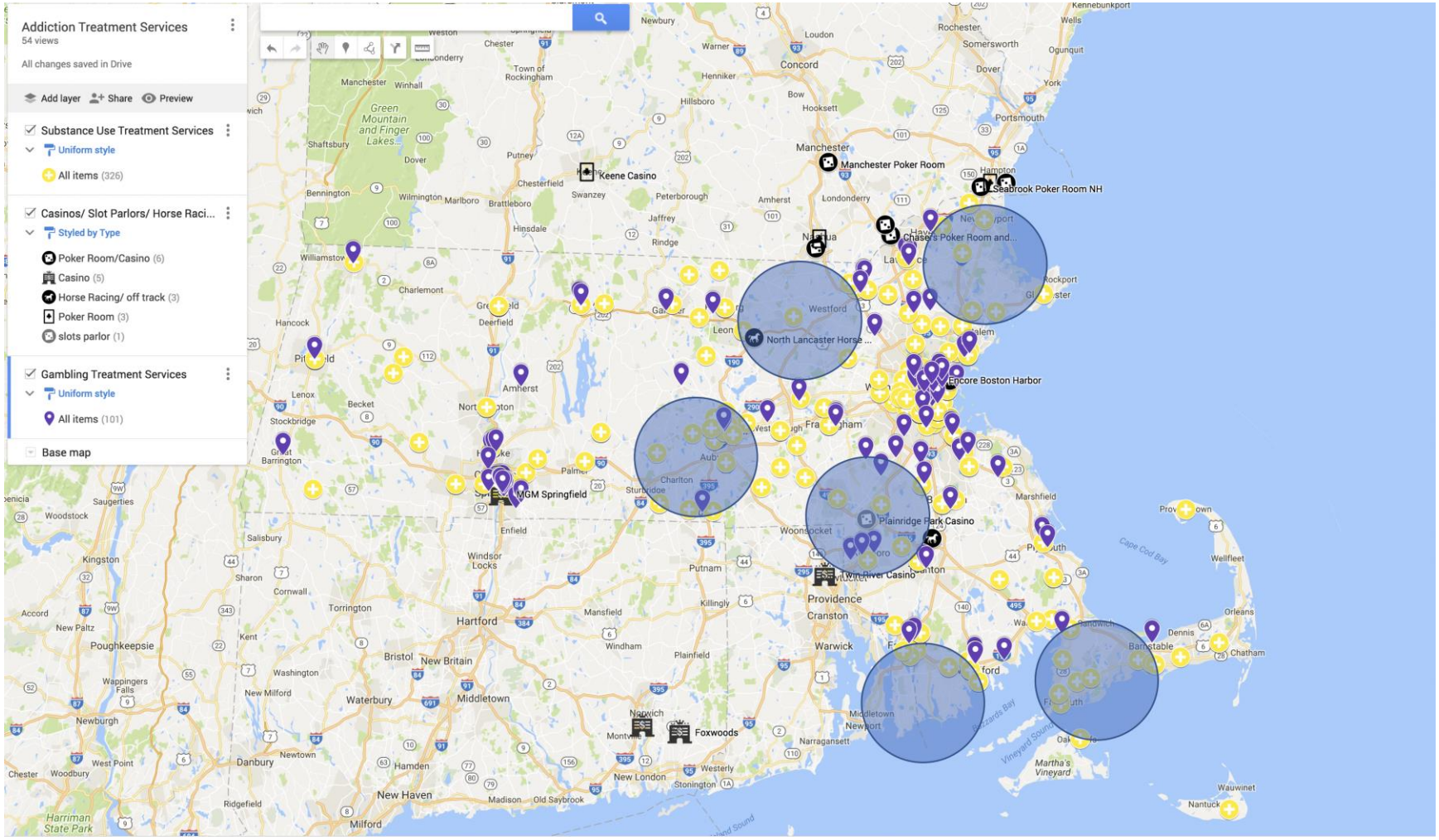
Note. In this map, pins are mapped to the center of the zip codes where they are located, so appear in slightly different locations than in Figures 4, 5, and 8.

Figure 7: Gambling Treatment Services in MA and VSEP Enrollments (2015-2017 enrollments)



Note. Green shapes indicate zip codes where voluntary self-exclusion enrollees reside. Darker green indicates more enrollees. In this map, pins are mapped to the center of the zip codes where they are located, so appear in slightly different locations than in Figures 4, 5, and 8.

Figure 8: Potential Gaps in Gambling Treatment Services in MA



Services Provided by MA Gambling Treatment Centers: Information from the Program Director Survey

Of the 180 respondents to the Program Director Survey, 25 represent programs listed by BSAS or MCCG as gambling programs, but 66 self-reported that their programs provided some form of gambling treatment services (19 of the 25 listed by BSAS or MCCG, plus an additional 47). To describe gambling treatment services provided in MA by BSAS-affiliated programs, we examine data for these 66; however, we include footnotes where results differed for the subset of organizations listed by BSAS or MCCG. The tables in this section also provide information for both the full set and subset of organizations. The number of respondents varies somewhat from question to question because not all program directors answered all questions.

Staff Providing Gambling Treatment Services

The survey asked program directors to indicate how many providers at their program were MA-PGS certified and how many staff provided gambling treatment services. Twenty-three (34.8%) of the 66 programs that reported providing gambling treatment services indicated that one or more of their providers were MA-PGS certified.[5] Among these 66 programs, 37.8% indicated that two or more of their providers provide gambling treatment services, 12.1% indicated that one provider provided gambling treatment services, and 31.8% indicated that none of their providers provided gambling treatment services; 18.3% did not answer the question.[6] These numbers did not overlap perfectly with MA-PGS certification numbers, meaning that some programs had providers who were not MA-PGS certified but still provided gambling treatment, and others had MA-PGS certified providers who were not providing gambling treatment services. These responses also indicate that some of the programs that indicated they provide gambling treatment services on the survey do not actually provide these services; some might have thought of screening as equivalent to providing services.

Screening and Assessment for Gambling Problems

Almost all (i.e., 92.4%) of the 66 programs that indicated that they provided gambling services or had a contract to do so, not surprisingly, screened their client populations for gambling problems. Among those programs that screened, almost all programs (i.e., 59 of 61; 96.7%) screened all of their clients. Only 9 of the 61 programs indicated that in an average month none of the clients they screened received a positive screen for gambling problems. As described in more detail in a later section, these programs that provided gambling treatment services were more likely to have clients screen positive for gambling problems in a given month than other types of programs that screened their clients (86.4% compared to 65.2%), $\chi^2(4, N=128) = 9.62$, $p < .05$. (It is important to note that all of the programs that provide gambling treatment services also provide substance use services, so the client populations they screen are not confined to people with gambling problems.)

Despite high rates of screening for gambling problems among programs that provided gambling treatment services, gambling assessment was more limited. Among the 66 programs that indicated that they provided gambling treatment services or were contracted to do so, only 23 (34.8%) reported that they conducted full assessments for gambling problems. Though this was a higher rate than that reported by programs that did not provide gambling treatment services (i.e., 16.2%; $\chi^2[1, N=165] = 7.66$, $p < .01$), it still

[5] Among programs listed by BSAS or MCCG as providing gambling services (n=25), 60.0% reported that at least one of their providers were MA-PGS certified.

[6] Among programs listed by BSAS or MCCG as providing gambling services (n=25), 40.0% indicated that two or more of their providers provide gambling treatment services, 24.0% indicated that one provider provided gambling treatment services, and 20.0% indicated that none of their providers provided gambling treatment services; 16.0% did not answer the question.

indicates that substantially fewer than half of these programs conduct comprehensive gambling assessments.[7]

The survey asked program directors who indicated their programs used gambling assessment instruments to describe what type of gambling assessment their programs used. Notably, as Table 2 shows, among programs that reported conducting full assessments of clients presenting with gambling problems, many of the listed assessments were screening instruments, not assessments. Other assessments that program directors listed appeared to ask about gambling behavior, not gambling problems or symptoms of gambling disorder. Program directors who listed actual instruments mentioned the Massachusetts Gambling Screen (MAGS) and the South Oaks Gambling Screen (SOGS).

Table 2. Gambling Assessment Instruments Used by BSAS-Affiliated Programs

Program Directors' Description of Gambling Assessments Used in Their Programs	Listed by BSAS or MCCG as providing gambling services	Indicated on survey that program provides or is licensed to provide gambling services
2-page questionnaire relating to types of gambling, age first started gambling, family members history of gambling		✓
All residents entering the program are given the Brief Biosocial Gambling Assessment. If they admit or score as having a gambling problem their counselor will then use the South Oaks Gambling Screen for further assessment.		
An assessment is done at the intake process		✓
Assessment tool, MSDP		
Behaviors related to gambling disorder are added to individualized treatment plans.		✓
Brief assessment tool that is included in the EMR	✓	✓
Brief Biosocial Gambling Screen	✓	✓
BSAS Enrollment Assessment; Gambling Enrollment Assessment; assess gambling history during substance use/addiction assessment	✓	✓
Clients are assigned to the gambling specialist on the team.	✓	✓
Clinical interview; DSM-5 criteria		✓
Comprehensive assessment		
DSM criteria	✓	✓
ESM asks this question and if the client says yes then we use the MAGS screening form.		
Intake screening form	✓	✓
MAGS	✓	✓
MAGS		✓
MAGS		✓
MSDP Adult Comprehensive Assessment	✓	✓
Part of our assessment to ask about gambling and other addictive behaviors		
Provide resources for gambling hotline		
Questions are asked on the intake and enrollment form on what types of gambling someone may do and are asked again in the Psych-Social History Assessment.		✓
Questions in the biopsychosocial assessment; MAGS		✓
South Oaks Gambling Screen; referred to Gamblers Anonymous		✓
South Oaks Gambling Screen; MAGS; Pathways Assessment; IGS	✓	✓

[7] Among programs listed by BSAS or MCCG as providing gambling services (n=25), 47.8% reported that they conducted full assessments for gambling problems among those who screened positive. This is higher than the rate among the larger sample those who reported providing gambling services, but still fewer than half of programs.

Table 2. (cont.)

Program Directors' Description of Gambling Assessments Used in Their Programs	Listed by BSAS or MCCG as providing gambling services	Indicated on survey that program provides or is licensed to provide gambling services
The MAGS		✓
The questions that we ask are integrated directly into our assessment process but then if further assessment is necessary, we use the NORC-SA self-administered screen for gambling problems.		✓
Upon Intake, gambling issues are discussed. If the client self-reports or has documented Gambling addiction, the client's primary counselor formulates a treatment plan with resident on addressing said addiction.		✓
We ask them if they have or ever had a problem with gambling.		
We do the standard BPS which has questions re gambling, and have 2 certified Providers.		✓
We use a gambling Assessment Screen.		
We use an assessment tool in the interview process.		
We use the MSDP Comprehensive Assessment.	✓	
We use Virtual Gateway for all intake assessments. If "Yes" is selected for a history of gambling, the system will then ask a series of questions regarding methods and frequency of gambling.		
We utilize our Comp assessment and document their gambling usage/how often/what type		
Within the biopsychosocial	✓	✓

Gambling Treatment Services

The programs that reported providing gambling treatment services indicated how many clients they treat for gambling problems in a given month. Table 3 displays those results. Most programs reported providing gambling treatment services to one to two clients in a given month.

Table 3. Number of Clients Receiving Gambling Treatment Services

	Listed by BSAS or MCCG as providing gambling services (n=17)	Indicated on survey that program provides or is licensed to provide gambling services (n=54)
# of clients treated for gambling problems in a given month	**# (%) of programs**	
0	3 (17.6%)	11 (20.4%)
1-10	13 (76.5%)	38 (70.4%)
11-20	0 (0.0%)	2 (3.7%)
20+	1 (5.9%)	3 (5.5%)

Note. The groups in the two columns are not independent. The N for each group varies slightly from table to table due to missing data.

These programs also indicated how long the clients they treated generally stayed in gambling treatment. Table 4 displays those results. Most programs indicated clients received treatment for 6 months or less. For the programs that indicated "other" as their response, most indicated that treatment time varied by individual client.

Table 4. Length of Gambling Treatment

	Listed by BSAS or MCCG as providing gambling services (n=17)	Indicated on survey that program provides or is licensed to provide gambling services (n=54)
Average length of time a client spends in gambling treatment	**# (%) of programs**	
1 or 2 sessions	2 (11.8%)	9 (16.7%)
1-3 months	6 (35.3%)	14 (25.9%)
4-6 months	5 (29.4%)	12 (22.2%)
7-12 months	1 (5.9%)	4 (7.4%)
1+ year	2 (11.8%)	2 (3.7%)
Other	1 (5.9%)	13 (24.1%)

Note. The groups in the two columns are not independent. The N for each group varies slightly from table to table due to missing data.

Table 5 indicates the percentage of clients who completed gambling treatment according to survey respondents. Most programs indicated that fewer than half of clients completed gambling treatment.

Table 5. Gambling Treatment Completion

	Listed by BSAS or MCCG as providing gambling services (n=17)	Indicated on survey that program provides or is licensed to provide gambling services (n=53)
% of clients completing gambling treatment	**# (%) of programs**	
0%	1 (5.9%)	3 (5.7%)
1-25%	6 (35.3%)	18 (34.0%)
26-50%	3 (17.6%)	7 (13.2%)
51-75%	4 (23.5%)	5 (9.4%)
76-100%	1 (5.9%)	7 (13.2%)
Unknown	2 (11.8%)	13 (24.5%)

Note. The groups in the two columns are not independent. The N for each group varies slightly from table to table due to missing data.

The programs that reported providing gambling treatment services also indicated the number of gambling treatment clients their program could serve at any given time. Table 6 displays those results.

Table 6. Gambling Treatment Capacity

	Listed by BSAS or MCCG as providing gambling services (n=17)	Indicated on survey that program provides or is licensed to provide gambling services (n=54)
# of clients w/ gambling problems program can serve at any given time	**# (%) of programs**	
0	2 (11.8%)	2 (3.7%)
1-10	5 (25.4%)	16 (29.6%)
11-20	5 (25.4%)	14 (25.9%)
20+	2 (11.8%)	14 (25.9%)
Other	3 (17.6%)	8 (14.8%)

Note. The groups in the two columns are not independent. The N for each group varies slightly from table to table due to missing data.

For the programs that indicated "other", half indicated that their programs have the capacity to serve as many as needed. The others indicated N/A or did not respond. Only four (7.5%) of the programs that reported providing gambling treatment services indicated that their programs had a waitlist for those services. Only one of these programs was listed by BSAS or MCCG as providing gambling treatment services. Three of the four programs indicated that an average stay on their waitlist was 1-3 weeks; the fourth, which also was the program listed by BSAS or MCCG as providing gambling treatment services, indicated that their waitlist stay was 1-3 months.

The survey asked program directors who reported providing gambling treatment services to describe the type of services their programs provide. Table 7 displays their responses. Most programs reported individual counseling, and many indicated that their programs integrated gambling treatment with other addiction treatment services.

Table 7. Gambling Treatment Services

Program Directors' Description of Gambling Services Offered in Their Programs	Listed by BSAS or MCCG as providing gambling services	Indicated on survey that program provides or is licensed to provide gambling services
1:1 counseling, treatment planning, information on community-based Gambling addiction fellowships and support groups		✓
Addressed as part of "Addiction" services		✓
Addressed in individual counseling sessions		✓
As a part of our outpatient services, gambling addiction is woven throughout our OP services, MH and SUD.		✓
Brief interventions with referrals to self-help (Gamblers Anonymous)		✓
CBT, DBT		✓
CBT, Motivational Interviewing, addressing underlying PTSD if applicable with EMDR/Cognitive Restructuring/Exposure	✓	✓
Clients who come in seeking treatment for their problem gambling would receive individual outpatient therapy with a clinician trained in addiction treatment, preferably one of our two clinicians who are Certified Problem Gambling Specialists.	✓	✓
Counseling		✓
Counseling services and psychoeducational groups, incorporated into treatment plans		✓
Currently, the numbers of screens that are positive are very low so the treatment is individual with our gambling specialist.	✓	✓
For gambling problems, residents are provided in-house psycho-education and skill-building groups to identify the triggers associated with compulsive gambling, develop coping skills mechanisms to deal with urges to gamble, and education around the neurochemistry/psychological factors that may influence the development of problematic gambling.		✓
GA and Individual Counseling		✓
GA, individual counseling		✓
Gambling & Compulsive Behaviors Group Weekly		✓
Gambling treatment protocols are incorporated into individual therapy when needed. ADAP program includes gambling in group on addiction education.	✓	✓
Group and individual therapy	✓	✓
Group work		✓
Groups, 1 on 1 counseling, outside therapy		✓
Groups, individual therapy	✓	✓
Incorporated in individual counseling sessions		✓

Table 7. (cont.)

Program Directors' Description of Gambling Services Offered in Their Programs	Listed by BSAS or MCCG as providing gambling services	Indicated on survey that program provides or is licensed to provide gambling services
Individual	✓	✓
Individual and group treatment; acupuncture clinic	✓	✓
Individual case management		✓
Individual counseling	✓	✓
Individual Counseling and referrals	✓	✓
Individual counseling services, skills building, DBT, Family Therapy, psycho-education		✓
Individual counseling services; educational groups		✓
Individual counseling to address gambling addiction, as part of dual diagnosis treatment- must have underlying substance abuse/ addiction issues		✓
Individual Counseling, Group Counseling, Case Management, and Referrals		✓
Individual therapy	✓	✓
Individual therapy		✓
Individual therapy		✓
Individual therapy with a gambling specialist	✓	✓
Individual therapy	✓	✓
Individual/family therapy	✓	✓
Individualized counseling; referral to outpatient counseling and support groups		✓
Individualized assignments		✓
Individual outpatient	✓	✓
Individual counseling, couples counseling, telephone counseling and support, referral to self-help groups, referral to financial planning and credit repair services	✓	✓
Integrated treatment of gambling use disorder with other addictive and mental health disorders		✓
Location of GA and educational groups		✓
Outpatient counseling and psychoeducation		✓
Outpatient individual counseling and relapse prevention groups (RPG not specific to gambling)	✓	✓
Outpatient therapy in conjunction with mental health and/or substance use disorders		✓
Psychotherapy		✓
Referral		✓
Screening		✓
Treated as an addiction; education, relapse prevention, triggers, GA		✓
We get them to GA as well a therapist who specializes in treating the gambling disorder.		✓
We have a group ready to run.		✓
We offer individual therapy including cognitive behavioral therapy and metacognitive therapy for people with problem gambling. We currently have two full-time staff that are Massachusetts problem gambling specialists.		✓
We provide the psychiatric component of the addiction treatment.		✓

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

Referral for Gambling Treatment Services

Ten of the 54 programs (18.5%) that reported providing gambling treatment services and answered questions about referrals indicated that their programs received referrals from MCCG.[8] Among programs listed on MCCG's website as providing gambling treatment services, 5 of 11 (45.5%) that answered this question reported receiving referrals from MCCG.

Among the ten programs that received referrals from MCCG, 40.0% received fewer than one referral per month, 50.0% received 1-2 referrals a month, and 10.0% received 3-5 referrals a month. Most of these 10 programs (60%) indicated that 1-25% of these referrals eventually received treatment at their program. Twenty percent of these programs indicated that none of the referrals end up receiving treatment with them, and 20% indicated that more than 25% end up receiving treatment with them. Only two of these programs indicated that their programs share any information back with MCCG about these referrals.

Thirteen of the 54 programs (24.1%) that reported providing gambling treatment services and answered questions about referrals indicated that their programs received referrals from other sources. Table 8 lists the sources of these referrals reported by the surveyed programs.

Among the thirteen programs that received referrals from other sources, 8.3% received fewer than one referral month, 50.0% received 1-2 referrals a month, 25.0% received 3-5 referrals a month, and 16.7% received 6-10 referrals a month. Slightly more than 40% of these programs (41.7%) indicated that 1-25% of these referrals end up receiving treatment at their program. The remaining 58.3% indicated that more than 25% of these referrals received treatment. Only two of these programs indicated that they share any information back with their referral sources about these referrals.

Table 8. Sources for Gambling Treatment Referrals

Court system, jail, self-referral, probation/parole, referrals from health care providers, hospitals
CSS and TSS
CSS, TSS, DOC
DCF/Probation/Hospitals
Detox, Inpatient, Outpatient, etc.
Internal, external
Just the clients who come into treatment
McLean Hospital, self-referral
Multiple agencies or private practice providers
Other SUD programs
Probation, DCF, residential services
Residential Recovery Homes, Homeless Shelters, EAP programs, colleges and universities

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

[8] Among programs listed by BSAS or MCCG as providing gambling services, 7 of 17 (41.2%) reported receiving referrals from MCCG.

Identifying the Current Client Entry Points into Gambling Treatment Services in Massachusetts

To document how referrals for gambling treatment typically occur within Massachusetts, we analyzed information from the MCCG about the Helpline and their referral process, as well as information from the Program Director Survey about how BSAS-affiliated programs that do not provide gambling treatment services screen and refer their clients.

MCCG Helpline Referrals

The MCCG receives funding from the Massachusetts Department of Public Health to manage a 24-hour, 7 day a week problem gambling helpline (Helpline). The Helpline, started in 1987, is funded each year in the State budget through a portion of the State's unclaimed lottery winnings. The objective of the Helpline is to provide callers with emotional support, information such as self-help and linkages to community resources, and referrals for treatment. Callers are most often problem gamblers, but about 25% are concerned family members and 5% are treatment providers (Massachusetts Council on Compulsive Gambling, 2018). In addition to calls for help, since FY'14 the MCCG also has provided similar help through an online chat available at their website; however almost all of the contacts to the Helpline (i.e., 99%) are by telephone.

To support this work, MCCG maintains a referral list of providers who treat gambling disorder in Massachusetts. MCCG includes on its list outpatient treatment facilities and private practices with at least one provider who has completed their MA-PGS training in the past two years.

According to MCCG, after identifying what support they can provide those requesting help, Helpline staff ask them a few questions to get a better understanding of the population that is seeking help. For those that seek help through online chat, they answer these same questions during chat registration before they speak with Helpline staff. Those seeking help answer questions about their, age, gender, marital status, why they are contacting the Helpline, race/ethnicity, how they learned about the Helpline, primary and secondary types of gambling, disability status, current living situation, ever or current homelessness, and Veteran status. This information allows Helpline staff to provide more personalized help. Finally, callers provide their city and zip code so that Helpline staff can share with them a list of treatment providers in their area. According to MCCG, unless otherwise requested, Helpline staff provide callers with the contact information for local treatment providers in private practices and generally only provide outpatient treatment center contact info upon request (personal communication, MCCG, July 2018). MCCG staff noted that, anecdotally, those who request outpatient sites often will call back and ask about referrals to private practice because wait times are too long (personal communication, MCCG, July 2018).

The Helpline provides callers with a list of treatment providers to contact. It does not help callers call through the list of private practice providers or set up appointments for callers. In addition, there is no system in place for providers to follow-up with MCCG about Helpline referrals, primarily because of concerns around protecting health information and avoiding the potential for HIPAA violations (personal communication, MCCG, July 2018). Therefore, there is no data to report on how many Helpline callers call providers, schedule appointments, or follow through to treatment. However, MCCG Helpline outreach coordinators do complete follow-up calls to check in with previous callers about their needs for materials and resources.

According to MCCG's Helpline report (Massachusetts Council on Compulsive Gambling, 2018), in FY'18 there were 5 people who reached out by online chat and a total of 778 Helpline calls of which 260 were first time callers. Among first time callers, the counties with the highest number of first time Helpline calls were Essex (20%), Worcester (17%), Middlesex (16%), Norfolk (14%), and Suffolk (12%) counties. In the

previous section on MA-PGS trained clinicians, we identified sections of Essex, Worcester, Middlesex, and Norfolk counties as areas where the number of treatment providers for gambling treatment services appeared proportionately low. This Helpline call data supports our recommendation that these areas require additional attention and support to expand their capacity for gambling treatment services.

Client Entry Points to Gambling Treatment Services: Information from the Program Director Survey

Earlier in the report, we presented information about screening and assessment among the programs that provide gambling treatment services to their clients. In this section, we discuss screening and assessment, as well as referral practices, among those programs *that do not provide gambling treatment services*. This analysis allowed us to better understand how prepared other BSAS-affiliated programs are to begin to identify and refer clients who present with gambling problems. Of the 180 respondents to the Program Director Survey, 114 indicated that their programs did not provide any gambling treatment services.[9] Among those 114, 38 directed outpatient programs and 76 directed other types of programs (i.e., residential, detox, CSS, TSS). We examine screening, assessment, and referral practices for the entire sample of 114, but also for the outpatient programs separately, because these programs are the most likely source for referrals to gambling treatment services.[10].

Screening and Assessment for Gambling Problems

Three quarters (i.e., 75.4%) of the programs that do not provide gambling treatment services reported screening their clients for gambling problems. Though this is fewer than the 92.4% of programs that provide gambling treatment services, $\chi^2(1, N=180) = 8.06$, $p < .01$, it still represents a decided majority of the programs that completed the survey.

Outpatient programs and other programs were equally likely to screen their clients for gambling problems, $\chi^2(1, N\text{-}114) = 0.94$, p = ns; however, among programs that screened, outpatient programs were less likely than other programs to screen all of their clients (82.8% compared to 96.4%), $\chi^2(1, N=84) = 4.60$, $p < .05$.

Among programs that indicated screening their clients for gambling problems, but do not screen all of their clients, respondents provided the following information about how their programs determine whom to screen, presented in Table 9.

Table 9. How Programs Determine Which Clients to Screen for Gambling Problems

The question is on our intake form, but not all of our providers specifically address it.
The completion of a comprehensive assessment
If they present with an addiction issue
If they are in a substance use disorder program and not just behavioral health
If a client reports substance use, then a substance use risk assessment is administered. Embedded into this risk assessment are questions asking about gambling addiction.
Clients who are court ordered or have a substance use diagnosis
Client report

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

[9] As noted earlier, a larger number (i.e., 155) are not listed by either BSAS or MCCG as providing gambling services. However, in this section we focus on the 114 who specifically indicated that they did not provide gambling services.

[10] In inpatient or crisis stabilization settings, though a client might present with a gambling problem, other services often take priority, such as medication assisted treatment.

Program directors also indicated how many clients their programs screen for gambling problems and how many screen positive. These numbers were indicated as ranges (e.g., 1-10). We took the average of each range and divided the number of positive screens by the number of clients screened for each program. We also created tables showing the actual ranges for clients screened and clients screening positive.

Among the programs that do not provide gambling treatment services but screen their clients for gambling problems (n=69[11]), 34.8% indicated that none of the clients they screened received positive screens for gambling problems, 14.5% indicated that 10% or fewer screened positive, 34.8% indicated that 11-75% screened positive, and 15.9% indicated that more than 75% screened positive. Table 10 includes the ranges endorsed for number of clients screened and number of clients receiving positive screens for these 69 programs.

Table 10. Number of Gambling Screens Conducted Per Month by Number of Positive Screens

	# receiving positive screens in a month						
# screened in a month	**0**	**1-10**	**11-20**	**21-50**	**51-80**	**81+**	**Unknown**
0							
1-10	14	11	0	0	0	0	0
11-20	5	12	0	0	0	0	1
21-50	2	11	0	0	0	0	0
51-80	0	3	1	0	0	0	0
81+	1	5	1	0	0	1	0
Unknown	0	1	0	0	0	0	0

Among these programs, outpatient programs were more likely to have clients screen positive for gambling problems in a given month than other types of programs that screened their clients (86.4% compared to 55.3%), $\chi^2(4, N=69) = 10.24$, $p < .05$.

Sixteen (14.0%) of the 114 programs that do not provide gambling treatment services indicated that their programs conducted full assessments for gambling problems for clients who screened positive.[12] Outpatient and other types of programs were equally likely to conduct gambling assessments.

Referrals to Gambling Treatment Services

Of the 93 programs that did not report providing gambling treatment services and answered the question, 62 (66.7%) indicated that their programs refer clients who present with gambling problems to other programs. This rate did not differ by whether a program was an outpatient program or not. Twenty-six percent of these indicated they refer to GA, 13% indicated they refer to MCCG or a state or national website or helpline, and 48% indicated they referred to other outpatient programs.

Among the programs that referred clients with gambling problems to other services, 42.6% reported referring fewer than one client a month, 44.3% reported referring 1-2 clients a month, and 6.5% reported referring 3-10. The remaining programs were unsure. These rates did not differ by whether a program was an outpatient program or not.

[11] 86 program that do not provide gambling services reported screening their clients for gambling problems; however, only 69 provided information about how many clients they screen and how many screen positive.

[12] 15 respondents from these programs did not answer this question, so the 16 programs represent 14.0% of the 114 programs that don't provide gambling services, but 16.2% of the 99 that answered the question.

About a third (36.1%) of the programs that reported referring clients with gambling problems to other programs indicated that their programs had a way to know whether the clients they referred received services. Most of these programs indicated this was accomplished through a release of information and follow-up.

Process for Handling Clients with Gambling Problems in Programs That Do Not Provide Gambling Treatment Services

Eighty-four of the programs that did not report providing gambling treatment answered a question about how the program deals with clients who present with gambling problems. Table 11 presents the program directors' answers and also indicates whether the response came from an outpatient program. These programs' responses were quite varied, but most indicated that their programs would address the gambling problem as part of the client's treatment plan, integrated with the other addiction services the client received. Some programs reported that they had never had a client with gambling problems and a few noted that their client population *didn't* experience gambling problems. Many programs indicated that their programs refer these clients elsewhere.

Table 11. Process for Handling Clients with Gambling Problems among Programs That Do Not Report Providing Gambling Treatment Services

Program Directors' Description of How Their Programs Handle Clients with Gambling Problems	Outpatient Program
Address it in the course of other addiction treatment services, i.e., IOP.	✓
Address it in an Individual service plan, and refer to outside treatment/12 step.	
Ask do they see themselves as having a problem in this area; most of the time they all say no.	✓
Ask them to contact BSAS for further assistance. We provide the contact number.	✓
Assess and provide resources.	
Assign to clinician with addiction specialty. Use motivational interviewing, etc.	✓
At this time, we do not offer any services for clients who present with gambling problems.	
Brief BioSocial Gambling Screen and if needed, the South Oaks Gambling Screen with inclusion of GA, AA, twelve step work, addressing financial ramifications, family consequences, as well as legal issues.	
Call SAMHSA's national help line.	
Can address on their treatment plan and recovery counseling.	
Counseling groups as well as referral.	
Create a treatment plan.	
Develop an IAP goal that would target the gambling issue.	
Discuss and process in individual therapy with the goal of increasing their readiness for changing this behavior.	
Discuss Gamblers Anonymous and how to use the program for any addiction.	
Discuss if gambling is part of mania in bipolar disorder.	✓
Discuss in terms of co-occurring disorder and the need to treat both.	
Discuss it in counseling; treatment plan for it, provide resources for clients to access.	
Embrace the 12 step recovery process.	
Give educational materials and helpline information.	
Give information on help that is available, follow up on Individualized Treatment Plans.	
Has never happened.	
Has never happened.	
Have our Clinical Supervisor refer them to the appropriate services.	
Have them participate in the program focusing on recognizing triggers and preventing relapse. Refer to more specific program at discharge if indicated.	
Include in treatment plan.	✓
Incorporate gambling into their other addiction treatments.	
Incorporate into treatment as comorbid condition.	✓
Incorporate it into other addiction services.	

Table 11. (cont.)

Program Directors' Description of How Their Programs Handle Clients with Gambling Problems	Outpatient Program
Incorporate treatment into their substance abuse treatment. Also, what was previously mentioned.	✓
Individual counseling with LCSW and referral.	
Individual therapy.	✓
It is incorporated into their Individual Service Plan.	
It would be in conjunction with substance abuse, as that is what we do. We refer.	
Monitor problem area through discussion in counseling.	
N/A	
None at this time.	
Not a specific intervention.	✓
Nothing at this level of care and length of stay.	
Offer a HLOC. Make additions to the TP or develop a TIP.	
Our I/P has a Gambler's Anonymous Commitment Meeting 1-2 times / weekly. Our IOP focuses on SUD, but incorporates gambling addiction in the program. We do not offer individual counseling.	✓
Place referral.	
Provide referrals.	
Refer.	
Refer.	✓
Refer for gambling services.	
Refer for treatment.	
Refer out.	✓
Refer out.	
Refer out to resources.	
Refer them for additional support.	✓
Refer them out.	
Refer them to counseling or GA.	✓
Refer them to Crossroads.	
Refer them to Stepping Stone.	
Refer them to the Steppingstone Outpatient Clinic.	
Refer to GA.	
Refer to GA.	✓
Refer to GA as well as psych tx.	
Refer to Gamblers Anonymous.	
Refer to self-help, utilize curriculums if clients are interested in addressing.	✓
Refer to the gambling treatment experts.	
Refer to therapist.	
Refer to therapy.	
Referral.	
Referrals and coordination of care.	✓
Screen, refer to needed services, include gambling treatment into service plan.	
Suggest they seek other treatment.	
The women that we serve do not present with gambling problems; they are primarily opiate addicts.	
Therapy, CBT, DBT.	
This hasn't happened most likely because we only treat adolescents.	✓
This is not a primary diagnosis; we provide referral.	✓
Transportation to GA Meetings, referral to specialist.	
Treat the behavior as part of the client's presenting issues, both in individual counseling and group (when appropriate).	✓
Treatment planning, counseling, case management.	✓
Utilize 12-step programming and abstinence.	
We do MAGS screening, they attend Gambling Addiction group and if there are strong indicators for needing more we would refer them for gambling addiction counseling.	

Table 11. (cont.)

Program Directors' Description of How Their Programs Handle Clients with Gambling Problems	Outpatient Program
We do not see gambling issues at this stage of treatment.	
We evaluate and treat minors and gambling problems are rare in our population.	✓
We rarely see this as a clinical need in patients that we interact with. In the event that we did, we would use evidence-based CBT and ACT interventions, or refer out when needed.	✓
We refer to MindCare Agency or other agencies that can help the patients.	
We refer them to GA.	
We would refer them out and address utilizing coping skills to effectively manage their spending habits and include it in their treatment plans.	
Work on it in counseling and Tx plans.	
Would seek services in the event a client was assessed with a gambling problem.	

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

Assessing the Current Data Systems and Inter-Agency Communications for Gambling Treatment Services in Massachusetts

According to *Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts* (Massachusetts Technical Assistance Partnership for Prevention [MassTAPP], 2016), there is no streamlined and integrated screening, referral, and reimbursement process for problem gambling treatment services. Our investigation confirmed this statement.

Information and Access

At a basic level, examination of publicly available information about gambling treatment services indicates some level of inconsistency and, potentially, a lack of updated resources. For example, as noted in the Data Sources section of this report, the lists of outpatient gambling treatment centers and private providers available on the MCCG website vary from link to link. In addition, the MCCG's list of 16-17 outpatient centers that contract with BSAS does not include all of the programs with which BSAS contracts. The source of such discrepancies is undetermined. However, as noted in the previous section on Helpline referrals, MCCG referrals tend to be confined to their list of private practice MA-PGS trained clinicians because of concerns about potential waitlists at outpatient centers.

From the BSAS website, it is possible to access the website for the Massachusetts Substance Use Helpline and search for services. One of the options is to search for gambling treatment services. However, every possible search produces one of two outcomes: (1) no results; or (2) two programs that are plotted as being located in downtown Boston on the map: the MCCG (actually located in Norwood), and the Gavin Foundation Center for Recovery Services (actually located in south Boston). The search database does not include any of the other available gambling treatment services in the state.

Data Sharing and the Gambling Helpline

As noted in the previous section on Helpline referrals, the Gambling Helpline is not set up to collect data systematically about whether its referrals are fulfilled. It does follow up with callers, when possible, but does not have systems in place to communicate with providers about referrals or track information about which referrals lead to treatment. The MCCG notes that HIPAA concerns are the primary barrier to this type of data collection (personal communication, MCCG, July 2018).

Information Systems and Data Sharing: Information from the Program Director Survey

As reported in earlier sections, only two of the programs that reported providing gambling treatment services indicated that their programs ever share information back with the Gambling Helpline or other

referral sources about clients received through referrals. However, a third of programs that report referring clients with gambling problems to gambling service programs indicate that, through releases and follow-ups, their programs are able to determine whether the clients they refer receive services.

Most programs (i.e., 87.9% of those that answered the question) reported that they did share their data with BSAS, including client demographics and any other information requested by BSAS.

Foreshadowing Future Capacity for Gambling Treatment Services in Massachusetts: Information from the Program Director Survey

BSAS-affiliated programs that do not provide gambling treatment services answered a few questions about what their programs would need to begin providing such services.

Approximately half of the programs that do not provide gambling services and answered this last set of questions (i.e., 47.7% of 86) indicated that they have space available that could, in theory, be used to host Gamblers' Anonymous meetings.[13] More than 80% of the programs that do not provide gambling treatment services and answered this last set of questions (i.e., 82.4% of 85) indicated that their organization's strategic plan did not include any plan to incorporate gambling treatment services into their programming. Only 3.5% indicated that their strategic plan *did* incorporate the development of gambling treatment services; the remaining 14.1% described plans to incorporate gambling treatment services that were not specified in their strategic plans. A larger percent (42.4%) expressed interest in incorporating the resources needed to begin treating clients with gambling problems into their programs; an additional 31.8% were unsure.

The survey asked programs that do not currently provide gambling treatment services to describe what infrastructure changes or additions the program would need to begin treating clients for gambling-related problems. Table 12 displays program directors' responses. The vast majority of responses indicated that training for staff was the primary barrier to providing gambling treatment services. Program directors also noted the need for additional staff and space. Notably, more than half of these programs (i.e., 62.3%) indicated that their programs provide an annual CEU benefit to providers to support additional trainings.

Table 12. Resources Needed to Begin Treating Clients w/ Gambling-Related Problems

Program Directors' Description of What Their Programs Needs to Treat Clients w/ Gambling Problems	Outpatient Program
A counselor who specializes in Gambling Addiction.	
Add a group if we had a bigger population with a Gambling addiction.	
Add additional training.	
Additional group offerings. Adding 12 step meetings specific to the problem. Ensuring payment from payors for this issue. Adding staff education opportunities to ensure competency of staff providing service.	
Additional information of best practices for this area.	
Additional staff training and curriculum to utilize.	
Additional staffing would be necessary.	
Additional support/resources.	✓
Additional training.	
Appropriately trained staff.	
Certification of at least one counselor; holding groups specific to gambling issues.	
Clinicians would need a comprehensive referral list for outside services.	

[13] None of the percentages presented in this section differed by whether programs were outpatient or not.

Table 12. (cont.)

	Outpatient Program
Contact Lowell House, Inc.: 978 459 8656	
Curriculum resources.	✓
Don't know but likely we need another conference room.	
Educating staff and materials on Gambling treatment specifically.	
Education.	
Funding and staff.	
Hiring more clinician with certification in treating gambling addiction.	
Hiring specialists, developing groups, clinicians going through certification process.	
Identify additional space	✓
Include an assessment (other than the question that is on the BSAS client intake form).	
Increase in certified gambling specialists that are billable.	
Licensing.	
Money, staff, space.	
More certified gambling specialists.	
More material and staff knowledgeable with gambling addiction.	✓
More space, specific training.	
More staff trained in tx of gambling related problems; space.	✓
More training.	
More training.	
Need a curriculum to address gambling.	✓
None	
None	
None	
None	
None	✓
None	
None	
Not sure	
Nothing infrastructure.	
Obtain a better understanding of symptoms, and resources.	
Referral sources, educate staff to the importance.	
Space.	
Space and counselor training.	
Staff education to start.	✓
Staff training.	
Staff training and information on resources.	
Staff training on gambling addictions.	
Staff training, increased client demand for services (based on increased # of clients who identify with gambling-related problems).	✓
Staff who are proficient in treating gambling.	
Staff with specialized education.	
Staffing.	✓
Staffing/physical space.	
This isn't an issue for our population.	✓
This would be an outpatient program, so would not involve our program.	
Train clinicians in process addictions.	
Trained specialists.	

Table 12. (cont.)

	Outpatient Program
Training.	✓
Training and certification for the clinical staff.	
Training the staff about different approaches and modules to address the gambling problem and /or being able to recognize it.	
Training, referrals.	✓
Training. Additional staffing (potentially).	
Training and space.	
Unknown.	✓
Unknown.	✓
Unknown.	
Unsure.	✓
Unsure at this time, though we are focused primarily on growth around substance use and HIV services at this time. We would likely need additional training and additional staffing resources to support such an expansion.	✓
We are an educational program.	
We are fortunate to have a 12,000 sq.ft. facility. With some minor renovation and furnishing cost we could host a program for gamblers.	✓
We do MAT, so we do not provide comprehensive psychiatric or psychological care.	
We would have to create a whole new program.	✓
We would need funding and additional resources. None of our current staff are trained in addressing gambling related disorders so we would need either additional funding for staffing or education.	
We would need to have a certified gambling specialist over there.	✓
We would need to train and certify counselors.	✓

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

Finally, these programs indicated the resources BSAS could provide that would be helpful to them in providing services to clients with gambling-related problems. These responses were similar to those provided in Table 12, so are not reproduced here, but are available in Appendix G. We encourage OPGS to examine the responses in Table 11 closely; there are several specific suggestions program directors made that could be useful (e.g., additional training and advocacy around reimbursement for gambling services; more flexibility around the MA-PGS certification process). Again, training was the most reported need by program directors who completed the survey. Some respondents also listed resources OPGS already provides, such as listings of evidence-based practices.

State of Services Analysis Recommendations

This report provides an overview of the current state of services in Massachusetts that can be used to assess how well-positioned the current system is to adapt to changes in gambling treatment need that might emerge as the Commonwealth expands gambling opportunities within the state. Based on this overview, we offer the following recommendations related to the three areas addressed in the report: (1) the current distribution and provision of services; (2) the current client entry points to services; and (3) the current status of data systems and interagency communication.

Identifying Gambling Treatment Services Currently Available

As noted in the body of the report, there are several areas of Massachusetts where the number of available gambling treatment service providers is lower than one might expect from the distribution of substance use treatment providers. In addition, some of these same areas are near gambling venues or exhibit particularly high lottery spending or voluntary self-exclusion rates.

Based on these examinations, we recommend that, as displayed in Figure 8, BSAS focus any gambling treatment service expansion efforts on the Cape, southeastern MA, and Worcester and its southern suburbs.

We identify these three areas in particular because they had disproportionately fewer gambling treatment services than substance use services. The Cape had the fewest gambling treatment service programs of any region, southeastern MA includes Plainridge Park Casino, and the area south of Worcester has few gambling treatment services despite encompassing the suburbs of a large city and having high lottery sales and enrollees in the MA Voluntary Self Exclusion program. Another area that might deserve further attention is northeastern MA, north of Boston. Northeastern MA has fewer gambling treatment services than expected based on the number of substance use treatment programs available and per the MCCG annual report (Massachusetts Council on Compulsive Gambling, 2018), includes more Helpline (not mapped) callers than other regions. Given the considerable infrastructure of substance use treatment programs throughout the state, we recommend that gambling treatment service expansion might occur most efficiently and be most accessible if organizations that manage current substance use programs are trained to provide these services. Organizations that provide other behavioral health services might also be well-poised to establish gambling treatment services, but additional research to determine their readiness is needed.

In addition to examining the distribution of gambling services, we also examined the current services being provided. The gambling assessments that programs use and the gambling treatment services they provide currently vary widely. In terms of assessment, many of the program directors, both those whose programs provide gambling treatment services and those whose programs do not, equated single items or brief screens with assessment instruments. Many programs relied on assessments that focused only on gambling behavior.

Therefore, we recommend that BSAS provide information and recommendations about validated gambling assessments to all BSAS-affiliated substance use programs. One means of doing this might be through expanding the Practice Guidelines for gambling treatment web resource to cover screens, assessment, and diagnostic instruments.

Also, though flexibility in the type of services programs provide is important, few programs that indicated that they provide gambling treatment services indicated specific curricula or evidence-based practices used to treat clients with gambling-related problems.

That fact, combined with programs' desire for additional training and curricula, leads us to recommend that BSAS continue to update and publicize its Practice Guidelines for gambling treatment and, where possible, disseminate resources related to the most promising approaches.

Client Entry Points to Gambling Treatment Services

There are two primary entry to points to gambling treatment services in MA other than self-referral: (1) referrals from the Gambling Helpline; and (2) screening within other substance use programs. Our review of both of these potential entry points leads to several recommendations.

The Gambling Helpline serves as an entry point for many clients to gambling treatment services. However, the Helpline does not appear to have a systematic protocol for which programs and providers are used as referrals.

Though we respect that MCCG has significant institutional knowledge about the best providers and programs, we recommend that the Helpline, when making referrals, make available information about the full range of gambling treatment services in a caller's area.

This would not preclude the Helpline from providing recommendations about programs or providers found to be particularly high quality. If the OPGS and the Helpline were to collect more data about referrals, as suggested in the next section, that data could then be used to prioritize the potential list of referrals in terms of speed and quality of service.

Though representatives from the Helpline follow up with callers, the Helpline does not regularly initiate contact with gambling treatment providers to whom they refer clients, instead providing the contact information for the referral directly to the client. Research and current collaborative care models suggest that warm handoffs (Agency for Healthcare Research and Quality, 2017) might be more effective at helping individuals engage with behavioral health care than more traditional referrals (Ober et al., 2018).

Therefore, we recommend that the Helpline adopt a warm handoff approach to referrals, communicating directly with the caller's potential treatment provider, as well as the caller, where possible.

Screening for gambling-related problems is fairly common within BSAS-affiliated substance use programs, with more than three quarters reporting some type of screening. This is encouraging and provides evidence that programs have the capacity to screen their clients. However, screening and assessment practices vary widely from program to program.

Consistent with OPGS Strategic Plan, to ensure that programs are using evidence-based screens, we recommend that BSAS support the use of a single validated screening instrument to screen all clients in substance use treatment programs for gambling-related problems.

Data Systems and Interagency Communication

Though MA appears to have the infrastructure in place for expanding gambling treatment services, including (a) a wide distribution of current services, and even wider distribution of organizations that are open to providing services, (b) training opportunities, and (c) current screening practices, there appears to a be a significant weakness related to data systems and communications. BSAS currently is the data clearinghouse for most programs that provide substance use treatment in the state, and as such, receives intake data from substance use treatment programs that provide gambling services, as well. It was beyond the scope of the current review to determine the quality and timeliness of that data. However, to gain a full understanding of gambling-specific treatment demand and capacity, it is particularly important that BSAS track information about clients presenting with gambling-related problems.

Therefore, we recommend that, if it is not doing so already, BSAS collect and compile for review the following information from the programs it licenses:

1. ***For all programs – in a given month or quarter***
    a. ***# of clients screened for gambling-related problems***
    b. ***# of clients who screened positive for gambling-related problems***
    c. ***# of clients referred to other programs for gambling treatment services and where they were referred***
2. ***For programs that provide gambling treatment services – in a given month or quarter***
    a. ***# of clients to whom they provided gambling treatment services***
    b. ***# of referrals received for gambling treatment services and how many of those referrals commenced treatment***
    c. ***# of clients discontinuing gambling treatment, identified as drop-out, transfer, or completion***

Our investigation of publicly available data, conversations with MCCG, and the program director survey revealed that there is very little planned communication and few data systems in place to support communication between organizations that serve individuals with gambling-related problems.

Though BSAS and MCCG work closely together, there is some evidence that the two agencies do not currently ensure that their resource lists and databases are consistent with each other and up-to-date. This is evidenced by the absence of information about gambling treatment services on the substance use helpline website, the discrepancies in the lists of service providers available on the MCCG website, and the lack of correspondence between the BSAS and MCCG lists of gambling treatment services. In addition, the agencies do not appear to have a clear system for identifying and sharing information about MA-PGS certified providers within organizations throughout the state. This is important if BSAS contracts for gambling treatment services require MA-PGS certification.

Therefore, we recommend that BSAS, through OPGS, develop and maintain an information exchange system and a database of organizations that provide gambling treatment services within MA, as well as the sites at which they do so and the MA-PGS certified providers who work at those organizations.

This database can in turn be used to populate both BSAS and MCCG lists of gambling treatment services as it is updated. If MCCG continues to maintain the list of MA-PGS certified treatment providers, integrating that list with the suggested database would be particularly important, including fields noting dates of MA-PGS certification, expiration, and renewal. Though these resources exist, to some extent, as standalone MS Excel files, it is important that they be integrated and kept up to date on an ongoing basis.

As noted earlier, the Gambling Helpline does not currently collect information about the referrals it makes (i.e., whether they result in scheduled appointments, successful treatment, etc.). The same can be said for most other programs that make referrals to gambling treatment services. This type of information is crucial to collect in order to determine the efficacy of the Helpline, potential gaps or deficits in treatment services, as well as actual demand for treatment. This type of information also would allow for better identification of barriers to treatment. The MCCG noted HIPAA concerns as one barrier to collecting data about the outcomes of Helpline referrals. However, there are integrated data systems in place in MA that address all HIPAA requirements and could serve as models for this type of system. Examples include the Prescription Monitoring System (https://www.mass.gov/prescription-monitoring-program-pmp) and the Springfield Coalition for Opioid Overdose Prevention (SCOOP) database (https://www.springfield-ma.gov/hhs/index.php?id=scoop-home).

Therefore, we recommend that OPGS implement a data system for the state Helpline(s) through which it collects information from treatment providers and programs about whether Helpline referrals are fulfilled, and how quickly the clients who are referred enter treatment.

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Appendices

Appendix A: OPGS e-Survey and Survey Responses

To conduct a comprehensive gap analysis, we need to first understand the scope of that analysis. Gambling treatment services in Massachusetts occur in a variety of settings.

According to the Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts (April 2016), the majority of treatment occurs "within independent practices or outpatient services." In addition, that plan indicates that at the time of the report, in April 2016, 140 service providers had been certified via the MAPGS to provide gambling services. Information available from the Strategic Plan, through the Massachusetts Council on Compulsive Gambling (MCCG), and via the Bureau of Substance Abuse Services varies somewhat in its terminology and the content provided. Therefore, we would like to clarify the gambling treatment services to be reviewed as part of this analysis and their relationships to each other.

1) These sources refer to BSAS-funded gambling treatment services, BSAS-licensed gambling treatment services, and BSAS-contracted gambling treatment services. Please clarify whether these terms can be used interchangeably, and if not, how they relate to each other.

2) The MCCG website provides a list of "outpatient treatment centers" for gambling. What determines whether an agency is listed within this list? Are all listed agencies BSAS- licensed/contracted/funded? Are all BSAS-licensed/contracted/funded agencies that provide gambling treatment services listed here?

3) The MCCG website also provides a list of "Other Treatment Services" listing an additional set of agencies. How do these relate to the listed "outpatient treatment centers"?

4) Is there a difference between "treatment centers", agencies that provide "gambling services", and "providers" who provide gambling services? What is that difference?

5) The MCCG website also provides a list of "trained clinicians" who have earned MAPGS certificates. This list varies from 14 to 16 providers depending on which link you click. How do these 14-16 relate to the 140 the Strategic Plan indicate have been certified, and why are the numbers different?

6) Can programs that are not BSAS-licensed and providers that do not have MAPGS certification provide gambling services in Massachusetts? What does that look like? Are there any regulations? How could these programs and providers be identified for purposes of the gap analysis?

7) How often do MAPGS certification trainings (and/or other trainings if there are other ways to be certified) occur? What is involved in becoming certified?

8) We are interested in identifying entry points to gambling treatment services within Massachusetts. An obvious (and manageable to evaluate) entry point is through substance use services. Does it make sense to you to investigate BSAS-licensed/contracted/funded substance use services as an entry point? Are there other entry points you would like to see investigated?

9) We have identified the following providers of gambling treatment services as potential targets for this gap analysis: (1) BSAS-licensed gambling treatment providers; (2) MAPGS-certified providers; (3) BSAS-licensed substance use treatment providers (as entry points to the system). Are there other providers who ought to be targets of this analysis? Is there a reason to include or not include the MAPGS-certified providers?

10) Where can we obtain the most up-to-date and accurate lists of the three groups identified above? (BSAS-licensed gambling treatment providers, MAPGS-certified providers, BSAS- licensed substance use treatment providers)?

11) Are there any other gambling treatment service providers we need to consider?

Table A1. OPGS e-Survey – December, 2017

OPGS Questions & Answers
Q1) Information available from the Strategic Plan, through the Massachusetts Council on Compulsive Gambling (MCCG), and via the Bureau of Substance Abuse Services varies somewhat in its terminology and the content provided. These sources refer to BSAS-funded gambling treatment services, BSAS-licensed gambling treatment services, and BSAS-contracted gambling treatment services. Please clarify whether these terms can be used interchangeably, and if not, how they relate to each other.
A1) All three terms are used interchangeably in the gambling space, although they have distinct definitions within BSAS Currently, there are 39 licensed outpatient centers that have been awarded contracts to provide gambling services. The funding for such service is the gambling blanket. The gambling blanket is the payer of last resort for gambling treatment services.
Q2) The MCCG website provides a list of "outpatient treatment centers" for gambling. What determines whether an agency is listed within this list? Are all listed agencies BSAS-licensed/ contracted/funded? Are all BSAS-licensed/contracted/funded agencies that provide gambling treatment services listed here?
A2) Please speak with MCCG.
Q3) The MCCG website also provides a list of "Other Treatment Services" listing an additional set of agencies. How do these relate to the listed "outpatient treatment centers"?
A3) Please speak to MCCG.
Q4) Is there a difference between "treatment centers", agencies that provide "gambling services", and "providers" who provide gambling services? What is that difference?
A4) Treatment centers are organizations that have been awarded and licensed to provide gambling treatment. Providers are the workforce that has received training and their MAPGS to provide services. Not all providers work for the treatment centers.
Q5) The MCCG website also provides a list of "trained clinicians" who have earned MAPGS certificates. This list varies from 14 to 16 providers depending on which link you click. How do these 14-16 relate to the 140 the Strategic Plan indicate have been certified, and why are the numbers different?
A5) Please speak to MCCG.
Q6) Can programs that are not BSAS-licensed and providers that do not have MAPGS certification provide gambling services in Massachusetts? What does that look like? Are there any regulations? How could these programs and providers be identified for purposes of the gap analysis?
A6) Yes. Not sure what that looks like as there is a large universe of services for treatment.
Q7) How often do MAPGS certification trainings (and/or other trainings if there are other ways to be certified) occur? What is involved in becoming certified?
A7) Please speak to MCCG.
Q8) We are interested in identifying entry points to gambling treatment services within Massachusetts. An obvious (and manageable to evaluate) entry point is through substance use services. Does it make sense to you to investigate BSAS-licensed/contracted/funded substance use services as an entry point? Are there other entry points you would like to see investigated?
A8) The Gambling Helpline

Q9) We have identified the following providers of gambling treatment services as potential targets for this gap analysis: BSAS-licensed gambling treatment providers, MAPGS-certified providers, BSAS-licensed substance use treatment providers (as entry points to the system). Are there other providers who ought to be targets of this analysis? Is there a reason to include or not include the MAPGS-certified providers?

A9) I think that this is a good list to start.

Q10) Where can we obtain the most up-to-date and accurate lists of the three groups identified above? (BSAS-licensed gambling treatment providers, MAPGS-certified providers, BSAS-licensed substance use treatment providers)?

A10) The Mass Council

Q11) Are there any other gambling treatment service providers we need to consider?

A11) Not at this time

Appendix B: MCCG e-Survey and Survey Responses

The Division on Addiction has been tasked with conducting a gap analysis of the BSAS service system as it pertains to gambling treatment. To conduct a comprehensive gap analysis, we need to first understand the scope of that analysis. Gambling treatment services in Massachusetts occur in a variety of settings. According to the Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts (April 2016), the majority of treatment occurs "within independent practices or outpatient services." In addition, that plan indicates that at the time of the report, in April 2016, 140 service providers had been certified via the MAPGS to provide gambling services. Information available from the Strategic Plan, through the Massachusetts Council on Compulsive Gambling (MCCG), and via the Bureau of Substance Abuse Services varies somewhat in its terminology and the content provided. Therefore, we would like to clarify the gambling treatment services to be reviewed as part of this analysis and their relationships to each other. We initially conducted this survey with Victor Ortiz within the Office of Problem Gambling Services. For many of our questions, he identified MCCG as having the most current knowledge. We would appreciate it if you could provide information in response to the questions below.

1) The MCCG website provides a list of "outpatient treatment centers" for gambling. What determines whether an agency is listed within this list? Are all listed agencies BSAS- licensed/contracted/funded? Are all BSAS-licensed/contracted/funded agencies that provide gambling treatment services listed here?

2) The MCCG website also provides a list of "Other Treatment Services" listing an additional set of agencies. How do these relate to the listed "outpatient treatment centers"?

3) The MCCG website also provides a list of "trained clinicians" who have earned MAPGS certificates. This list varies from 14 to 16 providers depending on which link you click. How do these 14-16 relate to the 140 the Strategic Plan indicate have been certified, and why are the numbers different?

4) Can programs that are not BSAS-licensed and providers that do not have MAPGS certification provide gambling services in Massachusetts? What does that look like? Are there any regulations? How could these programs and providers be identified for purposes of the gap analysis?

5) How often do MAPGS certification trainings (and/or other trainings if there are other ways to be certified) occur? What is involved in becoming certified?

6) Where can we obtain the most up-to-date and accurate lists of BSAS-licensed gambling treatment providers and MAPGS-certified providers?

7) Are there any other gambling treatment service providers we need to consider?

Table B1. MCCG e-Survey – February, 2018

MCCG Questions & Answers
Q1) The MCCG website provides a list of outpatient treatment centers for gambling. What determines whether an agency is listed within this list? Are all listed agencies BSAS-licensed/contracted/funded? Are all BSAS-licensed/contracted/funded agencies that provide gambling treatment services listed here?
A1) The outpatient treatment centers are those who have a contract with BSAS to offer services to clients with a gambling disorder. At least one of the staff from each of these centers has been trained (in most cases by the MCCG) in Gambling disorder as well as hold an MA-PGS.
Q2) The MCCG website also provides a list of "Other Treatment Services" listing an additional set of agencies. How do these relate to the listed "outpatient treatment centers"?
A2) The other treatment centers are not contracted with DPH but have an MA-PGS staff person on site (i.e., Holyoke Medical Center, River Valley.).
Q3) The MCCG website also provides a list of "trained clinicians" who have earned MAPGS certificates. This list varies from 14 to 16 providers depending on which link you click. How do these 14-16 relate to the 140 the Strategic Plan indicates have been certified, and why are the numbers different?
A3) The 14 to 16 are solely independent private practice clinicians who have an MA-PGS. The web-site will be updated to remove one of the links.
Q4) Can programs that are not BSAS-licensed and providers that do not have MAPGS certification provide gambling services in Massachusetts? What does that look like? Are there any regulations? How could these programs and providers be identified for purposes of the gap analysis?
A4) We, as an organization, we do not refer providers who are not certified.
Q5) How often do MAPGS certification trainings (and/or other trainings if there are other ways to be certified) occur? What is involved in becoming certified?
A5) The renewals are every two years and need 15 gambling specific CEU's whether through the MCCG or through other means. We offer a full training institute every fall and spring for those who want to receive an MA-PGS certificate or opportunity to receive towards their current MA-PGS.
Q6) Where can we obtain the most up-to-date and accurate lists of the three groups identified above? (BSAS-licensed gambling treatment providers, MAPGS-certified providers, BSAS-licensed substance use treatment providers)?
A6) Our website has a list of outpatient treatment providers trained in problem gambling or that hold an MA-PGS.
Q7) Are there any other gambling treatment service providers we need to consider?
A7) Not that we can speak of at this time.

Appendix C: Organizations Providing Gambling Services in Massachusetts

Figure C1: CONSORT Diagram of Organizations, Gambling Services, and Survey Respondents

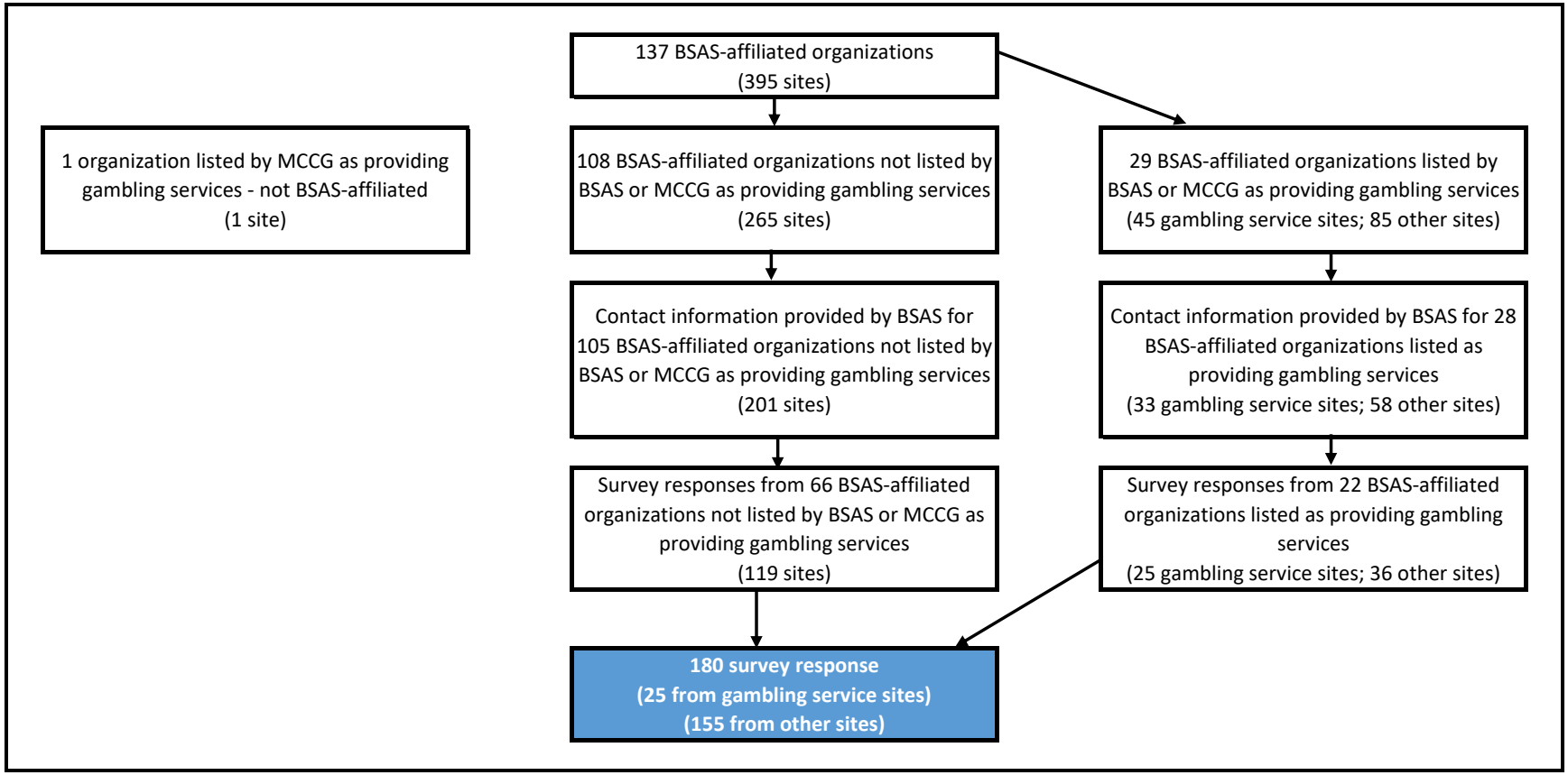

Table C1. Organizations Providing Gambling Treatment Services

Organization	Listed by BSAS as providing BSAS-licensed gambling services	Listed by MCCG as providing gambling	Indicated on survey that program is licensed by BSAS to provide gambling services	Indicated on survey that program provides gambling services
Boston ASAP, Inc.	yes	yes	yes	yes
Center for Human Development	yes	yes	yes	yes
Fenway Community Health Center	yes	yes	yes	yes
Gavin Foundation	yes	yes	yes	yes
High Point Treatment Center, Inc.	yes	yes	yes	yes
L.U.K. Crisis Center, Inc.	yes	yes	yes	yes
Mercy Hospital d/b/a Providence Hospital	yes	yes	yes	yes
Mount Auburn Hospital	yes	yes	yes	yes
North Suffolk Mental Health Association	yes	yes	yes	yes
South Middlesex Opportunity Council	yes	yes	yes	yes
Steppingstone, Inc.	yes	yes	yes	yes
Gandara Mental Health Center, Inc.	yes	yes	--	--
Lowell House, Inc.	yes	yes	--	--
NFI MA	yes	yes	--	--
Stanley Street Treatment and Resources	yes	yes	--	--
Bay State Community Services Inc	yes	no	yes	yes
Phoenix Houses of New England	yes	no	yes	yes
The Brien Center for MH And SA Services	yes	no	yes	yes
Massachusetts General Hospital Corporation	yes	no	yes	no
Bay Cove Human Services	yes	no	no	yes
Behavioral Health Network, Inc.	yes	no	no	yes
Boston Public Health Commission	yes	no	no	yes
Eliot Community Human Services, Inc.	yes	no	no	yes
Institute for Health And Recovery	yes	no	no	no
Casa Esperanza Inc.	yes	no	--	--
Dimock Community Services Corp,	yes	no	--	--
Luminosity Behavioral Health Services	yes	no	--	--
Justice Resource Institute, Inc.	no	yes	no	yes
Holyoke Medical Center, Inc.	no	yes	--	--
RiverValley Counseling	no	yes	--	--
Catholic Charitable Worcester	no	no	yes	yes
Community Health Care, Inc.	no	no	yes	yes
Crossroads Agency	no	no	yes	yes
Jeremiah's Inn, Inc.	no	no	yes	yes
Middlesex Human Service Agency	no	no	yes	yes
Pine Street Inn	no	no	yes	yes
Psychological Center, Inc., The	no	no	yes	yes
ServiceNet, Inc.	no	no	yes	yes
Spectrum Health Systems, Inc	no	no	yes	yes
Victory Programs, Inc	no	no	yes	yes
Volunteers of America of MA, Inc.	no	no	yes	yes
West Central Family and Counseling, Ltd.	no	no	yes	yes
Lahey Health Behavioral Services / NBHC	no	no	yes	no
Adcare Hospital	no	no	no	yes
Column Health, LLC	no	no	no	yes
Community Health Connections, Inc.	no	no	no	yes
Community Healthlink	no	no	no	yes
Counseling-Assessment Clinic of Worcester	no	no	no	yes
Gosnold, Inc.	no	no	no	yes
Harbor Health Services, Inc.	no	no	no	yes
Harrington Memorial Hospital	no	no	no	yes
HRI Clinics / Arbour Counseling Services	no	no	no	yes
Lowell Community Health Center	no	no	no	yes
Massachusetts Alliance of Portuguese Speakers	no	no	no	yes
McLean Hospital	no	no	no	yes
SBH Haverhill, LLC	no	no	no	yes
South Shore Halfway House	no	no	no	yes

Appendix D: Program Director Survey

MA Current State of Gambling Services – Survey for Program Directors

(1a) What is the name of your program?

(1b) What is your position at that program?

(1c) What client population(s) do you primarily serve (check all that apply)?

- ☐ Clients with problems with alcohol
- ☐ Clients with problems with opioids
- ☐ Clients with problems with other drugs
- ☐ Clients experiencing homelessness
- ☐ Other _____
- ☐ Clients with problems with gambling
- ☐ Clients with mental health problems
- ☐ Clients legally mandated to treatment
- ☐ Veterans

(2a) Does your program screen its clients for gambling problems?

☐ Yes ☐ No

[if yes, go to 2b; if no, go to 3a]

(2b) Does your program screen *all* of its clients for gambling problems?

☐ Yes ☐ No

[if yes, go to 2d; if no, go to 2c]

(2c) How does your program determine whom to screen?

(2d) About how many clients does your program screen for gambling problems in an average month?

☐ 0 ☐ 1-10 ☐ 11-20
☐ 21-30 ☐ 31-40 ☐ 41-50
☐ 51-60 ☐ 61-70 ☐ 71-80
☐ 81-90 ☐ 91-100
☐ 101+ (please specify)_____
☐ Other _____

(2e) In your estimation, about how many of the clients you screen for gambling problems in an average month receive a positive screen for gambling problems?

☐ 0 ☐ 1-10 ☐ 11-20
☐ 21-30 ☐ 31-40 ☐ 41-50
☐ 51-60 ☐ 61-70 ☐ 71-80
☐ 81-90 ☐ 91-100
☐ 101+ (please specify)_____
☐ Other _____

(3a) Does your program conduct a comprehensive assessment for gambling problems with clients who screen positive for gambling problems?

☐ Yes ☐ No

[if yes, go to 3b; if no, go to 4a]

(3b) Please briefly describe the assessment process your program uses for clients with gambling problems, including any specific measures or tools your program uses.

(4a) Is your program contracted by BSAS to provide gambling treatment services?

☐ Yes ☐ No

(4b) Does your program provide any gambling treatment services for clients with gambling problems?

☐ Yes ☐ No

[if yes, go to 4c; if no, go to 7a]

(4c) Please briefly describe these services

(4d) About how many clients do you provide gambling treatment services for in an average month?

☐ 0	☐ 1-10	☐ 11-20
☐ 21-30	☐ 31-40	☐ 41-50
☐ 51-60	☐ 61-70	☐ 71-80
☐ 81-90	☐ 91-100	

☐ 101+ (please specify)_____

☐ Other _____

(4e) What is the average length of time a client will receive gambling treatment services in your program?

☐ 1 or 2 sessions
☐ 1-3 months
☐ 4-6 months
☐ 7-12 months
☐ 1+ years
☐ Other _____

(4f) What percentage of your clients who receive gambling treatment services complete their gambling treatment (as opposed to dropping out)?

☐ 0%
☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Other _____

(4g) How many clients with gambling-related problems can your program provide gambling treatment services to at a given point in time?

☐ 0	☐ 1-10	☐ 11-20
☐ 21-30	☐ 31-40	☐ 41-50
☐ 51-60	☐ 61-70	☐ 71-80
☐ 81-90	☐ 91-100	

☐ 101+ (please specify)_____

☐ Other _____

(4h) Is there a waitlist for your gambling treatment services?

☐ Yes ☐ No

[if yes, go to 4i; if no, go to 5a]

(4i) What is the average time spent on the waitlist for your gambling treatment services?

☐ < a week
☐ 1-3 weeks
☐ 1-3 months
☐ 4-6 months
☐ 6+ months
☐ Other _____

(5a) Does your program receive referrals from the Massachusetts Council on Compulsive Gambling (MCCG) or from the MCCG Helpline for clients with gambling problems?

☐ Yes ☐ No

[if yes, go to 5b; if no, go to 6a]

(5b) How many clients with gambling problems do you receive referrals for from MCCG or the MCCG Helpline in an average month?

☐ 0 ☐ 1-2 ☐ 3-5
☐ 6-10 ☐ 11-20 ☐ 21-30
☐ 31+ (please specify)_____
☐ Other _____

(5c) What percentage of the referrals from MCCG or the MCCG Helpline actually end up receiving gambling treatment services from your program?

☐ 0%
☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Other _____

(5d) Do you share any information about these referrals (e.g., whether they attended an appointment) back with the MCCG or MCCG Helpline?

☐ Yes ☐ No

(5e) (If yes) Please describe

(6a) Does your program receive referrals from other programs for clients with gambling problems?

☐ Yes ☐ No

[if yes, go to 6b; if no, go to 12a]

(6b) From what other programs do you receive referrals for clients with gambling problems?

(6c) How many clients with gambling problems do you receive referrals for from these other programs (other than MCCG or MCCG Helpline) in an average month?

☐ 0 ☐ 1-2 ☐ 3-5
☐ 6-10 ☐ 11-20 ☐ 21-30
☐ 31+ (please specify)_____
☐ Other _____

(6d) How many of the referrals from these other programs (other than MCCG or MCCG Helpline) actually end up receiving gambling treatment services from your program?

☐ 0%
☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Other _____

(6e) Do you share any information about these referrals (e.g., whether they attended an appointment) back with the programs that referred them to you?

☐ Yes ☐ No

(6f) (If yes) Please describe

[Go to 12a]

(7a) Does your program refer clients who have gambling-related problems to other programs or services?

☐ Yes ☐ No

[if yes, go to 7b; if no, go to 8]

(7b) To what programs or services do you refer clients with gambling-related problems?

(7c) About how many clients with gambling problems do you refer to other programs or services in an average month?

☐ 0 ☐ 1-2 ☐ 3-5
☐ 6-10 ☐ 11-20 ☐ 21-30
☐ 31+ (please specify)_____
☐ Other _____

(7d) Do you have any way to know whether the clients you refer end up receiving the services you refer them to?

☐ Yes ☐ No

[if yes, go to 7e; if no, go to 8]

(7e) How?

(8) What do you do for clients who present with gambling problems?

(9) Does your program have space available that could, in theory, be used to host Gamblers Anonymous meetings?

☐ Yes ☐ No ☐ Other _____

(10) Does your program have a strategic plan that includes incorporating gambling services?

☐ Yes ☐ No ☐ Other _____

(11a) What infrastructure changes or additions would your program need to begin treating clients for gambling-related problems?

(11b) Does your program have an interest in incorporating the resources needed to begin treating clients for gambling-related problems?

☐ Yes ☐ No ☐ Other _____

(12a) How many providers work at your program?

☐ 0 ☐ 1-10 ☐ 11-20
☐ 21-30 ☐ 31-40 ☐ 41-50
☐ 51-60 ☐ 61-70 ☐ 71-80
☐ 81-90 ☐ 91-100
☐ 101+ (please specify) _____
☐ Other _____

(12b) How many of those providers are Massachusetts Problem Gambling Specialist (MA-PGS) certified [enter numeric value]?

(12c) How many of those providers provide gambling treatment services within your program [enter numeric value]?

(13) Does your program include an annual CEU benefit (e.g., a minimum number of paid hours that providers can use toward CE activities)?

☐ Yes ☐ No ☐ Other _____

(14) Does your program share data with BSAS or other programs within the state? Please describe.

(15) Please list any specific resources BSAS/DPH could provide that would help you provide services to clients with gambling-related problems.

Appendix E: Program Director Survey Data Cleaning

1) On July 9th, began with file of 216 respondents
   a. Removed 7 respondents with incomplete data and no record of organization or position
   b. Removed R_1GH5BoSdgBSkt6q – incomplete and a duplicate organization and position to R_2A0c6SHJ0k8urqw (AdCare VP)
   c. Two Channing House entries – kept the more recent entry because the location was closer to Channing House and the answers were more complete
   d. Two Crossroads Treatment Center entries; both same IP. Removed the incomplete one.
   e. Two Cushing House entries; both same IP. Kept the most recent entry because answers were more complete
   f. For the two DAE respondents, they were similar but not identifiable by location, so I assigned the first to MAPS Cambridge and the second to MAPS Somerville.
   g. Two responses for Experience Wellness Centers and three locations. One location matched. The other did not (lat/long was Portland, ME, so not helpful) – added it to Worcester location. All locations similar in scope of services.
   h. For respondent who entered Faith House/Beryl's House/Orchard Street, matched the answers to Faith House because already had responses for Beryl's
   i. Two Gavin Foundation CEO respondents. Deleted incomplete response.
   j. Two Gavin House responses. Deleted response that claimed they provided gambling services but then noted that they refer for gambling services, don't provide them. (Same respondent)
   k. Matched Gavin Quincy to Phoenix House Quincy because they recently took it over
   l. Two responses for Habit OPCO Fitchburg. Used a random number generator and deleted response R_27fyLsT4nBZb8Jx
   m. Two responses for Habit OPCO Boston. Deleted incomplete response
   n. Two responses for Habit OPCO Lowell. Deleted response with less information
   o. Two Health Care Resource Centers with same IP. Deleted less complete response
   p. Matched "Hello House & Shiloh House" to Hello House because response already in existence for Shiloh House.
   q. Two responses for Hurley House. Used a random number generator and deleted response R_WkDdzWme5zJSg4F
   r. Two responses for Interim House. Deleted incomplete one.
   s. Two responses for Jeremiah's Inn. Used a random number generator and deleted response R_1DT0I0mDu4UhSqY
   t. Changed Jerome Posey to High Point in Jamaica Plain (ATS/CSS)
   u. Two responses for LCHC. Used a random number generator and deleted response R_2uHXBqkS2SEsgTb
   v. Two responses for Link House. Deleted incomplete one.
   w. Two responses for McGee Unit. Deleted incomplete one.
   x. Two responses for McLean Naukaug. Deleted incomplete one
   y. Some confusion for New Bedford High Point. One respondent answered for "New Bedford High Point (Belleville location) and indicated that the site was contracted for gambling services, but did not provide gambling services, instead referring clients to 68 Front. Our database doesn't have a 68 Front. Therefore, I split the Belleville location into 195a and 195b and associated the

Belleville responses with 195a and the 68 Front responses (outpatient) w/ 195b

z. Two responses for North Cottage. Used a random number generator and deleted response R_rqZVmcODdFEGWjf
aa. Matched "Outpatient Substance Addiction Clinic" response to the Fitchburg site for "Structured Outpatient Addiction Program" because IP address was located in Fitchburg and there were no other obvious options.
bb. Two responses for Pegasus House. Used a random number generator and deleted response R_3P4vQiKC5o1OhTH
cc. By default, assigned responses labelled "Phoenix Family Treatment Program" to Phoenix House Dorchester. This makes sense because Phoenix House Dorchester is listed as a family program.
dd. Assigned response labelled "Rhodes to Recovery" to Rhode Street Program
ee. Two responses for Right Choice Health Group. Deleted incomplete one.
ff. Associated "Serenity at Summit New England" response with SBH Haverhill because the emails are "@summithelps"
gg. Associated "Shannon Gallagher" response with the Addiction Campuses of Massachusetts because that's the program she's listed as directing.
hh. Two responses for SMOC. Deleted incomplete one since they were from the same IP
ii. Couldn't match the three Spectrum Health Systems responses perfectly since there are so many possible locations. Ipaddress lookup suggested Boston, Brookline, Medford, but there are no Spectrum sites there. Responses were essentially interchangeable, so assigned them as follows:
    i. R_1Q4IJOhO6op1H3I (Brookline) to Waltham
    ii. R_33sxlmKS7yhj5Zq (Boston) to Weymouth
    iii. R_77mndE62PLRLLwJ (Medford) to Haverhill
jj. Have not precisely matched "Springfield" response. IP is from Rockville Maryland, suggesting a national company. Response is opioid specific. Matched it to only remaining Springfield opioid program – Providence.
kk. Two responses for SSTAR. Used a random number generator and deleted response R_sTNlefd3aAXsdod
ll. Assigned Steppingstone Fall River Womens Program response to Steppingstone Therapeutic Community 1 in Fall River
mm. Assigned Steppingstone Inc response to last remaining Steppingstone Fall River location with an associated email address– Steppingstone Halfway House
nn. Two responses for Sullivan House. Deleted incomplete one.
oo. Two responses for Taunton TSS. Used a random number generator and deleted response R_2anavliPpkDi02D
pp. Two responses for Counseling-Assessment Clinic of Worcester, LLC. Both incomplete. Used a random number generator and deleted response R_2us2VwfXfGmvotH
qq. Two responses for Transitions. Deleted incomplete one.
rr. Two responses for Lynn TSS. Deleted incomplete one.
ss. Two responses for Washburn House. Used a random number generator and deleted response R_xooWkGNF0kpBJ9n
tt. Two responses for WATC. Deleted incomplete one.
uu. Two responses for Mount Auburn. Used a random number generator and deleted R_1JWyDNJ4gmKYOoR

Appendix F: Program Director Survey Samples and Subsamples

- 180 responses
    - 72 are listed by BSAS or MCCG as providing gambling services ***or*** indicate that they provide gambling services in some way
        - 25 BSAS or MCCG-listed gambling programs
            - 6 of these either indicated on the survey that they do not provide gambling services or did not answer that question
        - 19 additional respondents indicate that they provide gambling services and are BSAS-licensed
        - 26 additional respondents note that they provide gambling services though they indicate they are not BSAS licensed
        - 2 additional respondents note that they are BSAS-contracted to provide gambling services, but don't
    - Of the remaining 108 responses:
        - 33 are outpatient programs (not including opioid programs)
        - 17 are opioid programs
        - 38 are residential programs, and
        - 20 are detox, crisis stabilization, or transitional support services.

- Analyzed data using multiple subsamples:
    - Full sample of 180
    - Gambling service subsamples
        - BSAS- and MCCG-listed gambling services (n=25)
        - Respondents indicating they provide gambling services or are licensed to do so (n=66: 19 of the BSAS- and MCCG-listed gambling services, plus 47 additional respondents)
    - Non-gambling service subsamples: All BSAS services
        - Programs not listed by BSAS or MCCG as providing gambling services (n=155)
        - Respondents indicating they do not provide gambling services and are not licensed to do so (n=114)
    - Non-gambling service subsamples: BSAS outpatient programs
        - Outpatient programs not listed by BSAS or MCCG as providing gambling services (n=52)
        - Respondents from outpatient programs indicating they do not provide gambling services and are not licensed to do so (n=38)

Appendix G: Program Director Survey Responses About Resources BSAS Could Provide

Table G1. Responses to Question: "Please list any specific resources BSAS could provide that would help you provide services to clients with gambling-related problems."

Program Directors' Responses About Resources BSAS Could Provide to Help Treat Clients w/ Gambling Problems
A basic curriculum.
A comprehensive assessment tool for those clients that qualify.
A list of gamblers anonymous meetings in Western Massachusetts any information regarding medication management for gamblers and any other referrals other than coming from the Massachusetts Council on Compulsive Gambling.
A more open less restrictive means of reimbursement for problem gambling treatment would be optimal for those clients who want treatment for their gambling but may already have another therapist for their mental health who is already billing insurance.
A training.
Accessible and consolidated training toward MAPGS at more convenient times.
Additional information required.
Additional training and resources.
Advertising campaign to raise public awareness reduce stigma and provide referral information to the public.
Any gambling resources and referral information would be great.
Any information and training would be helpful.
Assist with promoting that we offer this service.
BSAS training in problem gambling.
Comprehensive assessment to include during client intake.
Continuing Education about Gambling Addiction.
Curriculum.
Curriculum Amendment.
DPH BSAS Resources are not the issue for us. Lack of clients with an ICD Gambling diagnosis is our issue.
Easier certification process.
Education.
Financing.
Free training for staff. We already have a limited training budget which is exhausted by BSAS DPH mandated trainings. Training and info to program managers on BSAS requirements for gambling services.
Funding and training.
GA.
GA info and trainings.
GA lists.
Gambling certification and or education.
Gambling curriculum and training to teach Gambling Addiction groups.
Gambling Group Facilitators and Scheduling.
Gambling Specific Outpatient Services.
Gambling Training for clinicians.
Gambling training for residential programs associated with that site.
Gambling treatment training.
Group or individual curriculum.
Groups.
HELP LINE.
I think it would be more appropriate to address with Outpatient.
In service trainings for staff re treatment of gambling problems.
Increased funding for gambling related services and advocacy to MassHealth around reimbursable services. Increased public announcements and awareness around help being available.

Table G1. (cont.)

Program Directors' Responses About Resources BSAS Could Provide to Help Treat Clients w/ Gambling Problems
Info related to gambling treatment trainings in western MA.
Information on treatment availability and resources.
In-service trainings on the treatment of gambling disorders.
Literature.
Materials and education specific to gambling.
More awareness; educational tools to link the SUD with gambling related problems.
More gambling trainings.
More trainings.
More tx options.
N/A
N/A
No.
None.
None at this time.
Not applicable.
Not certain.
Not sure.
Not sure at this time.
Nothing at this time.
On Site training with Continuing Education Credits.
Opportunities for training for Clinical Directors and Case Manager.
Pamphlets and trainings.
Provide additional on-site training to programs.
Referral list.
Referrals.
Referrals as we only do OBOT.
Referrals RRS level of care.
Resources and or points of contact.
Screening tools and training on how to identify individuals with gambling disorder that are initially seeking tx for other reasons.
Specialist training.
Specific trainings related to treating gambling related problems.
Staff training and curriculum for groups on this topic.
Support groups and screening tools.
Text and treatment manuals as well as screening tools.
Training.
Training.
Training.
Training.
Training.
Training.
Training.
Training.
Training and certifications and quarterly meetings for Gambling problem providers.
Training and collateral material for clients.
Training and licensure.
Training and lists of certified providers.
Training for clinical staff.

Table G1. (cont.)

Program Directors' Responses About Resources BSAS Could Provide to Help Treat Clients w/ Gambling Problems
Training for providers.
Training on EBT gambling models.
Trainings.
Trainings.
Trainings.
Trainings; free material on best treatment practices.
Training.
Unable to assess at this time.
Uncertain.
Unknown.
Unsure.
Unsure at the moment.
Unsure at this time.
We are an inpatient program
We could use field workers like Recovery Coaches specifically for gambling problems like the Connecticut Bettor Choice program. Also PSA advertising directed to families of problem gamblers.
We currently use the clearinghouse information.
We have no current needs; we had GA come in and train the counselors.
Would require additional funding to take on this additional responsibility.

Note. We have edited responses for typos and grammar – unedited responses are available upon request.

Evaluation of the Massachusetts Voluntary Self Exclusion Program: June 24, 2015 – November 30, 2017

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The purpose of the current report is to provide an evaluation of the Massachusetts Voluntary Self Exclusion Program (MA-VSEP) and recommendations for improving the program. Though some findings should be interpreted with caution given sample limitations, results of both quantitative and qualitative data collected from MA-VSEP enrollees suggest that these enrollees have had positive experiences with the program and have demonstrated improvements in their gambling behavior, gambling-related problems, and general well-being in the 6-12 months since enrollment. Based on the multiple sources of data that informed this evaluation, this report provides recommendations for ways MA-VSEP can be improved to better serve MA-VSEP enrollees, increase the visibility of the program, and increase the quality of data collected from enrollees.

Introduction

- As part of its broader efforts to study the social and economic consequences of expanded gaming and to mitigate potential gambling-related harm, the Massachusetts Gaming Commission (MGC) contracted with the Division on Addiction to provide an evaluation of the Massachusetts Voluntary Self-exclusion Program (MA-VSEP).
- This initial report summarizes data collected from the MA-VSEP and its enrollees during its first twenty-nine months of operation in Massachusetts. Our goals were to (1) evaluate the MA-VSEP as implemented in collaboration with Plainridge Park Casino (PPC), and (2) assess the gambling behaviors, problems, mental health, and well-being of MA-VSEP enrollees across time.
- Voluntary self-exclusion (VSE) is a popular intervention that has been implemented by governments and casinos across the globe. VSE programs permit individuals to ban themselves from entering specific casinos for a specified time period or for a lifetime. The purpose of these programs has evolved from its more punitive intervention beginnings (i.e., charging people who violated their VSE contracts with criminal trespass) toward prevention and harm reduction.
- Prospective and/or retrospective longitudinal studies suggest that VSE is associated with advantageous changes in gambling experiences, such as reduced spending and reported experience of clinical gambling symptoms, but rates of VSE violation and continued gambling suggest that these changes might relate to the decision to self-exclude as much as to enrollment in VSE programs themselves.

The Massachusetts Voluntary Self-Exclusion Program (MA-VSEP)

- MA-VSEP provides interested patrons with three ways to self-exclude: (1) at the Plainridge Park Casino (PPC) either in the GameSense Info Center or with a Gaming Agent when GameSense is closed, (2) at the Massachusetts Council on Compulsive Gambling (MCCG) offices with a trained staff member, or (3) at the MGC main office in Boston with trained Gaming Commission staff (Massachusetts Gaming Commission, 2015). Introductory enrollment terms are 1-year, 3-years, or 5-years. The VSE contract covers all Massachusetts casino properties.
- Enrollment in MA-VSEP results in the forfeiture of casino rewards points and removal from casino direct marketing mailing lists. People who violate their MA-VSEP contract are escorted from the gaming floor of the establishment when detected, and forfeit any money wagered, won, or lost, including money converted to wagering instruments. Forfeited monies do not return to the casino but are instead transferred to the MGC to be deposited into the Gaming Revenue Fund.
- At the end of a VSE period, MA-VSEP enrollees wishing to renew their VSE contract can select from the same terms or select a lifetime exclusion. At any time after an individual's VSE period has expired, an enrollee can request that their name be removed from the VSE list. To finalize their removal from the list the individual must complete an "exit interview" with an MGC-designated agent (e.g., MCCG staff).

Current Study

- Division staff consulted to the MGC to help develop the MA-VSEP protocol. We worked collaboratively with staff from the MCCG and its GameSense Advisors (GSAs) to ensure both the MA-VSEP and its associated study protocols were well understood.
- The current evaluation includes (1) secondary data analyses of all MA-VSEP MGC records, including application data, (2) secondary data analysis of information related to one-week check-in calls conducted by the MCCG staff, (3) secondary data analysis of PPC player card records for MA-VSEP enrollees, and (4) baseline and 6-month longitudinal follow up of a subsample of MA-VSEP enrollees who agreed to participate in the study. This research agenda is consistent with initial evaluation processes for programs in their early development.
- Our primary evaluation goal was to understand the characteristics of MA-VSEP enrollees and their experiences with MA-VSEP so that we might make evidence-based recommendations for program improvements.

Methods

- The sample for this MA-VSEP evaluation included all 263 MA-VSEP enrollees who entered the program between June 25th, 2015 and November 30th, 2017. Within this full sample, we also examined several overlapping subsamples, including MA-VSEP enrollees who used player cards at PPC after May 2016 (n = 116),MA-VSEP enrollees who agreed to a one-week check-in with MCCG staff as part of their initial MA-VSEP enrollment (n = 67), and MA-VSEP enrollees who agreed to complete baseline and follow-up study surveys (n = 63 baseline; n = 46 baseline and follow-up).
- At the time of MA-VSEP enrollment, staff introduced enrollees to the study and requested their participation. Those who agreed to participate completed a baseline survey and provided their contact information to complete a follow-up interview about 6 months after enrollment. Division staff conducted follow-up interviews with willing participants over the telephone and also conducted baseline surveys over the telephone with MA-VSEP enrollees who did not complete the baseline survey at time of enrollment but agreed to participate in the study when contacted by Division staff.
- Measures included (1) a baseline survey assessing experiences with MA-VSEP enrollment as well as past gambling behaviors and experiences, (2) a follow-up interview assessing the same domains addressed in the baseline survey during the interval since MA-VSEP enrollment, (3) questions asked as part of the MA-VSEP application, (4) gambling variables derived from PPC player card data, and (5) information collected about one-week check-in calls conducted by MCCG staff.

Results & Discussion

What Are the MA-VSEP Enrollment Trends?

- Enrollment trends for the MA-VSEP differ somewhat from our previous work. New MA-VSEP enrollment rates have remained steady in the 29 months since PPC opened (i.e., from June 15th 2015 through November 30th 2017), following a linear trend for cumulative enrollments across time. This suggests that there is not yet any evidence of adaptation to PPC as a new gambling opportunity or the MA-VSEP as a novel program.
- Thirteen percent of enrollees formally un-enrolled when their term expired, and one third of those eventually re-enrolled in MA-VSEP.

Who Signs Up for MA-VSEP?

- The majority of MA-VSEP enrollees who lived in MA resided in the eastern half of the state; a quarter of enrollees were residents of Rhode Island.
- The majority of MA-VSEP enrollees for whom we had demographic data were non-Hispanic (98%) and white (79%), and approximately 60% were male. Enrollees were, on average, in their late 40s, though female enrollees tended to be older and male enrollees younger. Most were employed, the majority had a household income of $50,000 or greater, and just over a third were married. Compared to MA residents, MA-VSEP enrollees were more likely to be male and not married, and had lower household incomes.
- MA-VSEP enrollees who answered questions about gambling behavior on either the MA-VSEP application or the baseline survey reported electronic gaming machines as the gambling activity on which they lost the most money and reported large past year financial losses due to gambling: a median of $12,250 lost gambling in the past year, and a median of $1,600 as the most lost on any single day. Analysis of player card records confirmed these reports. More than 70% reported major difficulties with finances in the past year. Enrollees did not tend to constrain their gambling to PPC; the majority reported also gambling at casinos in states neighboring Massachusetts in the year prior to MA-VSEP enrollment. Those who selected longer enrollment terms tended to exhibit more severe levels of gambling behavior prior to enrollment. Not surprisingly, MA-VSEP enrollees had much greater involvement with gambling generally and casino gambling specifically than other residents. Compared to past research focusing on VSE participants, MA-VSEP enrollees had similarly elevated gambling spending and involvement. It will be interesting to note whether MA-VSEP enrollees at future MA casinos that offer both electronic gaming machines and table games will continue to report electronic gaming machines as the most problematic gambling activity for them.
- Analyses of both the larger sample of MA-VSEP enrollees and the subsample who completed the baseline survey indicated that the vast majority screened positive for (i.e., 84% of the larger sample) or qualified for (i.e., 89% of the baseline survey subsample) gambling disorder prior to MA-VSEP enrollment. Compared to past research focusing on VSE participants, MA-VSEP enrollees had similar rates of gambling disorder.
- Seventy percent of enrollees who answered questions about their gambling behavior on either the MA-VSEP application or the baseline survey reported an intention to quit all gambling upon MA-VSEP enrollment.
- A few additional results, based on the subsample of 63 MA-VSEP enrollees who agreed to complete study surveys, should be interpreted with caution given the low recruitment rate:
    - Participants who completed the baseline survey reported gambling for excitement, a good time, and financial reasons; more than a third also indicated that they gambled because they were depressed or lonely. The majority of enrollees believed that luck plays a role in gambling outcomes, and endorsed both positive (e.g., gambling is a fun activity) and negative (e.g., gambling is dangerous) attitudes about gambling.
    - More than half of the subsample of MA-VSEP enrollees who completed the baseline survey reported poor or fair mental health, 40% screened positive for depression, and 40% screened positive for anxiety.
    - MA-VSEP enrollees who completed the baseline survey tended to be involved with treatment prior to MA-VSEP enrollment: among those who completed the baseline survey, a quarter had received dedicated gambling treatment, half had called a gambling helpline, half had attended Gamblers Anonymous, and half had been in some other form of mental health treatment. Compared to MA residents, MA-VSEP enrollees were more likely to be involved in mental health, substance use, and gambling treatment.
    - Three quarters of MA-VSEP enrollees who completed the follow-up interview reported having signed up for VSE programs in other states.

Why Do Enrollees Sign Up for MA-VSEP?

- MA-VSEP enrollees who answered questions about gambling behavior on either the MA-VSEP application or the baseline survey endorsed a variety of reasons for MA-VSEP enrollment but were more likely to endorse self-focused reasons (e.g., didn't want to lose any more money; couldn't control gambling) than other-focused reasons (e.g., felt pressured; family or friends asked me to sign up).

What Are Enrollees' Impressions of and Experiences with the MA-VSEP?

Enrollee impressions and experiences with MA-VSEP are based on the subsample of 63 MA-VSEP enrollees who completed the baseline survey and 46 who completed the follow-up survey and should be interpreted with caution given sample limitations.

- Overall, MA-VSEP were satisfied with the enrollment process and held positive impressions of it as well as the GSAs who facilitated enrollment; however, program satisfaction declined over time, possibly indicating a need for program-related maintenance activities.
- At follow-up, among MA-VSEP enrollees who had enrolled in other VSE programs previously, more than 80% rated their MA-VSEP enrollment experience as better than their previous experiences. Many indicated that the MA-VSEP process was more caring and positive than other enrollment processes.
- More than 40% of MA-VSEP enrollees who completed the follow-up interview indicated that MA-VSEP enrollment influenced them to access additional help and resources.
- MA-VSEP enrollees who completed the follow-up interview indicated that the program was helpful to them because of the support it provided, as well as its role as a deterrent because of the risk of being caught.
- Specific suggestions to improve the program included incorporating more follow-up and check-ins, better advertising the program, allowing regional VSE, and setting up the program so that an individual does not have to enter the casino or be near the gaming floor to sign up.
- Among the 46 MA-VSEP enrollees who completed the follow-up interview, more than three quarters did not violate their contract. However, 10 (22%) returned to PPC during their exclusion term, 7 (15%) tried to enter the gaming floor, and 2 (4%) were caught. Among MA-VSEP enrollees with player card records we could access, only one recorded gambling activity on his player card after MA-VSEP enrollment.

How Do Enrollees' Behavior and Well-Being Change After Enrollment?

Analyses of changes in enrollee behavior and well-being after MA-VSEP enrollment are based on the subsample of 46 MA-VSEP enrollees who completed the follow-up survey and should be interpreted with caution given sample limitations.

- MA-VSEP enrollees who completed the follow-up interview reported statistically significant improvements in gambling problems, mental health, and relationship quality.
- MA-VSEP enrollees who completed the follow-up interview significantly reduced the frequency and amount they gambled. Though more than 70% continued to gamble, 80% reported that they were gambling less at follow-up than prior to MA-VSEP enrollment.
- MA-VSEP enrollees who completed the follow-up interview and intended to quit all gambling upon MA-VSEP enrollment had less success fulfilling that goal (i.e., only one third stopped gambling) according to their follow-up interviews than enrollees who intended to quit only casino gambling.
- Exploratory analyses suggest that MA-VSEP enrollees who selected longer enrollment terms at MA-VSEP enrollment demonstrated less reduction in their gambling than other enrollees according to the follow-up interview.

Do Enrollees Access Additional Resources After Enrolling in MA-VSEP?

Analyses of changes in enrollee behavior and well-being after MA-VSEP enrollment are based on the subsample of 46 MA-VSEP enrollees who completed the follow-up survey and should be interpreted with caution given sample limitations.

- Contrary to hypotheses and our previous research, MA-VSEP enrollment did not appear to serve as a gateway to treatment. Few of the MA-VSEP enrollees who completed the follow-up interview reported newly engaging with gambling treatment after MA-VSEP enrollment. This finding might be related to the high numbers of MA-VSEP enrollees who reported already having a treatment history. However, more were engaged in some way with mental health, substance use, or gambling services after MA-VSEP enrollment than in the year prior to enrollment. For most who reported engaging with services after enrollment, the follow-up service engagement represented a return to treatment or services, not a new engagement with services. For these individuals, enrollment appeared to provide a nudge to re-engage with services or self-help groups.
- Accessing treatment and self-help resources after MA-VSEP enrollment did not relate to any of the follow-up outcomes (e.g., gambling behavior, gambling problems, mental health) we investigated among follow-up interview respondents.

What Predicts How Well Enrollees Do After MA-VSEP enrollment?

Analyses predicting enrollee behavior and well-being after MA-VSEP enrollment are based on the subsample of 46 MA-VSEP enrollees who completed the follow-up survey and should be interpreted with caution given sample limitations.

- Higher ratings of social support at MA-VSEP enrollment predicted reductions in gambling problems both among all enrollees who completed the follow-up interview and among the subset of follow-up respondents who continued gambling after MA-VSEP enrollment. Higher social support at enrollment also related to improved relationship quality at follow-up.
- The improvements MA-VSEP enrollees evidenced across domains did not appear to be positively linked to whether they chose to stop gambling as part of MA-VSEP enrollment. In fact, those with abstinence goals experienced reduced mental health at follow-up, perhaps because of their inability to meet those goals as evidenced by reports of continued gambling.

Limitations

- The final design of this study limited our ability to draw causal conclusions about the role of the MA-VSEP in effecting change among its enrollees. Without randomized experimental conditions comparing program elements, it is impossible to state definitively what aspect of the program, if any, influenced enrollee behavior and experience.
- The recruitment rate for the survey portion of the study was 24%. Therefore, it is questionable whether we can generalize information from the baseline or follow-up surveys to the MA-VSEP enrollee population.
- Missing data from the MA-VSEP application, one-week check-in forms, and player card database also reduced the generalizability of findings from these data sources.
- As noted in the forthcoming PlayMyWay management system evaluation (Tom, Singh, Edson, LaPlante, & Shaffer, forthcoming), there also are data anomalies within the player card database; these problems raise important questions about the integrity, validity, and reliability of that data.

Recommendations

Program Recommendations

1) Publicize MA-VSEP more widely throughout the state.

2) Specifically collaborate with substance use and mental health treatment organizations to publicize MA-VSEP.

3) Consider making one-week check-in calls a standard part of MA-VSEP, not optional. At the very least, make sure to offer these calls and describe their purpose explicitly to every MA-VSEP enrollee.

4) Include motivational interviewing training for program staff.

5) Conduct an assessment of treatment history and enrollment goals (e.g., abstinence vs. harm reduction) with enrollees at the time of enrollment.

6) Provide resources for gambling treatment and other forms of mental health and substance use treatment in enrollees' regions.

7) Include Rhode Island as a region for which resources are provided.

8) Consider offering regional VSE and making VSEP enrollment available through gambling, substance use, and mental health treatment providers.

Data Systems Recommendations

1) Utilize a relational database to link application data with enrollment terms, one-week check-in data, player card data, and exit interview information.

2) Set up the MA-VSEP electronic application in a way that allows the information to feed directly into the relational database described above and does not default to specific answer options if a question is unanswered.

3) For any data important to the program, do not allow "optional" response within the MA-VSEP application.

4) Create a data system that can generate reports automatically detailing program enrollment, treatment resource access, program removal, and program violation, split by gender, age group, and length of enrollment term.

Continuing Evaluation Recommendations

1) Formalize the information collected during check-in calls and the exit interview for the MA-VSEP, collecting a standardized set of information about outcomes for all enrollees who complete these calls and/or an exit interview. This information should include gambling behavior, gambling problems, mental health, treatment access, MA-VSEP satisfaction and suggestions for improvement, and other domains of interest to the MA-VSEP.

2) Include key domains of interest as mandatory components of the MA-VSEP application, including gambling behavior (i.e., amount, frequency, and type) prior to enrollment, treatment history, enrollment goals and quit intentions, other substance use and mental health issues, and social support.

3) Track information about resources shared with enrollees upon enrollment, information discussed during the check-in call, and enrollee access to these treatment resources.

4) Examine MA-VSEP program features that might be particularly effective at facilitating change by conducting controlled experiments, randomly assigning half of MA-VSEP enrollees to each of two different program conditions and assessing outcomes.

ACKNOWLEDGEMENTS

The Massachusetts Gaming Commission funded this evaluation. The authors thank the following individuals and organizations for their contributions and support for the Massachusetts Voluntary Self-Exclusion evaluation: Mark Vander Linden, Terrance Lanier, Teresa Fiore, and Ny Mahasadeth at the Massachusetts Gaming Commission; and Marlene Warner, Amanda Winters, and Jodie Nealley, at the Massachusetts Council on Compulsive Gambling.

We thank Alec Conte, Layne Keating, Rhiannon Wiley, Pat Williams, Vanessa Graham, and Drs. Matthew Tom, Pradeep Singh, Timothy Edson, and Heather Gray for their contributions to the evaluation and this report.

We also extend our thanks to the GameSense Advisors at Plainridge Park Casino including Terence Murphy, Gerry Pacitti, Dennis Braun, Amy Gabrila, Bill Milhomme, Sarah Davis, Megan Daniels, and Eddie Delvalle for partnering with us in this research endeavor and recruiting MA-VSEP enrollees for participation in this study.

Finally, we wish to extend special thanks to the enrollees in the MA-VSEP who participated in this study and provided valuable information for the evaluation and improvement of the MA-VSEP.

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1. INTRODUCTION

1.1. Rationale

On November 22, 2011, Massachusetts Governor Deval Patrick signed into law the Expanded Gaming Act. The law allowed up to three destination resort casinos and one slots facility to operate in the Commonwealth. The law also created the Massachusetts Gaming Commission (MGC), a five-person regulatory body tasked with overseeing the licensing and regulation of gambling venues. The Expanded Gaming Act includes several mandates designed to mitigate potential harm associated with expanded casino gambling in Massachusetts. Among these, *section 45 subsection f* established a gambling establishments exclusion list ("Bill H03697," 2011)[1] to be maintained by the MGC. The exclusion list includes two groups: Involuntary Exclusion (e.g., those excluded for committing crimes) and Voluntary Self-Exclusion (i.e., those who voluntarily seek to ban themselves from the Commonwealth's expanded gambling venues, excluding, for example, lottery; VSE). The current report pertains to VSE.

VSE is defined as an agreement between an individual and a casino(s) and/or a state regulatory agency banning them from entering the casino(s) for a specified period. VSE programs vary, some are state-, province-, or company-wide; others concern a single casino. VSE terms also vary in that some programs allow people to ban themselves only for life, while others allow temporary bans. Some casinos/regions enforce VSE with legal actions, such as criminal trespassing, whereas others simply escort self-excluders off the premises. VSE policies also can include the forfeiture of any wagers, winnings, or losses if participating individuals get caught at a banned gambling venue.

During the fall of 2014, the MGC developed a Responsible Gaming Framework to inform all its responsible gambling-related regulations. Responsible gambling initiatives are industry focused harm reduction efforts that seek to reduce the incidence (i.e., new cases) and ultimately the prevalence (i.e., rates) of problem gambling by providing gamblers with strategies to reduce the frequency or duration of their gambling behavior (Ladouceur, Shaffer, Blaszczynski, & Shaffer, 2017). *Strategy 2.4* of the Responsible Gaming Framework (Massachusetts Gaming Commission, 2014) specifies that operators will make available to patrons three opportunities for VSE: (1) removal of patrons from marketing lists; (2) preventing patrons from using check cashing or house credits; and, (3) VSE from casinos state-wide. The framework dictates that the primary location for VSE programs will take place in responsible gambling information centers formally branded as GameSense Info Centers[2].

Part of the MGC's responsibilities under the Expanded Gaming Act also include establishing and maintaining a research and evaluation agenda to study the social and economic consequences of expanded gambling and assess the impact of its responsible gambling programming. This report, in part, supports this requirement. The MGC has contracted with the Division on Addiction at Cambridge Health Alliance, a Harvard Medical School teaching hospital to provide an evaluation of the Massachusetts Voluntary Self-Exclusion Program (MA-VSEP). The Division has worked with the MGC and the Massachusetts Council on Compulsive Gambling (MCCG) to develop this evaluation, and this evaluation's protocol reflects contributions from all organizations. This report summarizes data collected during the period of June 24, 2015 – April 24, 2017.

1.2. Understanding VSE & its Users

Missouri was the first statewide VSE program in the United States, created by the Missouri Gaming Commission (MOGC) in 1996. Applicants to the program added themselves to the List of Dissociated Persons, which required a lifetime ban. Through this contract, each enrollee assumed responsibility for remaining off casino property. Missouri casinos used the list of self-excluders to remove self-excluders from marketing lists, prohibit self-excluders from cashing checks on the premises, and check all gamblers' identifications against the list before compensating any jackpot winner of $1,200 or more. If an enrolled person returned to a casino, they could be arrested and charged with trespassing. MOGC now allows those who have served 5 years of self-exclusion to be removed from its List of Dissociated Persons upon request.

[1] https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter194

[2] The Division on Addiction has overseen an evaluation of the GameSense Info Center at Plainridge Park Casino. For information about this evaluation, please email info@divisiononaddiction.org .

As scientific reviews of VSE have described (e.g., Drawson, Tanner, Mushquash, Mushquash, & Mazmanian, 2017; Gainsbury, 2014; Kotter, Kraplin, Pittig, & Buhringer, 2018; Ladouceur et al., 2017; Nowatzki & Williams, 2002; Parke, Parke, Harris, Rigbye, & Blaszczynski, 2014), today, VSE is a popular intervention around the world. Governments across the globe have implemented VSE programs, from Australia to Asia to Europe to North and South America. However, the adoption of VSE programs is not exclusive to governments, as casinos and Internet gambling companies have implemented VSE programs that permit individuals to ban themselves from entering specific casinos or using specific websites for a specified time period or for a lifetime. The purpose of these programs has evolved from its more punitive beginnings (i.e., charging people who violated their VSE contracts with criminal trespass) toward harm reduction intervention – offering a variety of VSE options to help people better avoid the consequences of excessive intemperate gambling.

Although VSE programs are now prolific, published studies of such programs are more limited. Nonetheless, what we know about VSE and its users is growing. For example, a recent research synthesis suggests that people who self-exclude are predominantly male and middle aged, and often have extensive mental health problems, including gambling-related problems and other co-occurring disorders, such as anxiety, depression, and other expressions of addiction (Kotter, Kraplin, Pittig, et al., 2018). However, perhaps the most important research related to VSE includes studies that observe VSE over time. Studies such as this reveal, for example, that VSE programs go through periods of adaptation (i.e., enrollment slows and levels off) after initial patterns of increases in enrollment when a program launches (LaBrie et al., 2007). The dynamics of VSE are important to understand, as they are essential to evaluating how well such programs work for enrollees. Fortunately, the available peer reviewed literature includes dynamic studies of VSE, which we review briefly in the following section.

1.2.1. Longitudinal Studies of Voluntary Self-Exclusion Programs

Research on VSEs is limited; few quality longitudinal studies are available. Many early studies evaluating VSE either were cross-sectional or did not do an adequate job of controlling for confounding factors (e.g., LaBrie et al., 2007; Ladouceur, Jacques, Giroux, Ferland, & Leblond, 2000; Nower & Blaszczynski, 2006). These limitations prevent researchers from determining whether observations were a direct result of VSE participation, or due to some other factor. Several longitudinal studies address some of these concerns and provide useful insights about the potential effectiveness of VSE programs. The following brief summaries of some land-based VSE studies[3] provide information about the nature of VSE enrollees, observations about the impact of VSE, and areas that require further consideration and programmatic development.

- **Ladouceur, Sylvain, & Gosselin (2007):** A multi-year longitudinal study of 161 individuals who self-excluded from gambling in Quebec. Most participants were male, middle-aged, and employed. About a third chose to enroll in VSE for 6 months, almost half for 12 months, and the remainder for 24 months or more. About 75% indicated that financial problems stimulated their decision to self-exclude, and nearly 90% met criteria for the highest risk category on the South Oaks Gambling Screen (SOGS: Lesieur & Blume, 1987). At baseline, most study participants indicated that they believed that enrolling in VSE would be effective and a great way to help themselves. Most changes for key outcomes occurred between the baseline survey and a follow-up survey at six months. Many changes were maintained for the 18- and 24-month follow-up surveys. For example, participants reported enduring decreases in the urge to gamble, SOGS scores, and DSM-IV criteria met, and increases in perceived control, initiated especially between the baseline and 6-month follow-up. By the 6-month follow-up, 40.5%, 42.3%, and 22.2% of those who excluded for 6, 12, and 24 months reported returning to a casino.
- **Townshend (2007):** A small follow-up study of 35 individuals in treatment for gambling-related problems who self-excluded from gambling in New Zealand. Most participants were male, and many had co-occurring mental health problems. Further, many had a history of expressions of addiction other than gambling. At baseline, enrollees presented with significant problems; the average enrollee met six DSM-IV criteria and had lost $1,001 in the past month. At the time of follow-up, participants had been enrolled in VSE for 2 to 24 months, and this study did not control for the amount of time participants were involved with VSE. The researchers observed reductions in DSM-IV criteria met, as well as reductions in money lost during the previous month. The researchers also reported

[3] Studies of VSE from Internet gambling websites are available (Dragicevic, Percy, Kudic, & Parke, 2015; Haeusler, 2016; Hayer & Meyer, 2011; LaBrie & Shaffer, 2011; Nelson et al., 2008); however, the current report focuses upon studies of land-based programs because they are most directly relevant to the MA-VSEP in its current form.

increases in perceived control over gambling and abstinence. The researchers did not report a comparison of VSE enrollees to other in treatment for gambling-related problems, so it is unclear whether the reported findings are attributable to VSE enrollment, or their broader treatment engagement.

- **Tremblay, Boutin, & Ladouceur (2008):** A longitudinal evaluation of participants in a specialized VSE program in Montreal during 2005. At baseline, 79.5% met DSM-IV criteria for pathological gambling and another 15.4% were considered at-risk. About half of participants reported that they had previously self-excluded. The specialized program offered individuals the opportunity to meet in person with a psychologist for feedback about their gambling activities and additional referral resources, monthly phone meetings with the counselor for the duration of their VSE, and required a program exit meeting with the psychologist for those who wanted to end their VSE. About 75% of enrollees opted into the specialized program, and the remainder entered a standard program (i.e., no psychologist involvement). Among those who selected the specialized program, 40% requested to meet in person with a psychologist, and of those 37% actually did. About 70% of those eligible to exit VSE did so through the required exit meeting. Surveys completed with those who exited showed that the majority were satisfied with the program and its more supportive complimentary components. Among the minority who participated in both the optional in person meeting and the required exit meeting, most were males and a plurality excluded for 6 months. The researchers reported that these participants reduced their time and money spent gambling, reduced the number of DSM-IV criteria they endorsed, and improved on a variety of other gambling-related outcomes.
- **Nelson, Kleschinsky, LaBrie, Kaplan, & Shaffer (2010):** A retrospective longitudinal study of 113 Missouri lifetime self-excluders 10 years after the program was introduced. About 45% of study participants were male and most were white, employed, and middle-aged. At the time of the survey, length of VSE enrollment ranged from almost 4 years to just more than 10 years. About 13% reported that they had not gambled since enrolling in the program. However, about 81% of those who reported that they continued to gamble also reported that they gambled less than before their enrollment and no one reported gambling more. Likewise, participants reported experiencing fewer gambling-related symptoms after enrollment compared with before. The sample evidenced a 40% abstinence rate at follow-up. About 16% of the sample reported trying to re-enter Missouri casinos, on average 4.7 times, but only 50% of those did so successfully. Almost 75% of the sample reported gambling in other jurisdictions. The researchers note that the observation of improvements on key variables coupled with continued access to gambling suggests that the decision to enroll in VSE itself, rather than lack of access or enforcement, likely influenced success. Notably, enrollment was associated with an increased likelihood of pursuing and participating in treatment for gambling.
- **Cohen, McCormick, & Corrado, (2011):** A longitudinal study of 169 participants in a VSE program in British Columbia, Canada. Participants completed four rounds of surveys, at baseline, 6-, 12-, and 18-month follow-up. The majority of the sample was white, female, and middle aged. Mental health problems were prevalent in this sample with 62% and 58% reporting ever having anxiety or depression, respectively. Nearly half reported currently having either anxiety or depression problems. On average the sample spent $960 a week, and the three most popular gambling activities were slot machines (88%), lotto (76%), and keno (52%). The top three reasons for enrolling in VSE were having a problem with gambling (94%), financial problems (80%), and feeling it was there only option (71%). A majority of enrollees continued to gamble at 6 (59%), 12 (69%), and 18 months (54%) after enrollment with nearly three quarters of those at each time point identifying casino gambling as the most common location. Among those who were still gambling, more than half reported continuing to gambling at casinos in the region, 55% at 6 months, 94% at 12 months, and 58% at 18 months after enrollment. At 6 months after enrollment, 23% of respondents reported breaching their VSE agreement. That number grew to 47% at 12 months and 50% at 18 months.
- **Hing, Russell, Tolchard, & Nuske (2015):** A longitudinal assessment that compared 33 non-excluders who received counseling to two groups of self-excluders: (1) a group of 19 who did not receive counseling and (2) a group of 34 people who self-excluded and did receive counseling. All three groups improved on a variety of measures across time. Most outcomes did not differ according to whether self-excluders received counseling or not; however, more of those self-excluders who had counseling attempted to breach their contract compared to those who did not have counseling (32.4% versus 15.8%, respectively, with 55% and 33% of the same detected). Most

improvements were made between Time 1 and Time 2, not between Time 2 and Time 3. Also, there were few significant differences between self-excluders and non-excluders, though self-excluders appeared to have higher rates of abstinence. Overall, the results suggest that engaging with an intervention, whatever that intervention is, might account for most of the change observed.

- **Sani & Zumwald (2017):** A retrospective follow-up study that compared 86 female gamblers who obtained re-admission after completing a casino self-exclusion in Ticino, Switzerland. The sample was broken into four groups: (1) female gamblers who requested self-exclusion and then received readmission (68.6%); (2) female gamblers who requested a self-exclusion, followed by readmission, and then subsequent self-exclusion (18.6%); (3) female gamblers who self-excluded more than once, readmitted to casinos and then self-excluded again (4.6%); and (4) female gamblers who requested multiple self-exclusions, received readmission, and did not request any further self-exclusions (8.2%). Approximately half of the sample was married (49%) and 62% were between the ages of 41 and 60. The preferred forms of gambling were slot machines (87%), casino table games (9%), and both slots and table games (4%). A large majority of these self-excluders gambled at least weekly (85%). Half of self-excluders reported doing so for preventative reasons, 36% because they spent too much money, and 10.5% for spending too much time gambling. Nearly two-thirds of the sample (62%) continued to gamble during self-exclusion. They also found that those who requested more than one self-exclusion were more likely to be social gamblers (77.8%) compared to those with no previous self-exclusions (41.8%). Finally, the researchers compared the rates of problem and pathological gambling before and after signing up for subsequent self-exclusions and found reductions in problem gambling (40% to 12%) and pathological gambling (35% to 18%).
- **Kotter, Kräplin, & Bühringer (2018):** A retrospective longitudinal examination of VSE in Germany compared 187 self-excluders and 28 forced excluders on a variety of gambling outcomes. Type of VSE was not associated with any demographic characteristics. Participants were mostly male (81.4%), in their late 30s at first exclusion (M=38.4; SD=14.3), 84.7% with middle or high education, 84.2% with middle or high socioeconomic status, and 62.0% currently in a relationship. More than half (53.5%) met DSM diagnostic criteria for the most severe level of Gambling Disorder, and the remainder reported at least one symptom. After exclusion, enrollees experienced significant reductions in the breadth (i.e., types of games) and depth (i.e., time and money spent) of their gambling behavior. In fact, 20.5% of excluders in the sample abstained from all gambling and 66.5% reported reduced gambling behavior after enrolling in exclusion. That reduced gambling behavior extended beyond casino gambling to reductions in nearly all forms of gambling assessed. Interestingly, self- and forced- excluders both experienced similar reductions in the breadth and depth of their gambling involvement after excluding. Rates of abstinence and gambling reduction were similar for these groups. A limitation is that the number of forced self-excluders was quite small, and therefore, it is possible that the absence of significant effects might relate to low power. The researchers also note that successful enrollees might have been more willing to participate, which is a limitation that applies to all such studies.
- **Pickering, Blaszczynski, Gainsbury (2018):** A retrospective follow-up examination of the experiences, beliefs, motivations, and outcomes of 56 self-excluders selected from 266 self-excluders with contact information. The program was a multi-venue VSE system. Two-thirds of the sample described their motivation for self-excluding as stemming from a financial loss/hardship or loss of control. About half of the sample noted that they were not ready to stop gambling and wanted to chase their loses. About 86% of participants reported it being easy to obtain information about VSE. After self-excluding, 63.5% of enrollees reported seeking help Approximately one-third of enrollees (37.5%) reported breaching their contract during their VSE period. Breaches occurred, on average, 6.15 times. Those who breached were identified 42.3% of the time. A majority of enrollees reported benefits of VSE included a greater sense of control, reduced gambling behavior, and improvements in various areas of everyday life including relationships, work, and lifestyle activities. Nearly 4 out of 5 (78.7%) met the criteria for problem gambling at enrollment.
- **McCormick, Cohen, & Davies (in press):** A study of VSE in British Columbia involved 269 participants surveyed at baseline (within one month of enrollment), a 6-month, and a 12-month follow-up. Participants were about half male and middle-aged. Most were white and employed. The average amount reported lost in one gambling session was $1569 (Median = $700). Researchers compared changes in gambling activity among those who reported

abstaining (i.e., 12.4%), those who reported non-casino gambling (i.e., 68.0%), and those who attempted to violate their VSE contract (i.e., 19.2%, who attempted to re-enter venues an average of 10.8 times (median=3 times) and were successful 78% of the time). About 80% reported that they did not seek treatment after enrolling. At baseline, about 74% of participants met criteria for the highest risk category of the Problem Gambling Severity Index (PGSI: Ferris & Wynne, 2001). By the 6-month follow up, the researchers report large reductions in PGSI scores, which were maintained through the 12-month follow-up. People who attempted to violate their contract were less likely to report improvements on the PGSI than both other groups, but abstainers and non-casino gamblers were indistinguishable.

1.3. The Massachusetts Voluntary Self-Exclusion Program (MA-VSEP)

As indicated on the MGC website, to fulfill the regulations mandating that VSE be available to the public, interested patrons currently have the option to self-exclude at (1) the Plainridge Park Casino (PPC) either in the GameSense Info Center or with a Gaming Agent when GameSense is closed, (2) the Massachusetts Council on Compulsive Gambling offices with a trained staff member, or (3) the Massachusetts Gaming Commission main office in Boston with trained Gaming Commission staff (Massachusetts Gaming Commission, 2015). Introductory enrollment terms are 6 months, 12 months, 36 months, or 60 months. To complete enrollment, interested individuals must present a government-issued photo ID, complete an enrollment application, and meet with a qualified MA-VSEP agent. During the time of this study, all prospective enrollees also were invited to participate in this research at the time of enrollment.

Enrollment initiates protocols that result in the forfeiture of casino rewards points and removal from casino direct marketing mailing lists. People who violate their MA-VSEP contract are escorted from the gambling floor of the establishment when detected, and forfeit any money wagered, won, or lost, including money converted to wagering instruments, such as chips. Forfeited monies do not return to the casino but are instead transferred to the MGC to be deposited into the Gaming Revenue Fund. Individuals who are enrolled in MA-VSEP are allowed to be in non-gambling areas (e.g., restaurants) of the establishment.

After a patron's initial VSE period, if they wish to renew their MA-VSEP contract, they can select from the same 1-, 3-, or 5-year terms or select to be self-excluded for their lifetime. The MA-VSEP contract covers all Massachusetts casino properties, so those who are enrolled also will be restricted from MGM Springfield and Encore Boston Harbor when these properties open. At any time after an individual's MA-VSEP period has expired, they can request that their name be removed from the MA-VSEP list. To finalize their removal from the list the individual must complete an "exit interview" with an MGC-designated agent (e.g., MCCG staff).

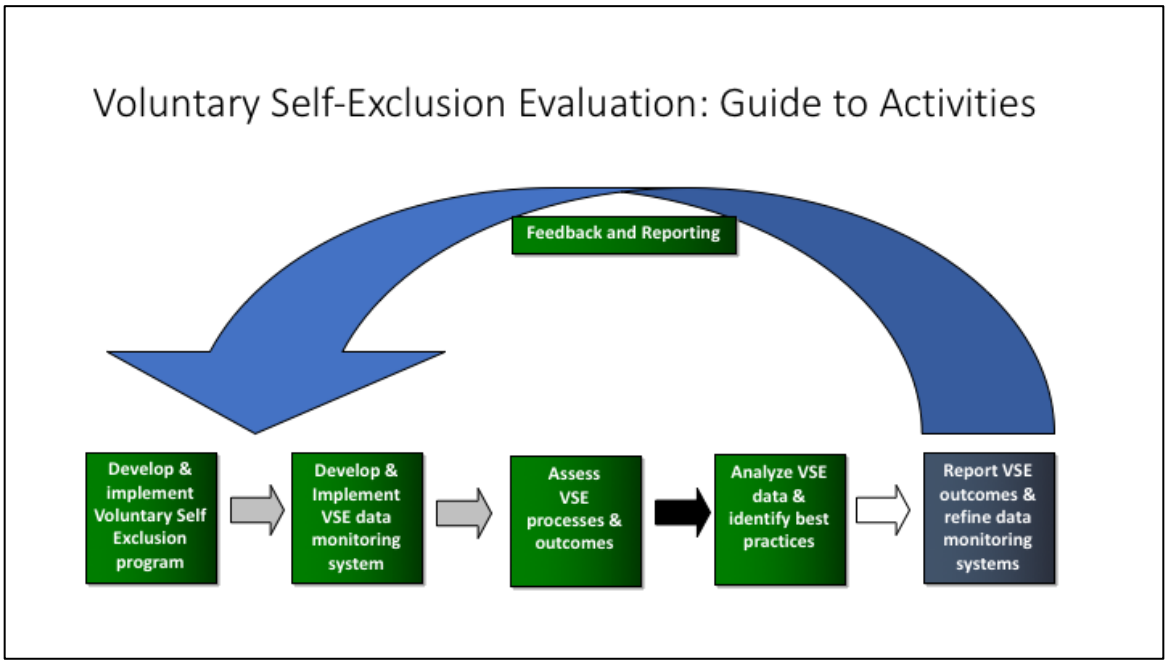
1.4. Current Evaluation of the MA-VSEP

The current study concerns an evaluation of MA-VSEP in Massachusetts, primarily implemented at PPC. Our evaluation efforts began in the early stages of the development of the MA-VSEP. Specifically, Division staff consulted to the MGC to build the MA-VSEP record keeping system and help develop the MA-VSEP protocol. We worked collaboratively with staff from the MCCG and its GameSense Advisors (GSAs) to ensure both the MA-VSEP and its associated study protocols were well understood. As a result of these efforts, this evaluation includes (1) secondary data analyses of MA-VSEP records, including application data, (2) secondary data analysis of information related to one-week check-in calls conducted by the MCCG staff, as well as (3) baseline and 6-month longitudinal follow up of a subsample of MA-VSEP enrollees who agreed to participate in the study. This research agenda is consistent with initial evaluation processes for programs in their early development.

As Figure 1 illustrates, an effective evaluation of VSE should start during the development of the program. Subsequently, planners should develop, implement, and refine data monitoring systems in tandem with the VSE program itself. The data monitoring system should allow program staff to gather all the data necessary for a thorough evaluation. Key outcomes for the evaluation might include program compliance, treatment seeking activities, program satisfaction, healthy changes in gambling behaviors, attitudes, and cognition, mental health and well-being improvements, and more. The evaluation team should meet on a regular basis with the program staff to check for issues with data monitoring, and correct issues, as needed. Additionally, the evaluation team should analyze data on a regular basis and report findings to key stakeholders, including program planners and staff. Doing so will create a data-driven feedback loop that further enhances the VSE

program. This knowledge increases the evidence base for the program, essentially "training" it to be more useful over time. This report represents the first cycle of this evaluation loop.

Figure 1: Feedback Evaluation Loop as Applied to Voluntary Self-Exclusion Programs



1.4.1 Overall Strategy of the Evaluation of the MA-VSEP

The strategy of the current study is to provide an objective evaluation of the MA-VSEP by assessing the gambling behaviors, gambling problems, mental health, and well-being of MA-VSEP enrollees across time. Our overall aim is to help the MGC to understand the characteristics of its MA-VSEP enrollees and their experiences with MA-VSEP so that we might make evidence-based recommendations for program improvements. To fulfill that aim, our specific evaluation goals are:

1) Understand enrollment trends across time and place.

2) Understand who signs up for MA-VSEP and why.

3) Evaluate MA-VSEP satisfaction and experiences of enrollees.

4) a) Examine outcomes for enrollees 6-12 months after MA-VSEP enrollment.

b) Examine whether MA-VSEP enrollment is a gateway to treatment.

To that end, this report includes the following analytic areas using the diverse data sources described above: (1) MA-VSEP enrollment trends across time; (2) MA-VSEP enrollee characteristics; (3) MA-VSEP enrollees' experiences and satisfaction with MA-VSEP; (4) MA-VSEP enrollees' changes in behavior and well-being after MA-VSEP enrollment; and (5) resource and treatment access before and after MA-VSEP enrollment. In addition, we include exploratory analyses of factors that influence positive changes among MA-VSEP enrollees, as well as moderator effects in the Appendix.

2. METHODS

2.1. Design

Due to a variety of circumstances discussed in detail below, the study design changed as the evaluation proceeded. In this section, we describe the varying conditions under which we collected data.

2.1.1. Initial Design

Initially, the MGC requested that we oversee a randomized controlled trial (RCT) of two different versions of the MA-VSEP. Participants were randomized to either (1) standard MA-VSEP enrollment; or (2) enhanced MA-VSEP enrollment. They completed a survey at enrollment and were interviewed over the phone 6 months after enrollment. GSAs conducted MA-VSEP enrollment procedures and the initial study protocol. Division staff conducted follow-up interviews.

2.1.1.1. Standard MA-VSEP Enrollment

The MGC's standard MA-VSEP enrollment involved filling out a MA-VSEP application, either on paper or via a fillable form on an iPad. The application included identifying information, photo, demographics, and questions about reasons for signing up and gambling behavior. The designated staff at PPC then reviewed the application and program requirements with the enrollee. This included confirming with the enrollee the desired length of enrollment (i.e., from six months to five years), his or her understanding of the agreement (i.e., that the enrollee will stay out of the gambling areas of MA casinos, will forfeit any money deposited in machines or winnings if caught, and will be ejected from the gambling floor if found there), his or her understanding that the length of enrollment cannot be decreased once enrolled, and his or her understanding that the application applies to all gambling establishments licensed by the MGC. The designated staff member then provided the MA-VSEP enrollee with a packet of resources (included in Appendix A), created by the Massachusetts Council on Compulsive Gambling (MCCG), which includes contact information and web links for gambling treatment and self-help resources. (There are three versions of this packet, tailored to fit each of the three MA casino regions.) The staff member briefly reviewed those resources with the MA-VSEP enrollee. The staff member then forwarded all materials related to MA-VSEP enrollment to the MGC offices for final processing.

2.1.1.2. Enhanced MA-VSEP Enrollment

The MGC's enhanced MA-VSEP enrollment was identical to the standard procedure described above, with three additions. First, when providing the MA-VSEP enrollee the packet of resources, the designated staff member offered to connect the enrollee directly with the MCCG helpline so that he or she could learn more about treatment resources and be referred to treatment. Second, in addition to the packet of resources described above, enrollees in the enhanced condition received a gambling self-help toolkit, *Your First Step to Change*. Third, an MCCG representative contacted all MA-VSEP enrollees in the enhanced condition one week after MA-VSEP enrollment to check in on them and offer support in accessing resources. For individuals who were not originally connected with the Helpline because they chose not to be at the time, the MCCG representative offered to connect the individual with gambling treatment or self-help resources during this follow-up call. For individuals who were connected with the Helpline when they signed up for MA-VSEP, the MCCG representative making the follow-up call checked to see if the individual had accessed treatment or needed any additional help scheduling an appointment.

2.1.2. Final Design

We implemented the initial design for three months, between November 25th, 2015 and February 28th, 2016.[4] During that time, 30 individuals enrolled in MA-VSEP, and 3 agreed to participate in the study. Through collaborative meetings, we determined that the procedures necessary to implement the RCT were too complex for the GameSense Advisors (GSAs)

[4] We received final drafts of VSEP protocols and procedures from MGC on June 1st 2015 and submitted our research application to the MA Department of Public Health (DPH) Institutional Review Board (IRB) on June 5th, 2015. The DPH IRB decided to cede review to the Cambridge Health Alliance (CHA) IRB on June 30th, 2015. We submitted our research application to the CHA IRB on July 10th, 2015 and did not receive final approval until November 3rd, 2015.

to execute, and likely contributed to the low recruitment.[5] In addition, it became clear that the "standard" version of MA-VSEP enrollment being implemented too closely resembled the enhanced version as designed. The GSAs tasked with implementing MA-VSEP were tailoring their behavior to the individuals who enrolled, which sometimes meant deviating from the standard protocol and offering those individuals additional resources.

As a result of this problem, with MGC collaboration, we decided to change the design and remove the randomized controlled component of the study. Instead, for the remainder of the study, beginning on March 1st, 2016, through November 30th, 2017, GSAs offered the enhanced version of MA-VSEP enrollment to all enrollees. Those who agreed to participate in this phase of the study completed a survey at enrollment and were interviewed over the phone 6 months after enrollment.

To supplement our available data, when we changed the design, we also added a procedure that included retroactive recruitment of individuals who already had enrolled in MA-VSEP and provided a release of their contact information to the Division. Specifically, GSAs asked enrollees who did not participate in the study at the time of enrollment, including the 64 who enrolled in MA-VSEP before the study began, for permission for the study team to contact them at a later date. Members of the Division research team then called individuals who provided permission and attempted to enroll them in the study. For respondents who consented, Division research team members administered the baseline survey over the phone.

2.2. Procedures

2.2.1. MA-VSEP Enrollment

Only designated individuals (i.e., MGC Gaming Agents, trained MCCG employees, or GSAs) who have been trained to handle inquiries about and enrollment in MA-VSEP can conduct a MA-VSEP enrollment. Individuals seeking MA-VSEP enrollment must enroll in person with a designated agent. MA-VSEP enrollment most often takes place[6] at the GameSense Information Center within PPC, run by GSAs, who are employees of the MCCG tasked with providing information and resources to PPC patrons. GSAs are trained by the MCCG to enroll individuals in the MA-VSEP. The Division trained these same individuals in human subjects research[7], so they are able administer study procedures to potential MA-VSEP enrollees interested in participating in the research study.

As described in Section 2.1.1., upon a request to enroll in MA-VSEP, a GSA or other designated agent explains the program, helps the potential enrollee complete a MA-VSEP application, and provides the enrollee with a packet of resources. Length of enrollment options range from six months to five years, with a lifetime enrollment allowed once an enrollee has completed one previous MA-VSEP term. Enrollment length cannot be altered once an application has been accepted. Enrollees agree to stay out of the gambling areas of MA casinos and are informed that they will be ejected from the gambling floor if they are caught and will forfeit any winnings. Enrollees must proactively request removal from the MA-VSEP program if they no longer wish to participate one their term is complete, regardless of their requested term of enrollment. Beginning in March 2016, in addition to providing treatment resources, designated agents offered all MA-VSEP enrollees the opportunity to receive a check-in call from the MCCG one week after enrollment.

All materials related to MA-VSEP enrollment are forwarded to the MGC offices for final processing, and contact information is forwarded to the MCCG for purposes of follow-up. As a research partner, the Division is provided with de-identified copies of applications and MCCG follow-up materials for *all* MA-VSEP enrollees, whether they choose to participate in the survey portion of the study or not.

[5] Because VSE enrollments are sporadic and infrequent, attempting to conduct the RCT with other research study staff would have been impractical.
[6] Both the MCCG and MGC are also listed as locations where individuals can enroll in MA-VSEP. At the time of this report, only 4 individuals enrolled at a location other than PPC.
[7] GSAs completed human subjects training through the National Institutes of Health Office of Extramural Research's online course, "Protecting Human Research Participants" and also attended a 3-hour training by Division personnel on specific study procedures, human subjects issues, and best research practices.

2.2.2. Research Study Consent Procedures

2.2.2.1. Study Enrollment During MA-VSEP Enrollment

During the period this study was in the field, once a GSA or other MCCG staff member[8] had conducted the MA-VSEP enrollment process, he or she invited the enrollee to participate in the research study. The staff member described the research study and reviewed the research study informed consent form with the MA-VSEP enrollee.[9] If the potential enrollee chose to participate in the research study and signed the informed consent form, the staff member provided the participant with a copy of the signed consent form. A copy of the informed consent form is attached in Appendix B.

2.2.2.2. Consent Procedures for MA-VSEP Enrollees Who Provide Permission for Division Contact

There was a four-month delay between the time Massachusetts began the MA-VSEP and the date on which the Cambridge Health Alliance Institutional Review Board approved the MA-VSEP study. During that time, 64 individuals signed up for the MA-VSEP. Because the research study was not yet active, MA-VSEP enrollment staff asked these enrollees to sign a release form to give Division staff permission to contact them at a later time to invite them to participate in the research study. MA-VSEP enrollment staff also asked individuals who enrolled in MA-VSEP once the study was active but did not have time or desire to participate in the informed consent procedure for the study at the time of their MA-VSEP enrollment, to provide permission for Division staff to contact them later to inform them about the study.

Within the first month of the study, Division research team members attempted to contact all MA-VSEP enrollees who enrolled prior to the study start date and agreed to be contacted. For MA-VSEP enrollees who provided permission once the study had begun, Division research team members attempted to contact these individuals within a week of their MA-VSEP enrollment. Contact procedures included leaving messages, but not mentioning MA-VSEP in those messages, in order to protect the individual's privacy. (The telephone scripts for these calls are attached in Appendix B.) Once the research team member succeeded in speaking with the MA-VSEP enrollee, the research team member described the study and read the informed consent form to the potential participant, answering any questions that came up. If the individual agreed to participate, the research team member recorded their consent in a study log.

2.2.3. Data Collection Procedures

2.2.3.1. Baseline Survey Administered during MA-VSEP enrollment

Once the GSA or MCCG staff member completed the MA-VSEP enrollment process, and the MA-VSEP enrollee had provided informed consent to participate in the study, the staff member then gave the study participant the baseline MA-VSEP study survey to complete, with assurances that the staff member would not look at the survey. The participant did not enter their name on the survey and returned the survey in an envelope. Separately, the participant completed a contact information sheet so that a Division research team member could contact the participant for his or her 6-month follow-up interview. Upon completion of the survey and contact information sheet, the participant received a $15 gift card. Division research team members collected the surveys and entered them into a database using Qualtrics.

2.2.3.2. Baseline Survey Administered via Telephone

For study participants enrolled by telephone by Division research team members, once the individual provided informed consent for the study, the research team member offered to conduct the baseline survey immediately over the phone or to schedule a time to do so that was convenient for the participant. The research team member then administered the survey over the telephone, either as part of the initial contact or at the later scheduled time. The telephone version of the survey had language modified to reflect that questions were being asked about the timeframe prior to signing up for MA-VSEP, and not the time period between MA-VSEP enrollment and present time. During administration, the research team member entered the respondent's answers into a version of the survey programmed into Qualtrics. Upon completion of

[8] We trained GSAs and MCCG staff to conduct research study procedures. Individuals who enrolled with a Gaming Agent when GSAs were not on duty were offered a release to sign; signing the release allowed Division researcher to contact these participants, who did not undergo consent procedures onsite.

[9] Beginning in 2017, GSAs also were instructed to offer to play a short 1-2 minute video about the study to enrollees. In discussions with the GSAs, it is not clear that any enrollees accepted the offer. That video is available upon request from the MGC.

the survey, the research team member collected contact information from the participant for the 6-month follow-up interview and mailed a $15 gift card to the participant.

2.2.3.3. 6-Month Follow-Up Interview

Procedures for administering the 6-month interview were largely identical to those used to administer the baseline survey over the telephone. Six months after MA-VSEP enrollment, research team members attempted to contact the participant to schedule the follow-up interview. Once the research team member reached the individual, the research team member reminded the participant of the study and answered any questions about the follow-up. If the individual agreed to participate, the research team member offered to conduct the follow-up survey over the phone or schedule a time to do so that was convenient for the participant. At the scheduled time, the research team member administered the interview over the telephone. During administration, the research team member entered the respondent's answers into a version of the survey programmed into Qualtrics. Upon completion of the survey, the research team member mailed a $25 gift card to the participant.

2.2.3.4. Additional Recruitment and Retention Procedures

At MA-VSEP enrollment, enrollees who were interested in participating in the research evaluation either by enrolling in the baseline study or releasing their contact information to the Division, completed a comprehensive contact sheet. The contact sheet provided the Division with a variety of modes of contact including telephone, e-mail, and mail, as well as providing permission for Division staff to leave voicemails or text messages. For both initial recruitment and follow-up interviews, the Division did not utilize a specific cut-off for contact attempts, but continued to call, email, and text those who had not responded throughout the study period. Interviewers met weekly to strategize best times to call or text or troubleshoot numbers or email addresses that appeared to be incorrect. For individuals we were unable to reach by phone, text, or email, we sent out mailings to check the contact information we had and remind them of the study.

2.2.4. Protection of Human Subjects

This study and protocol modifications were reviewed and approved by the Cambridge Health Alliance Institutional Review Board. All research team members, both Division staff and GSAs and MCCG staff involved in the study, completed human subjects training (i.e., CITI; NIH). In addition, to prepare the GSAs for the current research project, the Division provided a training prior to the beginning of the study and additional trainings for all new GSAs who were hired during the study period. The training covered the research protocols specific to this project, as well as human subjects issues such as the voluntary nature of the study, the confidential nature of study participation, and the importance of data security. The Division also regularly monitored the study through meetings with the GSAs, and weekly check-ins reviewing each MA-VSEP enrollment and any issues that arose.

2.3. Study Sample

2.3.1. MA-VSEP Enrollees

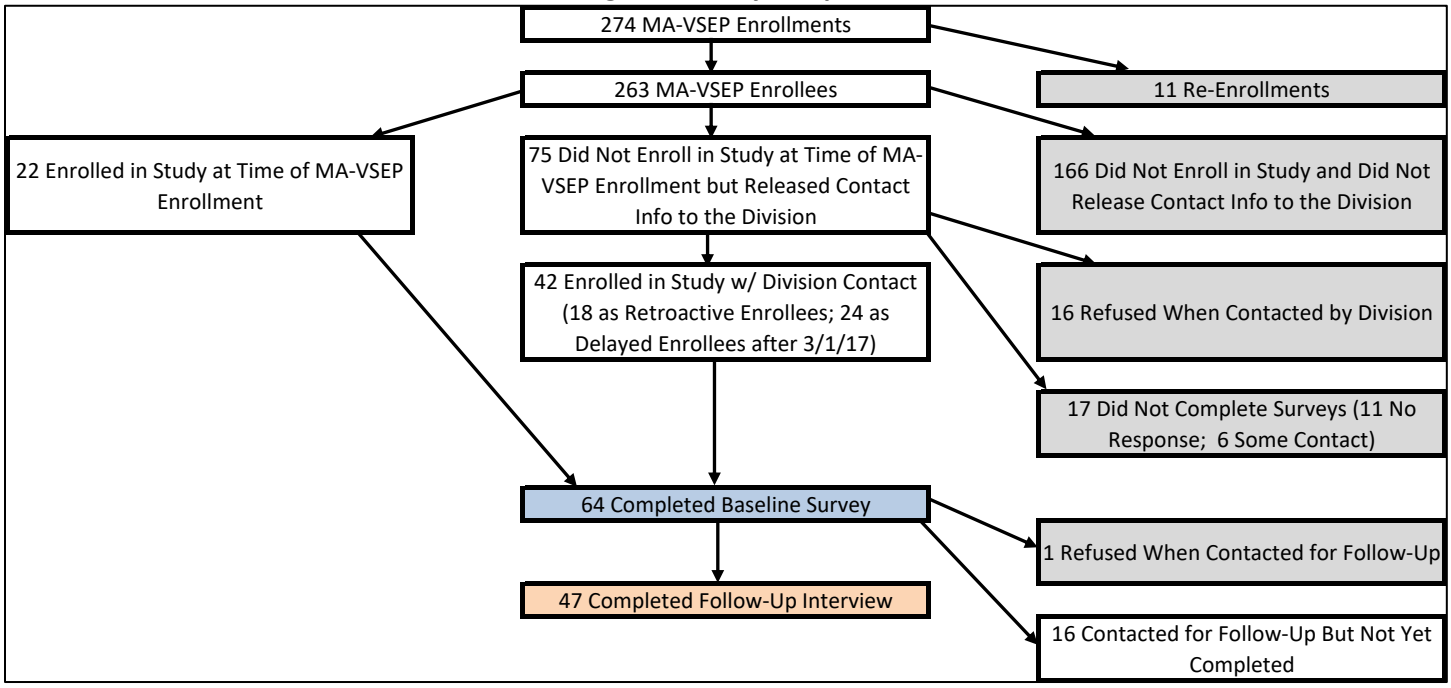
Between June 24th, 2015, when MA-VSEP began, and November 30th, 2017, when this study ended baseline data collection, there were 274 enrollments in the MA-VSEP program. Eleven of these were program re-enrollments (i.e., individuals who went through the process to be removed from the list and then re-enrolled in MA-VSEP at a later time), so these enrollments represent 263 unique individuals.

2.3.2. Baseline Study Sample

Figure 2 provides a diagram of study enrollment. As noted in the Procedures section, there were three possible avenues to participation in the study: (1) study enrollment during MA-VSEP enrollment; (2) study enrollment after MA-VSEP enrollment, by providing a release to be contacted by Division staff and (3) retroactive study enrollment, by providing a release during MA-VSEP enrollment occurring prior to study initiation and completing baseline with Division staff once the study began. Sixty-four individuals enrolled in MA-VSEP prior to the beginning of the study; 28 of those signed releases to allow Division staff to contact them, and 18 of those (64.3%) completed retroactive baseline interviews with Division staff once the study began. Among the 199 individuals who enrolled in MA-VSEP during the study period, 22 completed baseline

surveys at the time of MA-VSEP enrollment, 47 provided releases for Division staff contact, and 24 of those (51.1%) completed baseline surveys with Division staff after MA-VSEP enrollment. Therefore, 64 of the 263 MA-VSEP enrollees (24.3%) agreed to participate in the study. One of these 64 completed the baseline interview upon re-enrollment in MA-VSEP instead of upon initial enrollment. That individual's baseline and follow-up interview data were not used in analyses.

Figure 2: Study Sample



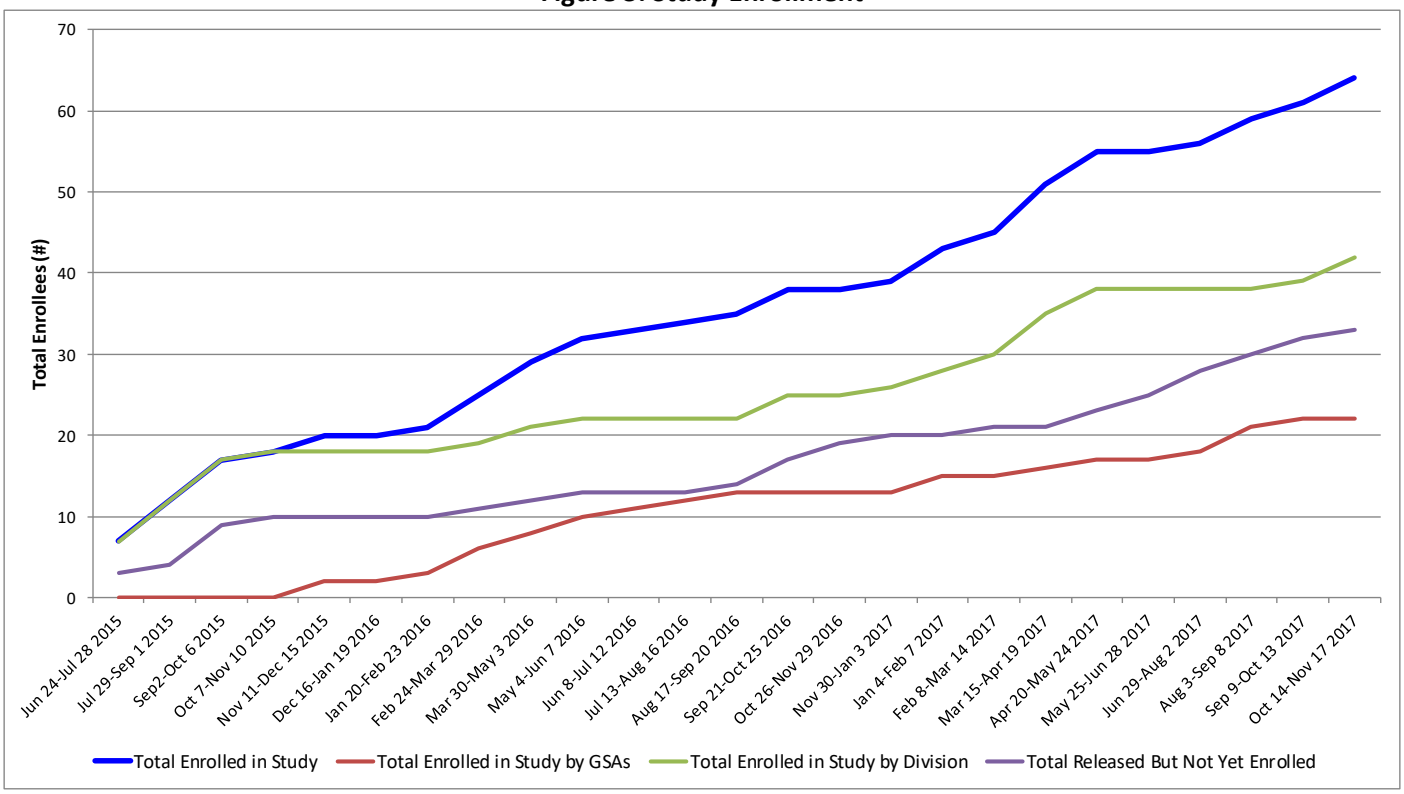
For study enrollment after MA-VSEP enrollment and retroactive study enrollment (i.e., the 28 enrollees who signed releases prior to the beginning of the study and the 47 who provided releases during the study period), the Division was able to establish contact with 64 of those 75 individuals (85.3%). Among the 75 individuals who released their information to us, 42 (56%) enrolled in the study.

Figure 3 provides a depiction of study enrollment across time and method. The figure includes data for MA-VSEP enrollees who agreed to be contacted by the Division but did not respond to contact attempts (i.e., released but not yet enrolled). In our analyses, we compare those who agreed to participate in the study with the rest of the MA-VSEP population on the application data we had available for everyone. We also compare those who completed their baseline interview more than a month after MA-VSEP enrollment to those who completed the baseline interview within a month of MA-VSEP enrollment.

2.3.4. Retention

At the time of this report, we have completed follow-up interviews with 47 of the 64 study participants (73%). Among the remaining 17, we have had some contact with 7 of them, were unable to reach 9, and had one refusal. In our analyses, we compare those who dropped out to those who completed follow-up on baseline and application data.

Figure 3: Study Enrollment



Note. "Released But Not Yet Enrolled" refers to MA-VSEP enrollees who signed releases, but did not respond or refused to participate when contacted by Division staff.

2.4. Measures

2.4.1. Baseline Survey

The baseline survey, attached in Appendix C, asked individuals about their gambling behavior, gambling attitudes, gambling problems, mental and physical health, substance use, social support, and past treatment. The survey took between 10 and 20 minutes to complete. The bullet points that follow describe the domains that compose the survey.

- Satisfaction with the Self Exclusion Process. To assess satisfaction with the VSEP enrollment process, the baseline survey included questions asking respondents to rate their satisfaction with enrollment, as well as provide their impressions about the enrollment location and interactions with staff. The survey also asked respondents to select from a list of reasons for their decision to self-exclude, compiled based on previous self-exclusion research (Nelson et al., 2010), and also provide their own reason for self-excluding on that day in particular.

- Gambling Behaviors and Problems. To assess gambling behavior, the survey included questions about how often respondents had gambled in their lifetime using a 7-point scale ranging from never to 1,000+ times, how old they were when they first began gambling, and, for nineteen different game types (e.g., casino table games, casino slots, non-casino poker, lottery), how often they played the game (from "never" to "daily or more" on an 8-point scale). To assess gambling problems, the survey incorporated a past-12 month adaptation of the gambling section of the Alcohol Use Disorder and Associated Disabilities Interview Schedule IV (AUDADIS-IV: Grant et al., 2003). The AUDADIS-IV Gambling Section assesses signs and symptoms of disordered gambling. Each of the 16 items pertains to one of the 10 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: American Psychiatric Association, 2000) criteria for pathological gambling. Examples include, "Ever find that you became restless, irritable, or anxious when trying to quit or cut down on your gambling" and "Ever more than once try to quit or cut down on your gambling, but found you could not do it". When scoring the AUDADIS-IV, endorsement of any item pertaining to a DSM criterion results in a score of 1 (i.e., yes) for that criterion; endorsing more than one item pertaining to a single criterion does not increase a respondent's score. In addition to reframing the AUDADIS-IV questions to ask only about the past 12 months, we altered one question, originally "Did you ever spend a lot of time gambling, planning your bets, or studying the odds?" to read "Did you

ever spend a lot of time thinking about gambling, planning your bets, or studying the odds?" This question, a measure of preoccupation, would have been confounded with gambling frequency had we not altered it. We have used this adaptation of the AUDADIS-IV questions in previous work (Nelson, Kleschinsky, LaPlante, Gray, & Shaffer, 2013). For the current study, to create a measure of DSM-5 gambling disorder, we combined the AUDADIS-IV criteria according to DSM-5 rules instead of DSM-IV rules, including only the nine criteria present in DSM-5 and coding endorsement of four or more of these nine criteria as indicative of gambling disorder. We also coded whether that disorder was mild (4-5 criteria endorsed), moderate (6-7 criteria endorsed), or severe (8-9 criteria endorsed).

- Gambling-Related Beliefs and Attitudes. To measure gambling attitudes, the survey included 15 statements adapted from previous work with casino employees (LaPlante, Gray, LaBrie, Kleschinsky, & Shaffer, 2012) and expanded to include questions about attitudes toward gambling expansion. Participants rated each statement on a 5-point Likert scale from "disagree strongly" to "agree strongly".
- Mental and Physical Health. To screen for mental health problems, the survey included several short screens. Respondents answered a modified version of the Patient Health Questionnaire-4 screen for anxiety and depression (PHQ-4: Kroenke, Spitzer, Williams, & Lowe, 2009), indicating how often in the past 2 weeks they had experienced specific symptoms of anxiety and depression (on a 4-point scale from "not at all" to "nearly every day"). Individual items adapted from the Composite International Diagnostic Interview (CIDI: Kessler & Ustun, 2004) also assessed how respondents rate their physical and mental health in the past year (on a 5-point scale from "poor" to "excellent"). Finally, 10 items the Division developed as part of another project (see the CARS project) assessed life stressors that individuals have encountered in the past 12 months.
- Readiness to Change. To measure readiness to change, the survey included the readiness ruler (Heather, Smailes, & Cassidy, 2008) tailored to gambling. The readiness ruler includes two items, both on a 10-point scale. One asks how prepared respondents are to change their behavior; the other asks how confident respondents are that they can make a change.
- Support. To measure support, the survey included the TCU Social Support Scale (Joe, Broome, Rowan-Szal, & Simpson, 2002), as well as several questions asking respondents to rate the quality of their relationships.
- Treatment. To assess treatment engagement, the survey included items asking respondents whether they had ever received treatment for gambling-related problems, substance use problems, and mental health problems, as well as whether they had attended support groups for gambling or other problems. Each question asked about both lifetime and past year engagement.

2.4.2. Follow-Up Interview

The follow-up interview, attached in Appendix C, covered similar domains to the baseline survey. Specifically, using the same measures described above, it re-assessed satisfaction with the MA-VSEP program, gambling behaviors, gambling problems, mental and physical health, readiness to change, support, and treatment since MA-VSEP enrollment. In addition, the follow-up interview asked about experiences during MA-VSEP enrollment, attempts to enter the casino since MA-VSEP enrollment, and overall impressions of the MA-VSEP.

2.4.3. Existing Records from MGC, Plainridge Park Casino, and MCCG

As part of this study, the Division also collected copies[10] of the 274 MA-VSEP applications and 73 one-week MCCG check-in records that occurred during the study period from MGC and MCCG. We also collected player card records for those 116 MA-VSEP enrollees who used player cards at PPC prior to exclusion and enrolled in MA-VSEP after May, 2016[11]. As mentioned previously, the results of this report include information about the application data, one-week follow-up records, and player card data for all MA-VSEP enrollees, not just study participants. Notably, the MA-VSEP application changed three times during the course of our study, though its primary components remained the same. All three versions are attached as part of Appendix D.

[10] These materials were de-identified for MA-VSEP enrollees who were not study participants.

[11] PPC was only was able to provide player card data from June 2016 forward due to established data storage processes and delays associated with the development of appropriate data acquisition routines.

2.4.3.1. MA-VSEP Application: June 2015 Version

The first version of the application, in circulation from June 2015 through November 2015, included six sections. The first section gathered name, contact information, information about length of exclusion term, and the enrollee's Player Card number, if he or she had one. Only data related to exclusion start date and length of exclusion term were provided to the Division, to preserve confidentiality. The second section gathered information about demographics and identifying information including ID number (e.g., driver's license), social security number, and date of birth. The Division received information about demographics and birth year, but not ID number, social security number, or full birthdate. The third section was developed through collaboration between the Division and the MGC. It included some of the most important questions from the baseline survey to ensure that all MA-VSEP enrollees provided some information about their gambling prior to enrollment, especially during the time period prior to the study start date. This section asked respondents to indicate reasons for signing up for MA-VSEP, gambling behavior before enrollment, and additional demographics. This section was clearly labelled as "OPTIONAL" and "NOT REQUIRED".[12] The Division received all information from this section for those who completed it. The fourth section included statements the respondent was required to initial to acknowledge understanding of the terms and conditions of MA-VSEP enrollment. The Division did not receive any information from this section. The fifth section included three statements for respondents to initial allowing the MGC to share information to gambling licensees for purposes of maintaining the VSEP database and allowing the MGC to share de-identified information for the purpose of evaluating the MA-VSEP. The Division did not receive any information from this section. The sixth and final section included the signatures of the enrollee and the staff member overseeing enrollment. The Division did not receive information from this section.

2.4.3.2. MA-VSEP Application: December 2015 Version

The second version of the application, in circulation from December 2015 through February 2016, included five sections. The five sections were identical to Sections 1, 2, 4, 5, and 6 of the first application version. MGC removed the section about gambling behavior and reasons for enrollment because the study began in December, it was assumed that most enrollees would provide this information as part of their participation in the study, and MGC was concerned about the length of this application section.

2.4.3.3. MA-VSEP Application: March 2016 Version

The third version of the application, in circulation from March 2016 through the present, was introduced to address low recruitment rates to the study that occurred during the first three months of the study. Because of low recruitment, the Division and MGC together decided to re-introduce a set of questions about gambling behavior and reasons for enrollment into the MA-VSEP application. This allowed for some level of information about pre-enrollment to be gathered from all MA-VSEP enrollees, whether they participated in the study or not. This version also included an additional "Release of Contact Information" section.

Sections 1, 2, and 4 were identical to the first version of the application. Section 3 introduced a more extensive set of questions about gambling behavior and demographics than had been included in the first version of the application. These questions were no longer labeled as optional. Section 5, though the wording changed somewhat, included the same items to initial as in the first application. Section 6 of this application included two new statements to which enrollees could check either yes or no. The first asked whether the enrollee gave permission for the Division to contact them about the research study. The second asked whether the MCCG could contact them to conduct the one-week follow-up call described previously. Section 7 of this application was identical to Section 6 of the first version of the application.

2.4.3.4. MA-VSEP Application: Data Anomalies

In February of 2017, the Division received the first batch of application data from MGC. This included application data for all MA-VSEP enrollees (n=173) from June 25th 2015 through January 15th 2017. During data entry, Division staff identified a pattern of responses that appeared to be out of the ordinary. For a specific set of questions, respondents who fit this pattern had answered all questions with the first answer option. The pattern impacted sixteen questions from Section 3 of the MA-VSEP application, all of which required a single multiple-choice response. Upon completion of data

[12] The labeling of this section as optional was a decision made by the MGC to reduce the potential length of the application process.

entry, we determined that 50 out of 173 (28.9%) of respondents shared this same identical pattern of responses (i.e., selecting the first answer option on all 16 impacted questions). To determine the full scope of the issue, Division staff spoke with MGC staff as well as GSAs. After these meetings, Division staff determined that the issue related to the coding of questions in the electronic form. As drafted, these questions had radio buttons forcing respondents to select one of the provided options. When MGC programmed the MA-VSEP application as an electronic pdf that could be completed electronically, they programmed these questions not with radio buttons, but with drop down responses where the default response was the first answer option. Therefore, any respondent who completed version 3 of the application and tried to leave Section 3 blank had these questions auto-filled for them. GSAs confirmed this conclusion as consonant with their experience. After we identified this issue and brought it to the attention of MGC, their programmer updated the application to allow for non-response. After the initial batch of 173 applications, only 2 more applications fit this pattern. These applications were all completed between the time we received the first batch of data and when we notified MGC of the error. We addressed this issue with the help of the MGC by first gathering as many original paper copies of Section 3 from VSE applications that we could. MGC provided us with original paper applications for 41 of the 52 applications that fit the pattern. For the remaining 11 applications, we deleted responses to the 16 questions that fit the pattern.

2.4.3.5. MA-VSEP One-Week Check-In Form for MCCG

The MA-VSEP check-in form used by the MCCG for one-week check-ins initially was a study document to be filled out only for those MA-VSEP enrollees who participated in the study and were randomized to the enhanced MA-VSEP condition. When the study design changed during March 2016, the check-in form became a standard part of MA-VSEP enrollment materials to be completed for all MA-VSEP enrollees. The form, attached as Appendix E, includes two parts: one to be filled out at time of MA-VSEP enrollment, and one to be completed by MCCG staff during the one-week check-in call.

The first part, in addition to collecting contact information, asks the GSA facilitating the MA-VSEP enrollment to indicate whether they reviewed resources with the enrollee, whether they provided individualized information about resources in an enrollee's residential area, whether the enrollee accepted an offer to connect him or her directly with resources, and whether the GSA was able to connect the enrollee directly with the MCCG Helpline or other resources. For each answer, the GSA also records information about the resources offered and notes about why the enrollee declined to hear about resources if they did so.

The second part, to be completed by the MCCG staff member attempting the check-in call, includes fields for the staff member to enter number of contact attempts and whether they were able to reach the enrollee. For MA-VSEP enrollees with whom they are able to check in, staff indicate whether the MA-VSEP enrollee reported having accessed any resources since enrollment, whether they offered to connect the enrollee with resources during the call (if the enrollee was not already accessing resources), whether the enrollee accepted that offer, and whether they were able to connect the enrollee directly with resources. For each answer, the MCCG staff member also records information about the resources offered, notes about why the enrollee declined to hear about resources if they did so, and next steps.

Division staff received de-identified information from these forms for all 67 MA-VSEP enrollees for whom GSAs and MCCG staff completed forms upon initial MA-VSEP enrollment[13], and a link to study number for matching purposes for those 37 enrollees who also were participants in our study.

2.4.3.6. Plainridge Park Player Card Records for MA-VSEP Enrollees Who Used a Player Card

As mentioned previously, the Division intended to collect and analyze player card records for those MA-VSEP enrollees who used player cards at PPC prior to exclusion. However, PPC, using their database of gambling activity and the software provided to them by Scientific Games, was only able to deliver gambling activity data for the 116 MA-VSEP enrollees who had player card activity after May, 2016. For these individuals, we report their frequency of play, amount wagered, and amount lost during the period between June 2016 and their MA-VSEP enrollment date, as well as whether they used their player cards at any point after their MA-VSEP enrollment date.

[13] Six of the check-in form records were for re-enrollments and thus excluded from our data set.

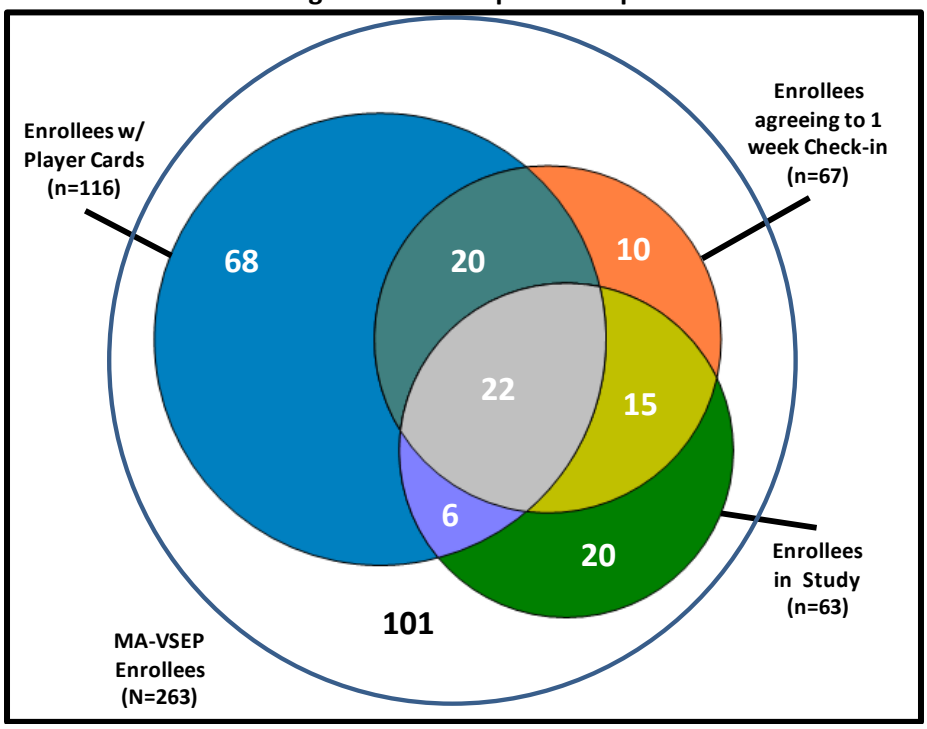
2.5. Analytic Plan

Because our data for this report derive from multiple sources, we have basic information about the entire population of 263 enrollees in the MA-VSEP between June 24th 2015 and November 30th 2017, as well as several subsamples with more detailed information. These subsamples include (1) enrollees who agreed to one-week check-ins with MCCG staff as part of their initial MA-VSEP enrollment (n = 67), (2) MA-VSEP enrollees who used player cards at PPC after May 2016 (n = 116), (3) MA-VSEP enrollees who agreed to participate in our evaluation (n = 63) after their initial MA-VSEP enrollment, and (4) MA-VSEP enrollees who completed both baseline and follow-up interviews in our study after their initial MA-VSEP enrollment (n = 46). These groups are not mutually exclusive, and their overlap is depicted in Figure 4.

To provide an understanding of how our subsamples relate to the population of MA-VSEP enrollees, after examining general MA-VSEP enrollment trends, we provide a comparison of these subsamples to other MA-VSEP enrollees on demographics and key metrics within the application data available for the full sample. We use ANOVA and Chi-Square analyses for these comparisons. We also include demographic data from MA residents and PPC patrons for comparison.

Other than these comparisons, we organize our analyses according to our study goals and research questions, rather than by sample. Within each set of analyses, we clearly demarcate which sample or subsample is involved in the analysis.

Figure 4: Subsample Overlap



Note. Follow-up subsample not pictured here due to its complete nesting w/in study enrollees.

In addition, we have included in Appendix F an analysis of missing data by item and instrument, including the VSEP application, the MCCG check-in form, the baseline survey, and the follow-up survey. Finally, for each set of analyses, we include a series of exploratory analyses in Appendix I examining moderators. In these analyses, we test whether MA-VSEP enrollee characteristics, behaviors, and changes in behavior vary by gender, age (via median split: younger than 49 or older than 48), and term of enrollment (via median split: 12 months or less or 36 months or more). We did not include race or ethnicity in these comparisons because of the uneven distribution of race and ethnicity in the sample.

2.5.1. Analyses of MA-VSEP Enrollment Trends

We provide descriptive information about MA-VSEP enrollment trends across time, examining enrollment location, length of enrollment term, unenrollment, and re-enrollment. We use curve estimation analyses to examine enrollment patterns across time.

2.5.2. Analyses of Characteristics of MA-VSEP Enrollees

We provide descriptive information about the geographic distribution, demographic profiles, gambling experiences, gambling opinions and attitudes, substance use and mental health, social support, and treatment history of MA-VSEP enrollees. We also describe the motivations MA-VSEP enrollees endorse for signing up for MA-VSEP. Finally, we examine actual gambling activity at PPC prior to MA-VSEP enrollment among the subsample of enrollees with player card data.

2.5.3. Analyses of Enrollees' Satisfaction and Experiences with MA-VSEP

We provide descriptive information about how many MA-VSEP enrollees engaged in the optional follow-up check-in with MCCG after enrollment, whether they reported using the treatment resources offered, and, based on follow-up interviews, how many attempted to enter the PPC casino floor after MA-VSEP enrollment. MA-VSEP enrollees who participated in the study provided information about their impressions of and satisfaction with MA-VSEP both at baseline and follow-up. We present descriptive information about these impressions.

2.5.4. Analyses of Enrollees' Changes in Behavior and Well-Being after MA-VSEP Enrollment

We provide descriptive information about changes in behavior and well-being after MA-VSEP enrollment, based on the baseline and follow-up interviews. We use repeated measure ANOVAs and paired t-tests to examine these changes.

We include a series of exploratory regression analyses in Appendix J to examine factors that predict positive change among MA-VSEP enrollees. In each analysis for which we have baseline and follow-up measures of the outcome, we enter the baseline measure into the regression first, followed by baseline measures of demographics, enrollment characteristics, gambling behavior, gambling problems, attitudes, motivations, and intentions at enrollment, physical and mental health, social support and relationships, and MA-VSEP experiences. Table J1 in Appendix J includes a list of those predictors. Because of the small sample size for these analyses, these analyses should be interpreted with caution and require future replication.

2.5.6. Analyses of Resource and Treatment Access before and after MA-VSEP Enrollment

We provide detailed descriptive information about treatment-seeking and treatment engagement before and after MA-VSEP enrollment and use regression analyses to determine whether those variables predict improved outcomes among MA-VSEP enrollees. In these regression analyses, we first enter the baseline measure of the outcome, followed by orthogonally contrast-coded variables (see Davis, 2010) that capture treatment, treatment-seeking, and self-help before and after MA-VSEP enrollment. As with the other regression analyses presented in Appendix J, because of the small sample size for these analyses, these analyses should be interpreted with caution and require future replication.

3. RESULTS

3.1. MA-VSEP Enrollment Trends

As noted in the Methods section, there were 274 enrollments in MA-VSEP between the opening of PPC on June 24th, 2015 and the end of November, 2017. Figure 5 displays cumulative MA-VSEP enrollments across time, how many enrollments occurred at PPC with GSAs, and how many occurred with Gaming Agents (i.e., off-hour enrollments) or off-site. Figure 6 displays new enrollments across time. Throughout the course of the study, though there was considerable fluctuation, as evident in Figure 6, enrollment rates did not decline, as evident from the linear cumulative enrollment trend. Comparison of models with linear, quadratic, cubic, and logarithmic components confirmed that a linear model fit the cumulative data best (R^2 = .99, F(2,22) = 1,937.2, p< .001). Most enrollments occurred with GSAs at PPC. Gaming agents conducted twenty-four enrollments (9%), and four enrollments (1%) occurred offsite at either MCCG (n=3) or MGC (n=1).

Figure 5: MA-VSEP Cumulative Enrollments Across Time

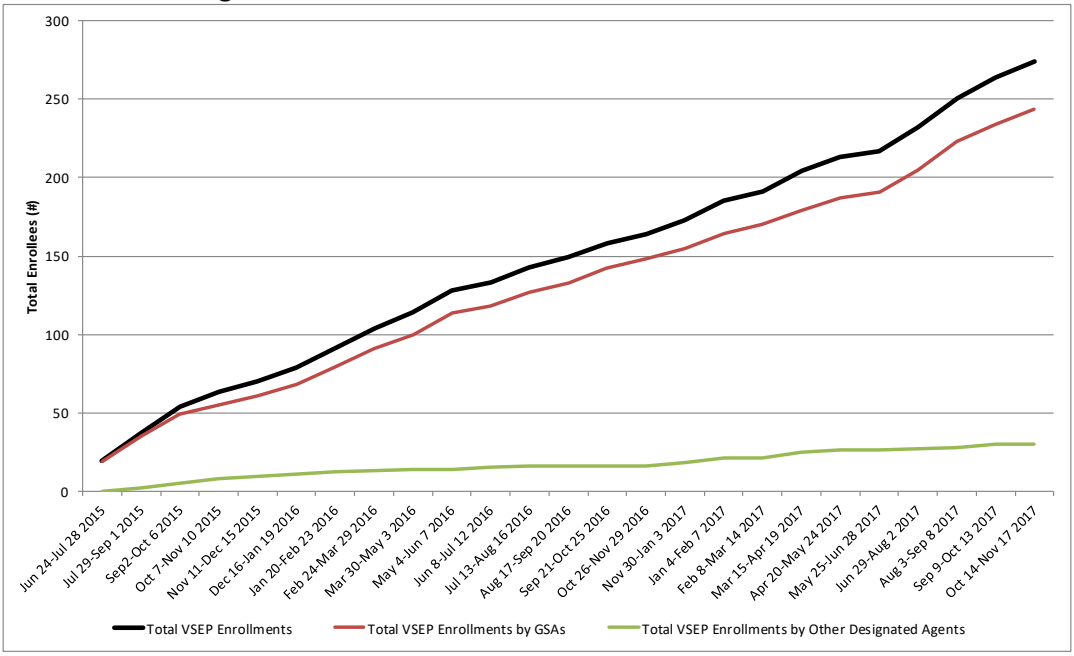
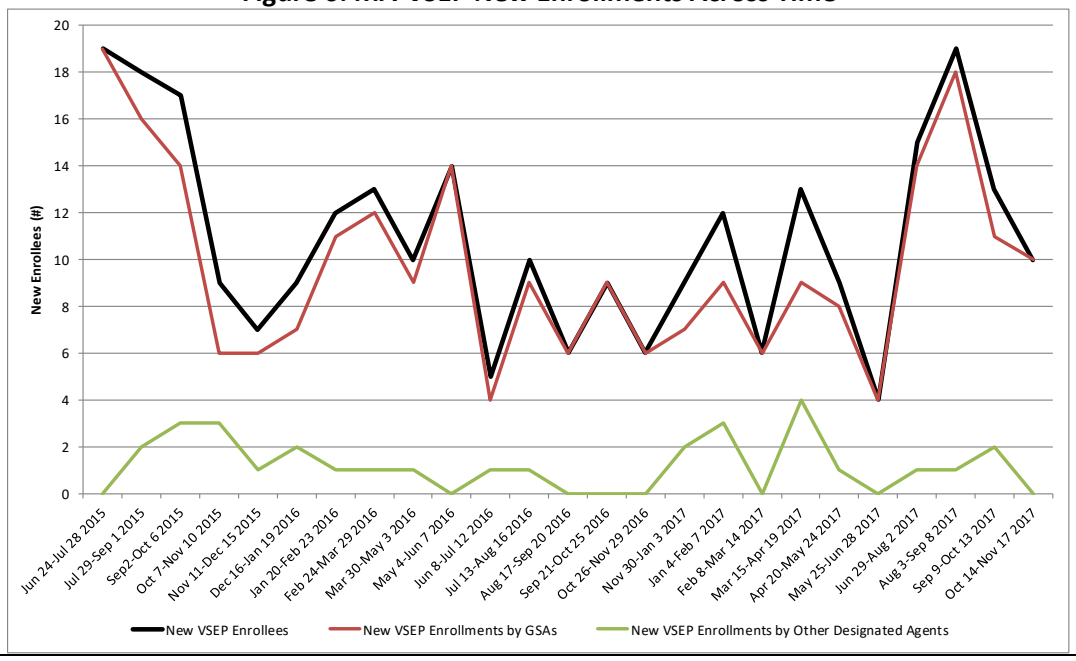
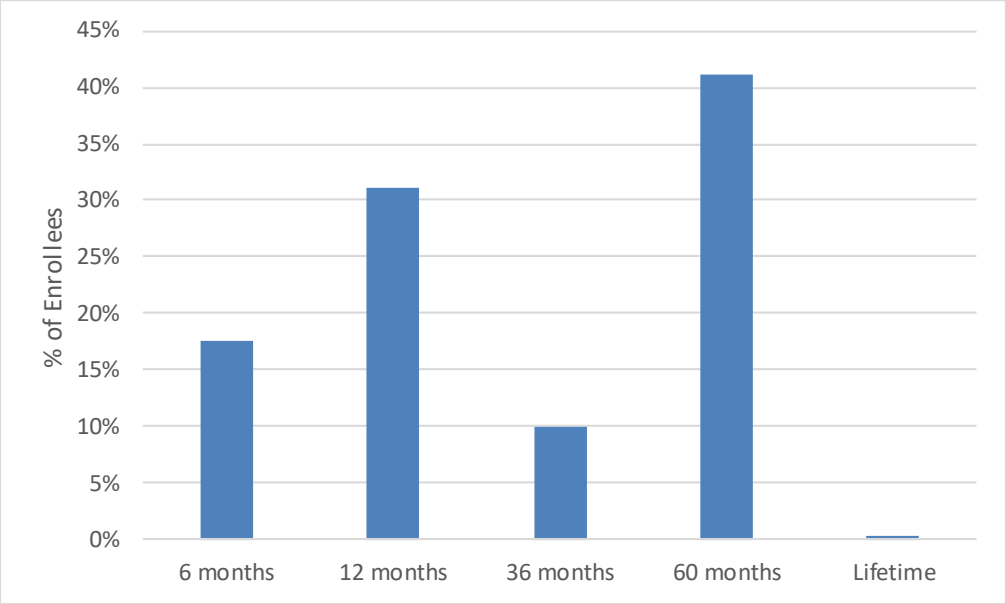


Figure 6: MA-VSEP New Enrollments Across Time



Upon initial enrollment, MA-VSEP enrollees selected whether to enroll for six months, one year, three years, or five years. After completing one enrollment term, enrollees were able to re-enroll for a lifetime term. As Figure 7 shows, the most common initial enrollment term was five years, selected by 108 (41%) of initial enrollees. One enrollment was listed as lifetime, even though it appeared to be a first enrollment.

Figure 7: Enrollment Terms



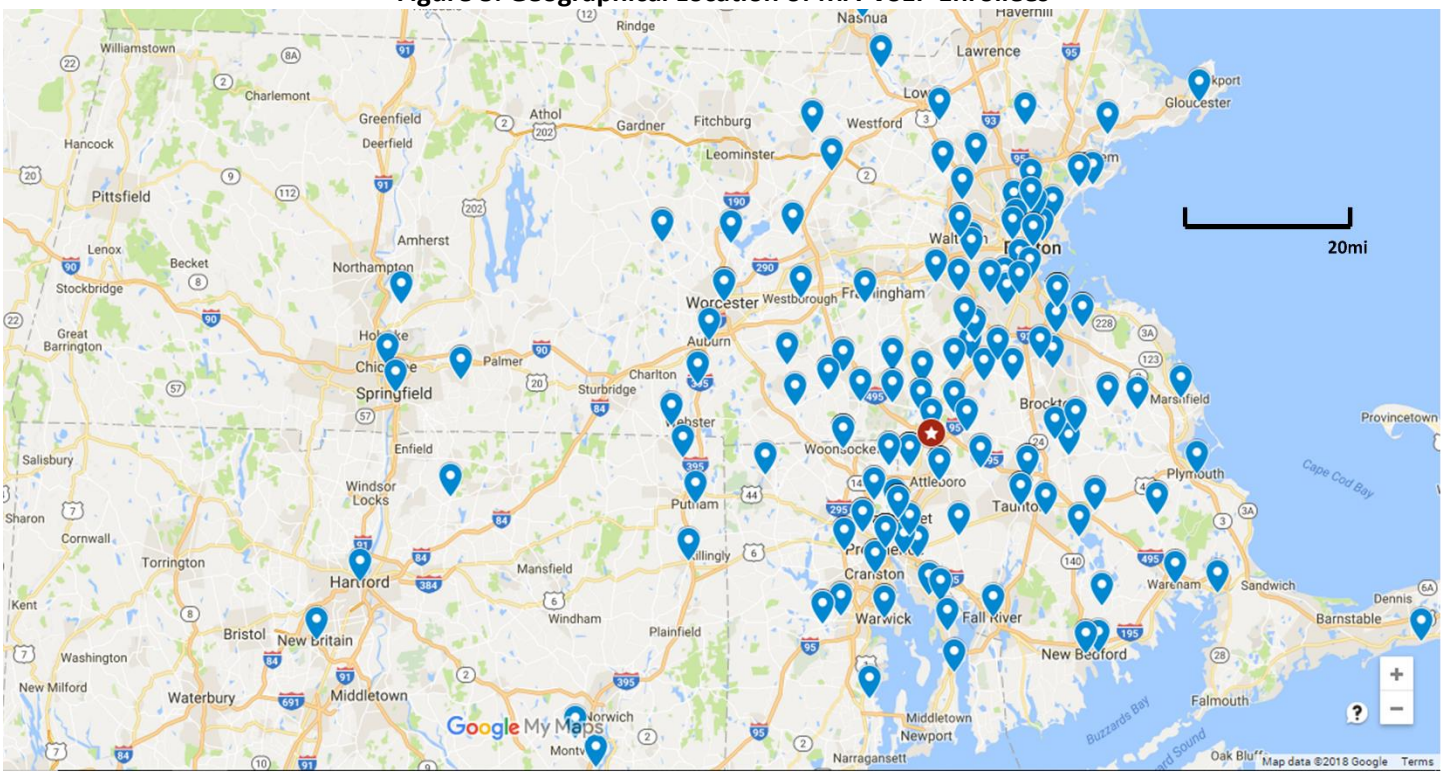
Throughout the course of the study, thirty-three MA-VSEP enrollees (12.5%) removed themselves from the MA-VSEP list after their terms expired. Eleven of those thirty-three re-enrolled, four for a lifetime term. Time between term expiration and re-enrollment ranged from 33 to 519 days with a mean of 147 days (SD=155) and a median of 90 days. However, time between formal removal from the MA-VSEP list (i.e., completing the exit interview) and re-enrollment was considerably shorter for these 11 re-enrollees, ranging from 8 to 332 days with a mean of 107 days (SD=115) and a median of 60 days.

3.2. Characteristics of MA-VSEP Enrollees

3.2.1. Geographic Distribution

MA-VSEP enrollees were residents of towns and cities throughout Massachusetts and neighboring states. As the map in Figure 8 shows, the majority of enrollees (65.8%) were residents of Massachusetts, and most of those lived in the eastern half of the state. However, more than a quarter were residents of Rhode Island, four percent lived in Connecticut, two percent lived in New Hampshire, and two percent lived in states not neighboring Massachusetts. There were no MA-VSEP enrollees who were residents of Plainville, MA, where PPC is located.

Figure 8: Geographical Location of MA-VSEP Enrollees



Note. The red marker indicates the location of Plainridge Park Casino. The blue dots indicate the cities in which MA-VSEP enrollees reside.

3.2.2. Demographics

Table 1 includes demographics for MA-VSEP enrollees, as well as for the non-exclusive subsamples of enrollees who (a) agreed to the MCCG one-week check-in, (b) had player card information available, (c) agreed to participate in the study, and (d) completed study follow-up. As Table 1 shows, MA-VSEP enrollees were slightly more likely to be male (58%) than female (42%) and were primarily non-Hispanic (98%) Whites (79%). Their average age was 48, though age ranged from 22 to 84. Half of enrollees were employed full-time, and almost 60% had a household income of $50,000 or higher. In addition (not shown in Table 1), slightly less than five percent of enrollees (4.8%) reported that they had an immediate family member who worked in the gambling industry, but only three enrollees had worked in the industry themselves. Twenty percent of enrollees were divorced or separated, and most had not been in the military.

These full-sample demographics varied by gender and age. Female enrollees were older (M=54.3, SD=12.3) than male enrollees (M=44.0, SD=13.0), $F(1,261)=42.5$, $p<.001$. Female enrollees were as likely to be employed full-time as male enrollees, but less likely to be self-employed and more likely to be retired, $\chi^2(7)=19.5$, $p<.01$. Female enrollees were more likely than male enrollees to be divorced, separated, or widowed, and less likely to be married or never married, $\chi^2(4)=27.3$, $p<.001$. Younger enrollees (i.e., those under age 49) were less likely to be White, $\chi^2(5)=22.2$, $p<.001$, more likely to be employed full-time (and less likely to be retired), $\chi^2(7)=32.3$, $p<.001$, and less likely to be divorced, separated, or widowed, $\chi^2(4)=25.3$, $p<.001$, than older enrollees (i.e., those older than age 48).

Demographics did not vary substantially by subsample, as summarized in Table 1. The only significant difference that emerged was between the income of enrollees who had player cards that were active after May of 2016 and those who did not. In this case the difference was not linear (e.g., with one group having higher household incomes than the other); those with player cards were more likely to have very low household incomes (i.e., less than $20,000), less likely to have low household incomes (i.e., $20,000-$49,999), and more likely to have household incomes over $50,000.

Table 2 displays MA-VSEP enrollee demographics compared to MA resident demographics obtained from the US Census (US Census Bureau, 2016, 2017), as well as PPC patron demographics obtained from a study of PPC patrons conducted in 2016 by the SEIGMA (i.e., Social and Economic Impacts of Gambling in Massachusetts) team (Salame et al., 2017).

Table 1: MA-VSEP Enrollee Demographics

	MA-VSEP Enrollees (N=263)	Enrollees Agreeing to One-Week Check-in (n=67)	Enrollees w/ Available Player Card Data (n=116)[a]	Enrollees w/ Baseline Study Data (n=63)	Enrollees Completing Study Follow-Up (n=46)
	Valid %				
Gender					
Male	57.8%	50.7%	54.3%	61.9%	60.9%
Female	42.2%	49.3%	45.7%	38.1%	39.1%
Race					
White	78.7%	82.1%	75.9%	87.3%	91.3%
Black	8.0%	7.5%	9.5%	3.2%	2.2%
Asian	6.1%	4.5%	5.2%	3.2%	4.3%
Middle Eastern	0.8%	0.0%	0.0%	1.6%	0.0%
AI/AN[b]	0.0%	0.0%	0.0%	0.0%	0.0%
Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%
Other/Unknown	6.5%	6.0%	9.4%	4.8%	2.2%
Ethnicity					
Non-Hispanic	97.0%	97.0%	96.5%	97.7%	100.0%
Hispanic	3.0%	3.0%	3.5%	2.3%	0.0%
Household Income					
<$20K	9.8%	16.1%	16.9%	10.9%	9.8%
$20K - $49K	30.8%	23.2%	16.8%	29.0%	34.2%
$50K - $74K	24.8%	23.2%	31.0%	27.3%	29.3%
$75K - $99K	14.4%	14.3%	16.9%	10.9%	9.8%
$100K+	20.2%	23.2%	18.3%	22.0%	17.1%
Employment Status					
Full-Time	56.5%	49.1%	56.6%	48.2%	46.3%
Part-Time	6.0%	10.9%	7.9%	8.9%	9.8%
Self-Employed	11.3%	12.7%	7.9%	14.3%	14.6%
Student	1.2%	0.0%	0.0%	1.8%	0.0%
Disabled	4.2%	5.5%	5.3%	7.1%	7.3%
Retired	16.1%	16.4%	18.4%	16.1%	17.1%
Homemaker	2.4%	3.6%	1.3%	3.6%	4.9%
Unemployed	2.4%	1.8%	2.6%	0.0%	0.0%
Marriage Status					
Married	36.0%	30.9%	29.2%	31.5%	29.3%
Divorced or separated	19.5%	29.1%	25.0%	24.1%	22.0%
Widowed	5.5%	7.3%	9.7%	3.7%	4.9%
Marriage-like relationship	9.8%	9.1%	6.9%	9.3%	12.2%
Never Married	29.3%	23.6%	29.2%	31.5%	31.7%
Military Status					
Never in the military	92.5%	87.3%	91.5%	88.9%	87.8%
Military service	7.5%	12.7%	8.5%	11.1%	12.2%
	M(SD)				
Age	48.3 (13.7)	49.4 (13.9)	49.9 (13.1)	48.9 (14.0)	51.0 (14.3)

Note. Hispanic was not included as an option on Version 1 of the MA-VSEP application; therefore, the valid percents presented in this table for ethnicity include only the 197 for whom Hispanic was provided as an option. In Version 2 of the MA-VSEP application, Hispanic was listed as a race, not an ethnicity. In those instances, we categorized responses as unknown for race and Hispanic for ethnicity. Version 3 of the MA-VSEP application included a separate question about ethnicity. Household income was only available for 153 of 263 enrollees. Employment only available for 168 of 263 enrollees. Relationship status was only available for 164 of 263 enrollees. Veteran status was only available for 160 of 263 enrollees.

[a]Enrollees with player cards were more likely to have low or high incomes than those without player cards, p< .01.

[b]AI/AN = American Indian or Alaska Native

Compared to the general population, MA-VSEP enrollees were more likely to be male, less likely to be Hispanic, and had slightly lower household incomes. Compared to other PPC patrons, MA-VSEP enrollees were more likely to be male, were younger, and had lower household incomes.

Table 2: MA-VSEP Enrollee Demographics Compared to MA residents and PPC Patrons

	MA-VSEP Enrollees (N=263)	MA Residents (2016-2017 Census)[a]	SEIGMA PPC Patron Survey Data[b]
Gender			
Male	57.8%	48.5%	51.6%
Female	42.2%	51.5%	48.3%
Race			
White	78.7%	81.3%	81.8%
Black	8.0%	8.8%	5.1%
Asian	6.1%	6.9%	5.7%
Middle Eastern	0.8%	--	--
AI/AN[b]	0.0%	0.5%	--
Pacific Islander	0.0%	0.1%	--
Other/Unknown	6.5%	2.4%	2.9%
Ethnicity			
Non-Hispanic	97.0%	8.1%	95.4%
Hispanic	3.0%	11.9%	4.6%
Household Income			
<$20K	9.8%	<$15K: 11.0%	<$15K: 6.3%
$20K - $49K	30.8%	$15K-$49K: 25.8%	$15K-$49K: 23.8%
$50K - $74K	24.8%	15.5%	$50K-$69K: 19.9%
$75K - $99K	14.4%	12.5%	$70K-$99K: 20.3%
$100K+	20.2%	35.3%	29.7%
Employment Status			
Full-Time	56.5%	--	Employed: 59.1%
Part-Time	6.0%	--	--
Self-Employed	11.3%	--	--
Student	1.2%	--	--
Disabled	4.2%	--	--
Retired	16.1%	--	30.5%
Homemaker	2.4%	--	--
Unemployed	2.4%	--	2.4%
Marriage Status			
Married	36.0%	--	Married/Partner/Widow: 68.1%
Divorced or separated	19.5%	--	13.6%
Widowed	5.5%	--	--
Marriage-like relationship	9.8%	--	--
Never married	29.3%	--	18.3%
Military Status			
Never in the military	92.5%	93.6%	84.1%
Military service	7.5%	6.4%	15.9%
Age [Mean SD)	48.3 (13.7)	--	56.4 (--)

Note. Hispanic was not included as an option on Version 1 of the MA-VSEP application; therefore, the valid percents presented in this table for ethnicity include only the 197 for whom Hispanic was provided as an option. In Version 2 of the MA-VSEP application, Hispanic was listed as a race, not an ethnicity. In those instances, we categorized responses as unknown for race and Hispanic for ethnicity. Version 3 of the MA-VSEP application included a separate question about ethnicity. Household income was only available for 153 of 263 enrollees. Employment only available for 168 of 263 enrollees. Relationship status was only available for 164 of 263 enrollees. Veteran status was only available for 160 of 263 enrollees.

[a]MA Census information obtained from https://www.census.gov/quickfacts/fact/table/ma/PST045217 and https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

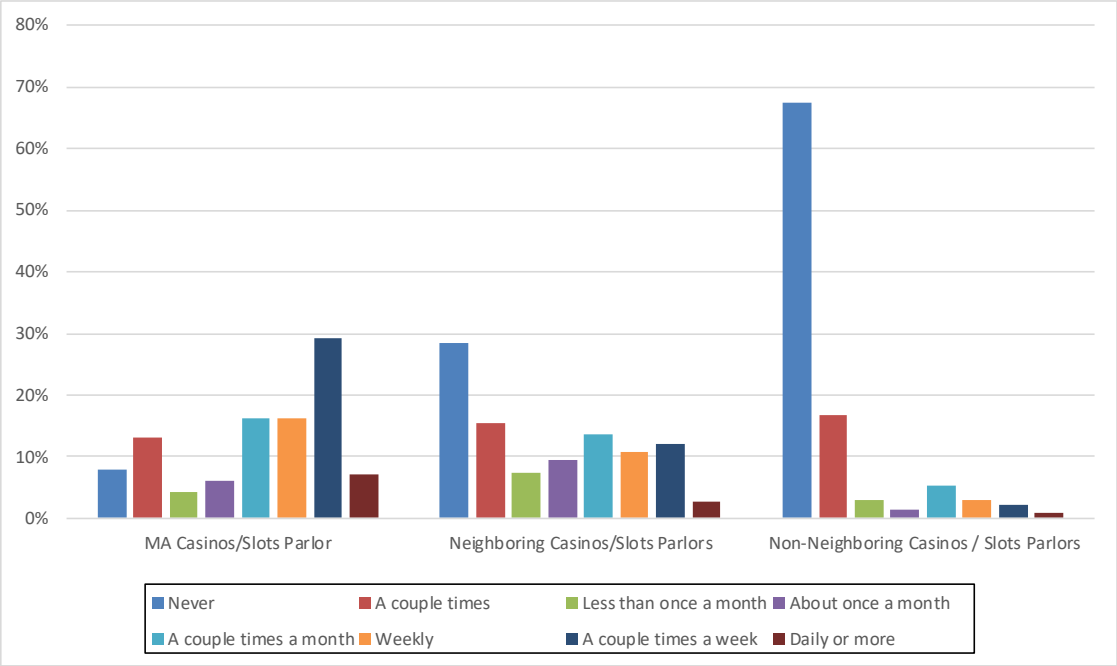
b SEIGMA PPC Patron Survey data obtained from (Salame et al., 2017).

[b]AI/AN = American Indian or Alaska Native

3.2.3. Past Gambling Behavior

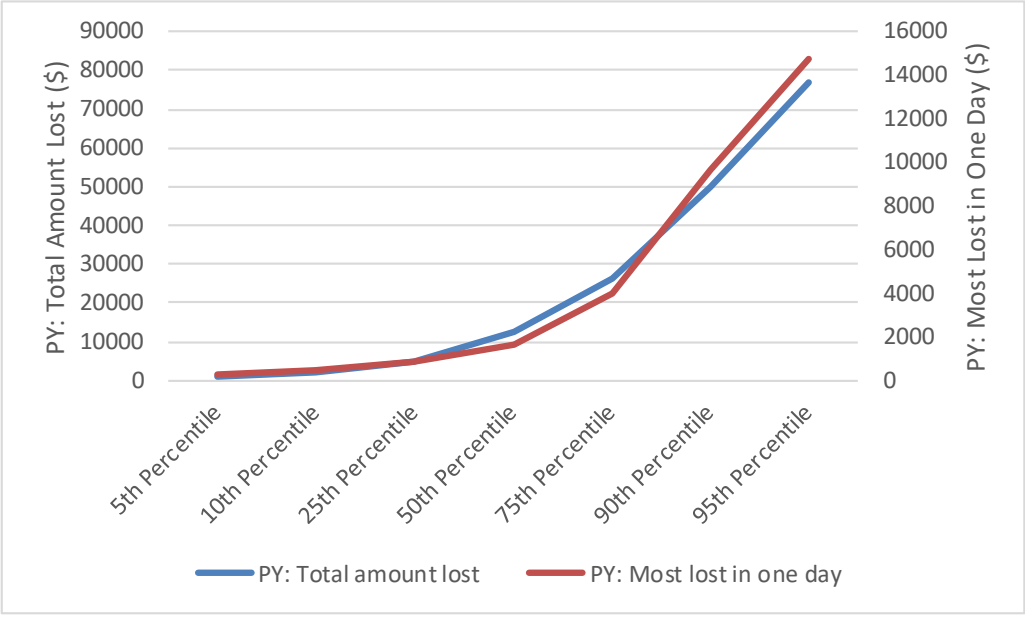
Among those in the full sample who responded to questions about their gambling behavior, the vast majority of MA-VSEP enrollees (86.2%) reported that the games they had lost the most money on during the past year were electronic gambling machines at casinos. As shown in Figure 9, about 30% of these enrollees reported gambling a couple times a week at PPC, and more than 70% had frequented casinos or slots parlors in neighboring states in the past year. Most enrollees (87.6%) had placed their last bet within a week of signing up for MA-VSEP.

Figure 9: Frequency of Play at MA, Neighboring, and Non-Neighboring Casinos & Slots Parlors (n=167)



MA-VSEP enrollees who responded to questions about their gambling behavior reported losing substantial amounts of money, both overall, and in any one day. The mean estimated total amount lost in the past year was $30,000 (SD=$94,810), and the mean maximum daily loss in the past year was $3,747 (SD=$6,655). The medians for each of these variables were considerably lower (Median=$12,250 and $1,600, respectively) indicating positive skew. Figure 10 displays the distributions for these variables.

Figure 10: Past Year Total Lost and Most Lost in One Day – Percentiles (n=122; n=129)



In both cases, a few enrollees reported substantially greater losses than the rest of the sample. Eighty-eight percent of enrollees also endorsed needing to get more money in the middle of a gambling outing at some point in the past year.

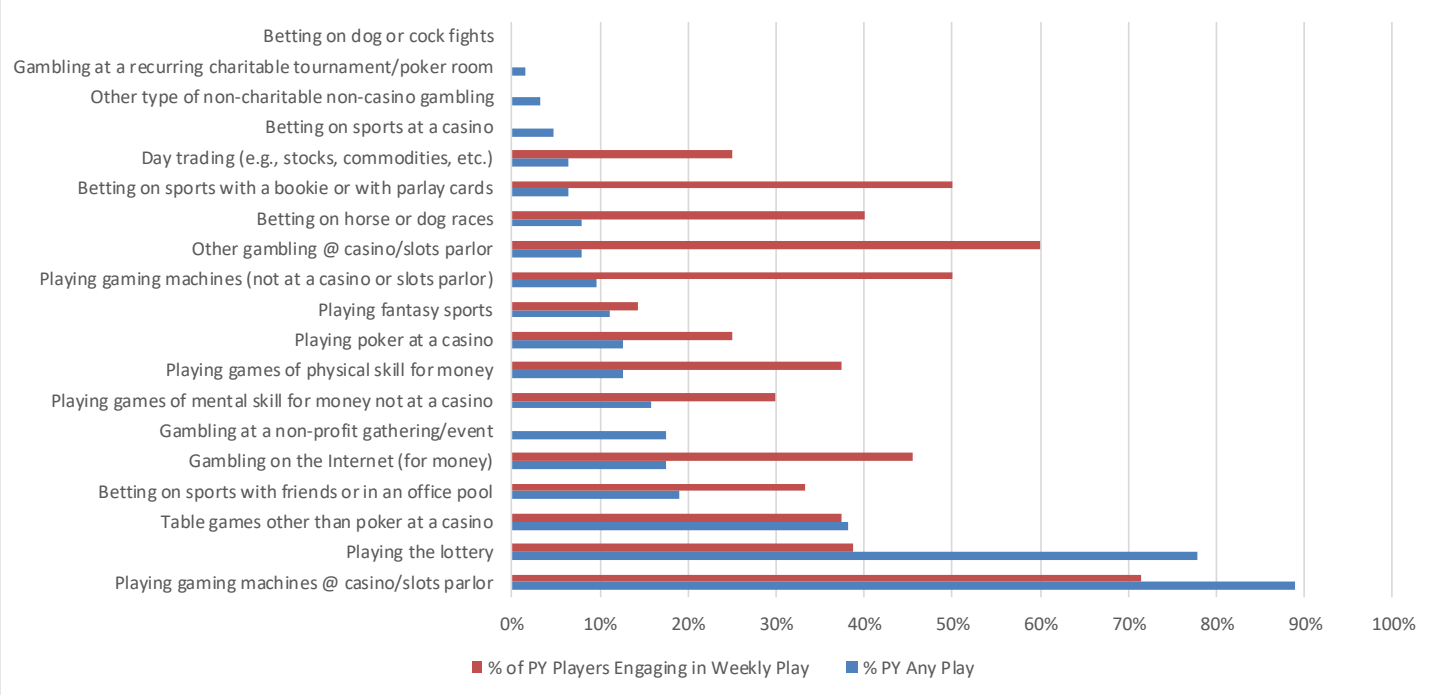
3.2.3.1. Past Gambling Behavior: Baseline Survey Respondents (n=63)

Though these results should be interpreted with caution due to the low recruitment rate, MA-VSEP enrollees who completed the baseline survey (n=63) provided additional information about their gambling behavior prior to MA-VSEP enrollment. On average, these enrollees reported beginning to gamble during their 20s (M=23.3, SD=12.5, Median=20.0). Most enrollees (i.e., 85.7% of those who completed the baseline survey) had gambled more than 1,000 times during their lifetime.

Enrollees who completed the baseline survey gambled on a variety of game types in the year prior to exclusion. For each game, Figure 11 displays the percent of enrollees who played each game at all during the past year, as well as the percent who played it on a weekly or more frequent basis. This figure shows that the gambling machines at slot parlors or casinos, in addition to being the most commonly played game, also had the largest percentage of players who played weekly or more. The figure also shows that many of the game types that were less prevalent in this sample were nevertheless played frequently by those who played them.

On average, enrollees who completed the baseline survey had engaged in between 3 and 4 different types of gambling during the year prior to enrollment (M=3.6, SD=2.5, Median=3.0), with a range from 0 to 13.

Figure 11: Frequency of Engagement with Game Types Prior to MA-VSEP Enrollment (n=63)



3.2.4. Past Gambling Behavior at PPC – Player Card Data

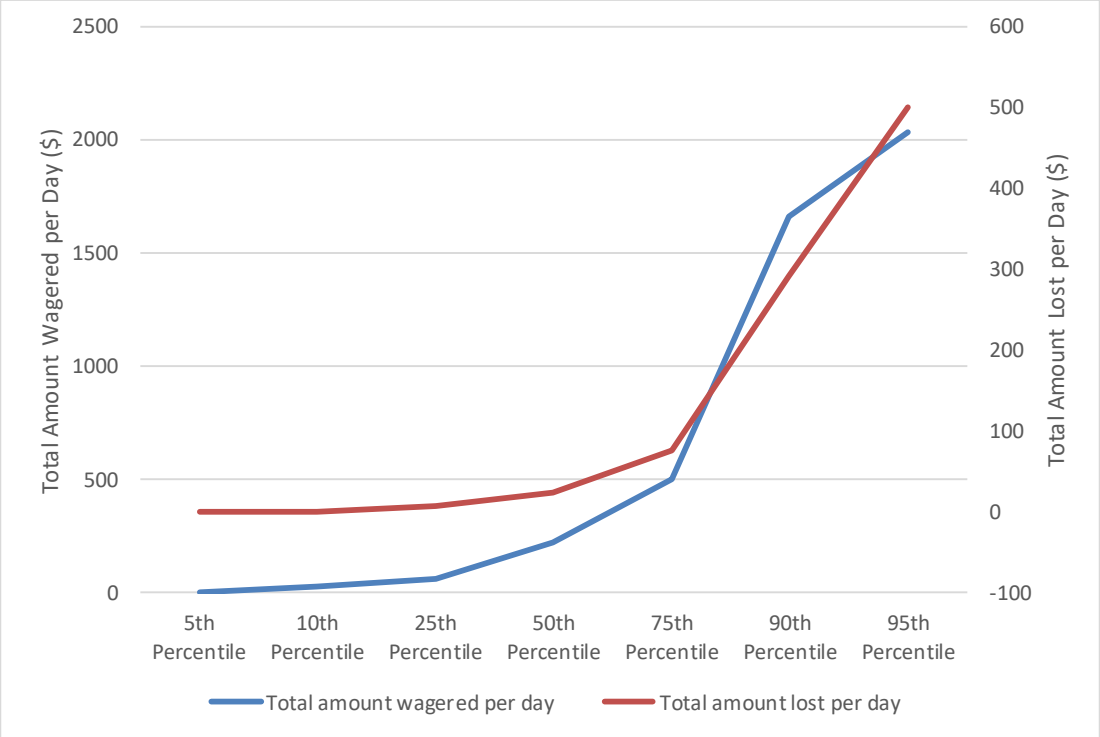
One hundred sixteen MA-VSEP enrollees had player card activity in the PPC system after May 2016 (i.e., the earliest records PPC made available to us). Of those 116 enrollees, 91 had recorded gambling activity in the PPC system that could be used to calculate measures of amount wagered, amount lost, and frequency of play.[14] For each of the 91 with player card gambling activity, we calculated the total amount they had wagered and the total amount they had lost using their card prior to their date of MA-VSEP enrollment, and the number of visits they had made to PPC during which they recorded gambling activity prior to their date of VSEP enrollment. To control for their time at-risk (i.e., some enrollees had hundreds

[14] The other 25 enrollees had registered activity within the PPC player card system prior their MA-VSEP enrollment date, but that activity did not include placing bets. Examples of alternate player card activity include depositing money on a card or withdrawing a voucher for money remaining on a card. It is unclear why these 25 did not record bets. Given this data anomaly, other problems with the data described in our forthcoming PlayMyWay management system evaluation report, and the limited sample, caution should be used in interpreting these data.

of days during which they could have recorded card activity prior to MA-VSEP enrollment and others had only a few weeks), we calculated three additional variables: amount wagered per day (i.e., total amount wagered divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment), amount lost per day (i.e., total amount lost divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment), and frequency of play (i.e., number of visits divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment).

Information about amount wagered and amount lost among MA-VSEP enrollees who had player cards generally reflected MA-VSEP enrollees' self-reported behavior in that there was considerable positive skew for these variables. The mean total amount wagered per day[15] using a player card prior to MA-VSEP enrollment was $518.7 (SD=$924.8), and the mean total amount lost per day prior to MA-VSEP enrollment was $99.7 (SD=$251.2). However, the medians for each of these variables were considerably lower (Median=$223.5 and $24.1, respectively), due primarily to a single outlier who wagered $ 3,149,292.4 and lost $951,720.5 over the course of 135 visits within a 460-day timespan. Figure 12 displays the distributions for these two variables. MA-VSEP enrollees who had player cards visited PPC and used their cards on an average of 19.6% of the days they could have visited between the first day they recorded gambling activity on their card and their date of MA-VSEP enrollment, approximately 1.4 days per week. Their median frequency of visits was 15.6%, approximately 1.1 days per week.

Figure 12: Total Amount Wagered and Lost per Day Prior to MA-VSEP Enrollment – Percentiles (n=91)



Note. Data derive from player card records for MA-VSEP enrollees who used player cards prior to MA-VSEP enrollment and after May 2016.

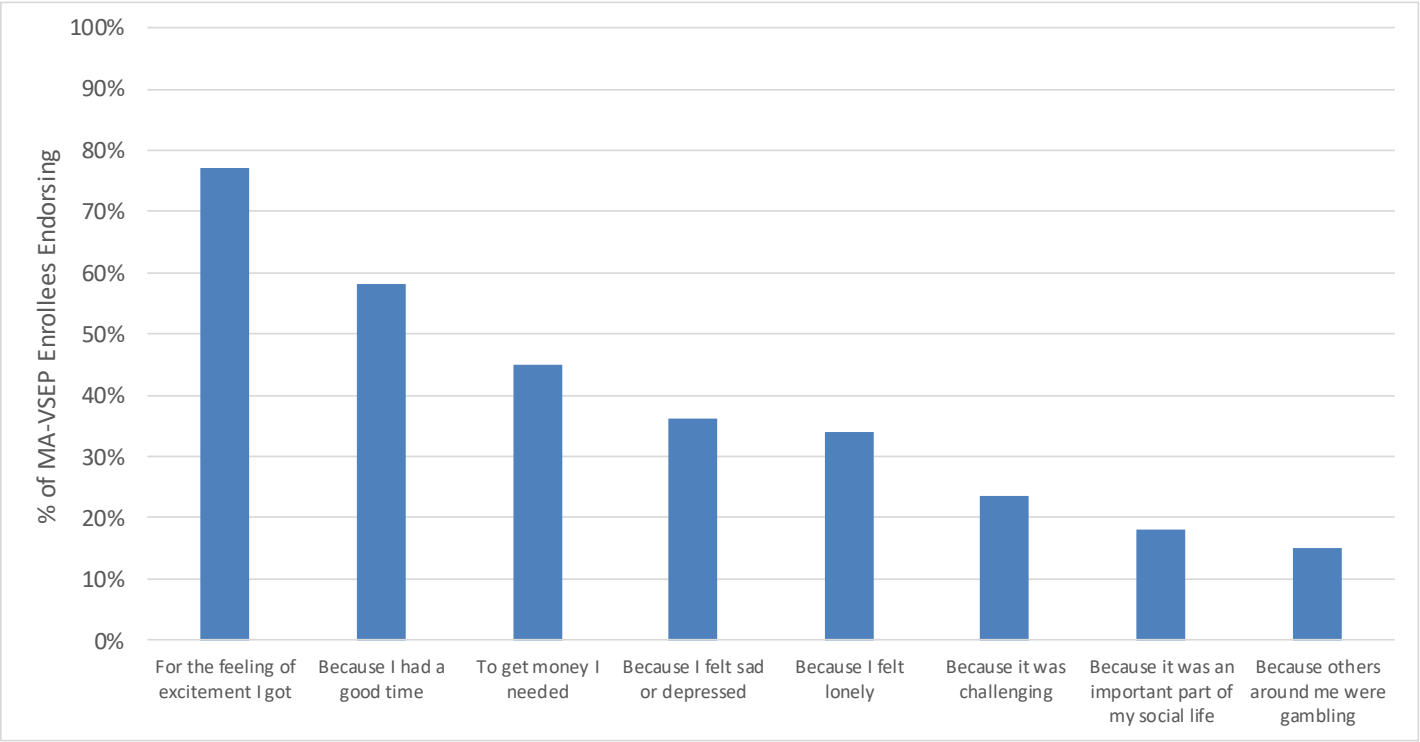
3.2.5. Past Gambling Motivations, Attitudes, and Experiences

Figure 13 displays the reasons MA-VSEP enrollees endorsed for gambling. Enrollees were able to select more than one reason, so the categories are not mutually exclusive. This question was included on both the VSEP application and the baseline survey, so we combined these data sources.[16] In all, one hundred twenty-seven MA-VSEP enrollees answered this question.

[15] The per day measures refer not to days the enrollee were actually at PPC, but days that they could have been at PPC between the first day they recorded gambling on their card after May 2016 and their date of MA-VSEP enrollment.

[16] For this question and the question about motivations for MA-VSEP enrollment, if an enrollee endorsed a reason on either their application or the baseline survey, we included their response.

Figure 13: Endorsed Reasons for Gambling Prior to MA-VSEP Enrollment (n=127)



Note. Categories are not mutually exclusive.

The most commonly endorsed reason for gambling prior to MA-VSEP enrollment was for excitement, followed by to have a good time and to get money. More than 30% of enrollees also endorsed gambling out of loneliness or feelings of depression, as well. Thirty-nine enrollees also provided other reasons for gambling, displayed in Table 3. Some of these responses overlapped with provided categories. Others referred to escape, boredom, and addiction.

3.2.5.1. Past Gambling Attitudes and Experiences: Baseline Survey Respondents (n=63)

Though these results should be interpreted with caution due to the low recruitment rate, MA-VSEP enrollees who completed the baseline survey answered question about their beliefs about luck and probability as they relate to gambling, as well as their attitudes about the benefits and costs of gambling. Table 4 summarizes the results of those questions.

Almost half of these respondents agreed that gambling machines could be lucky, and about a third agreed that machines or numbers could be hot or cold or that numbers were "due" if they hadn't shown up for a while. However, most of these enrollees did not believe that there were actions they could take individually to improve their luck. Enrollees expressed slightly favorable attitudes about gambling, with most agreeing that gambling is fun and that casinos will increase job opportunities. However, they did not support gambling expansion within their communities, and a large majority of enrollees viewed gambling as dangerous.

Table 3: MVEP Enrollee Reasons for Gambling prior to MA-VSEP Enrollment (n=39)

Open Response: "What are the primary reasons that you gamble? → For other reasons – specify"
A way to escape my responsibilities and commitments, a way to avoid things that were going on in my life.
Addicted to it
Addiction
Because I am a compulsive gambler
Because of an addiction.
Being lonely, escaping.
Big part of my social life
Bored
Bored
Bored
Boredom
Boredom
Chasing losses
Chasing money/addiction
Didn't have a particular reason for gambling before signing up for VSE. Started gambling after being in a very controlling relationship. Was a Buddhist at the time and my partner was a Quaker. My partner made me quit my job and I started gambling as a method of rebellion.
Enjoyed doing it
Entertainment, addicted to it
Escape worry and frustration
Escapism
Fill in a void
Financial distress, plus hoping things will get better
Forces me to feel emotions
I don't know, I am trying to figure it out
I get bored
I'm completely by myself, alone. When you are alone you keep talking to yourself (a sick person). The worst person an addict can be with is themselves. They told me I had cancer and I needed a biopsy. I kinda let myself go. You can get out of yourself, you can be a part of the slot machine and you are not alone.
Instead of going to club
It's fun and challenging
Love it
Loved eating, got a gastric bi-pass and couldn't eat, and gambling became my new companion instead of food
Medication
Recreational
Rush and excitement of the win
Something to do
Stress
To escape life of abuse from husband
Too much time on my hands
We all want to win, cannot help myself
Winning streak
Work anxiety

Table 4: MVEP Enrollee Beliefs about Gambling (n=63)

	Agreement w/ Statement (1=Disagree Strongly; 5=Agree Strongly)	
Beliefs about Luck and Probability	*M (SD)*	*% Somewhat or Strongly Agreeing*
A gambling machine can be lucky	2.9 (1.6)	49.2%
If someone keeps betting, their luck will turn around	1.9 (1.3)	18.0%
After a few losses, people are due to win	1.8 (1.3)	17.5%
A gambling machine or certain numbers can be "hot" or "cold"	2.7 (1.6)	39.7%
If a number or symbol hasn't shown up for a while, it is due to show up	2.4 (1.5)	30.2%
People can do things that will make them luckier	1.6 (1.1)	9.5%
A lucky charm can help someone win	1.3 (0.8)	4.8%
Positive Attitudes about Gambling	*M (SD)*	*% Somewhat or Strongly Agreeing*
Gambling is an acceptable form of entertainment	3.2 (1.4)	49.2%
I would support having a resort casino in my community	1.8 (1.3)	15.9%
Casinos lead to increased job opportunities in an area	3.5 (1.3)	63.5%
Gambling is a fun activity	3.3 (1.5)	60.3%
I would support having a slots parlor in my community	1.6 (1.2)	12.7%
Concerns about Costs of Gambling	*M (SD)*	*% Somewhat or Strongly Agreeing*
Gambling is dangerous	4.3 (1.3)	81.0%
Overall, the costs of having casinos in Massachusetts outweigh the benefits	3.4 (1.3)	47.6%
Casinos lead to increased crime in an area	3.5 (1.4)	55.6%

3.2.6. Past Gambling Problems

Both the application and the baseline survey included the Brief Bio-Social Gambling Screen, which includes three criteria of gambling disorder found to be most indicative of that disorder (BBGS: Gebauer, LaBrie, & Shaffer, 2010). Figure 14 displays enrollees' responses to these criteria and whether they screened positive on the BBGS (i.e., endorsed any of the criteria). Eighty-four percent screened positive.

3.2.6.1. Past Gambling Problems: Baseline Survey Respondents (n=63)

Though these results should be interpreted with caution due to the low recruitment rate, MA-VSEP enrollees who completed the baseline survey responded to a full assessment of gambling problems, a past 12-month adaptation of the gambling section of the Alcohol Use Disorder and Associated Disabilities Interview Schedule IV (AUDADIS-IV: Grant et al., 2003) that we have used in previous work (i.e., Nelson et al., 2013). As noted in the Methods section, we used these responses to calculate whether respondents endorsed each DSM-IV criterion for gambling disorder, but also created variables measuring whether respondents qualified for gambling disorder, as well as severity of disorder, using the nine DSM-5 criteria. Figure 15 displays the percent of enrollees endorsing 0 (no disorder), 1-3 (subclinical gambling problems), 4-5 (mild gambling disorder), 6-7 (moderate gambling disorder), and 8-9 (severe gambling disorder) criteria, broken out by whether enrollees were younger (i.e., under 49) or older (i.e., 49 or older).

Figure 14: Gambling Problems within the Past Year Prior to MA-VSEP Enrollment (n=139)

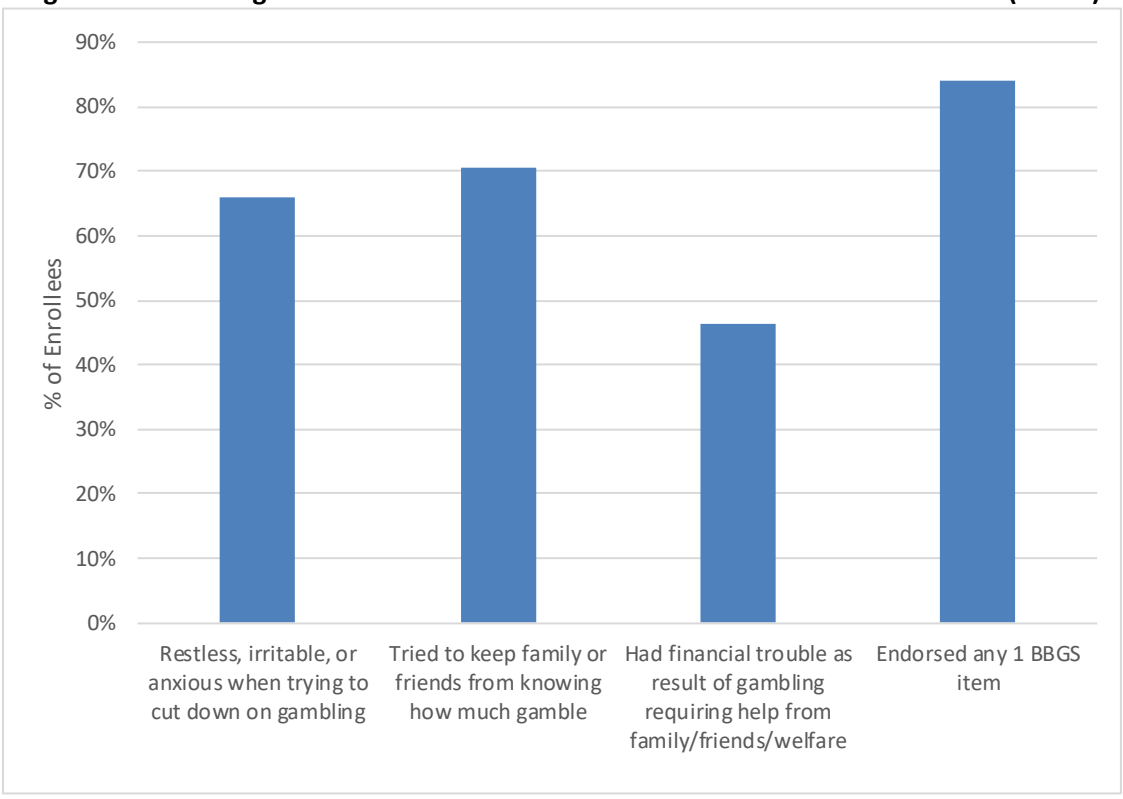
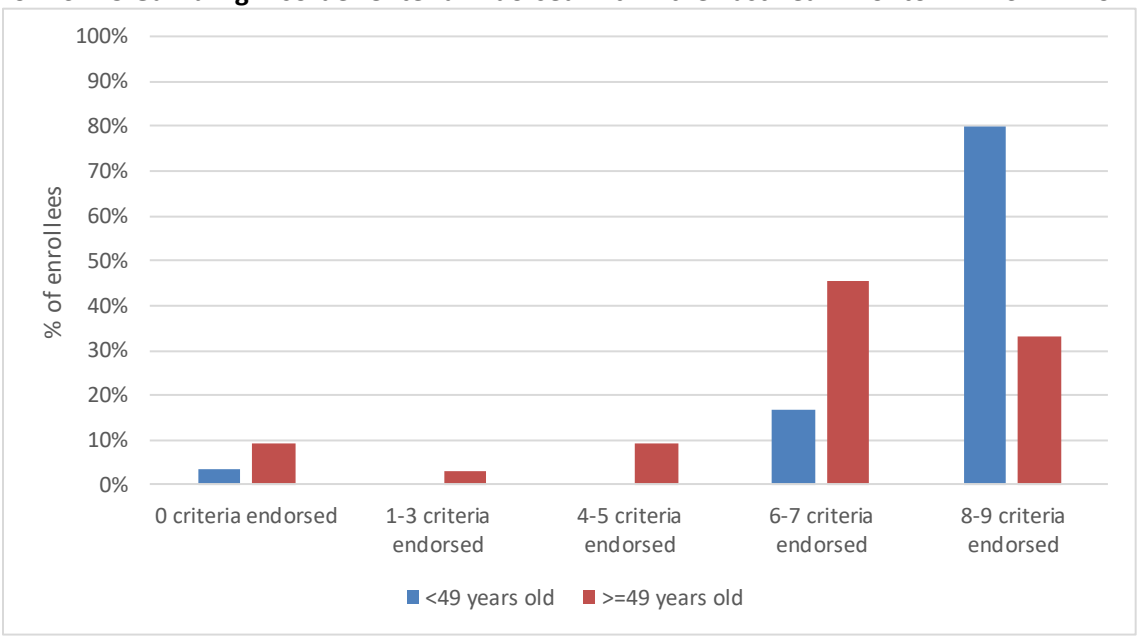


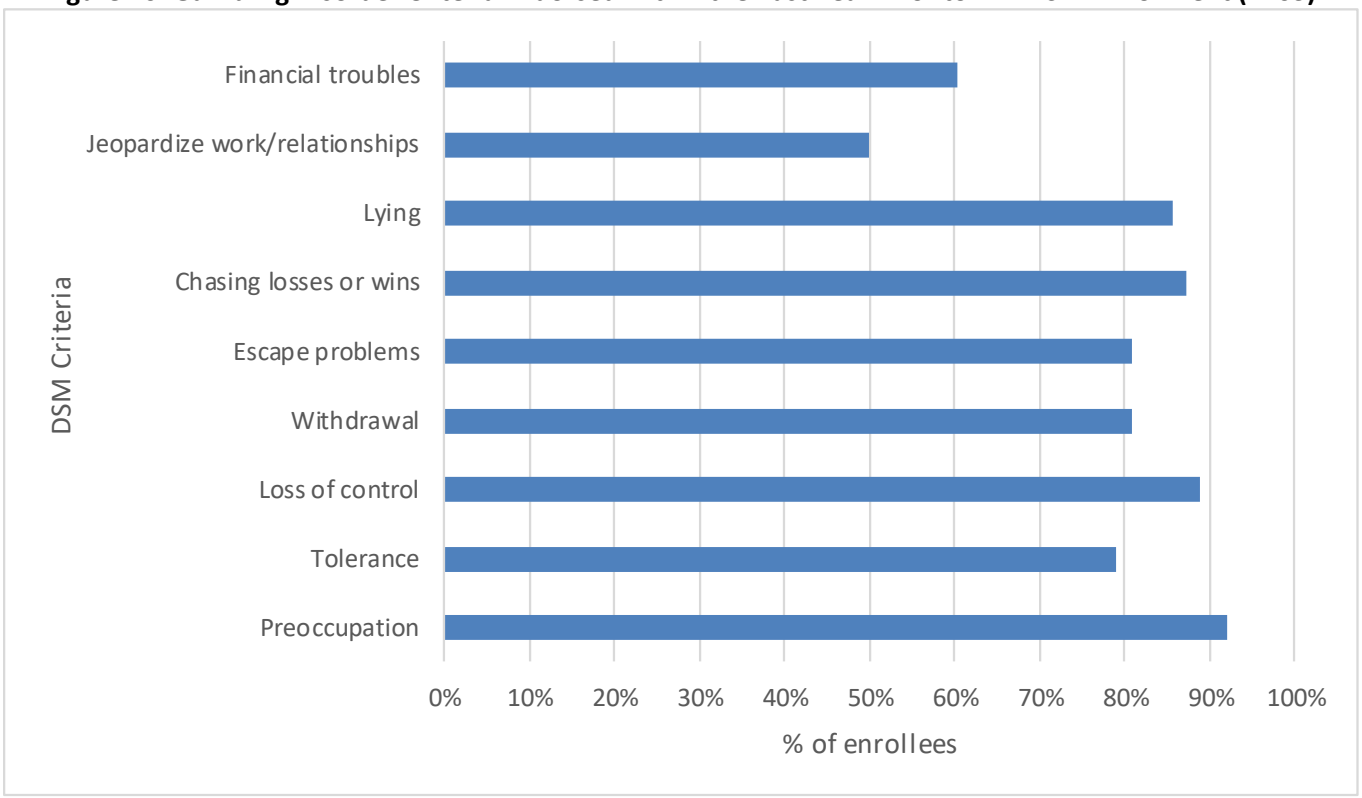
Figure 15: # of DSM-5 Gambling Disorder Criteria Endorsed within the Past Year Prior to MA-VSEP Enrollment (n=63)



Overall, 92.1% of MA-VSEP enrollees who completed the baseline survey qualified for past year gambling disorder (i.e., endorsed 4+ criteria). Younger enrollees endorsed more DSM criteria (M=7.8, SD=1.8) than did older enrollees (M=6.4, SD=2.7), $F(1,61)=6.0$, $p<.05$. Figure 16 displays the specific criteria endorsed. Enrollees most commonly endorsed preoccupation, loss of control, chasing behavior, and lying to friends and family about their gambling.

In addition to gambling-related problems, 38% of MA-VSEP enrollees who completed the baseline survey reported sometimes drinking or using drugs while gambling, and 12.7% reported doing so often or always.

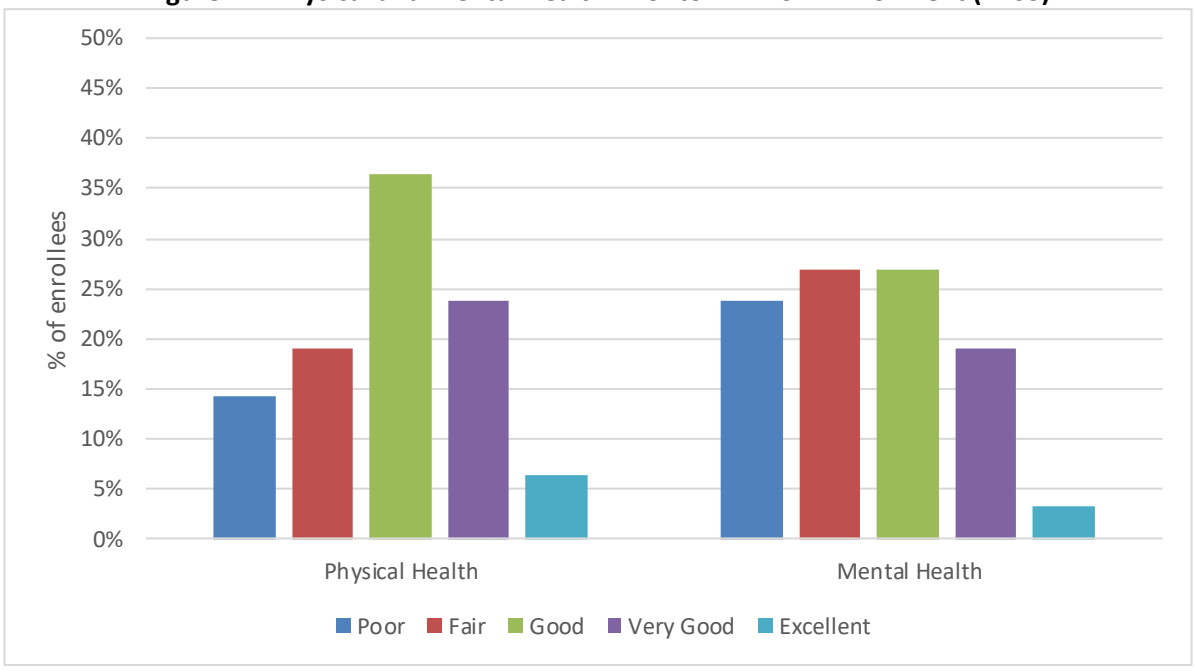
Figure 16: Gambling Disorder Criteria Endorsed within the Past Year Prior to MA-VSEP Enrollment (n=63)



3.2.7. Physical and Mental Health: Baseline Survey Respondents (n=63)

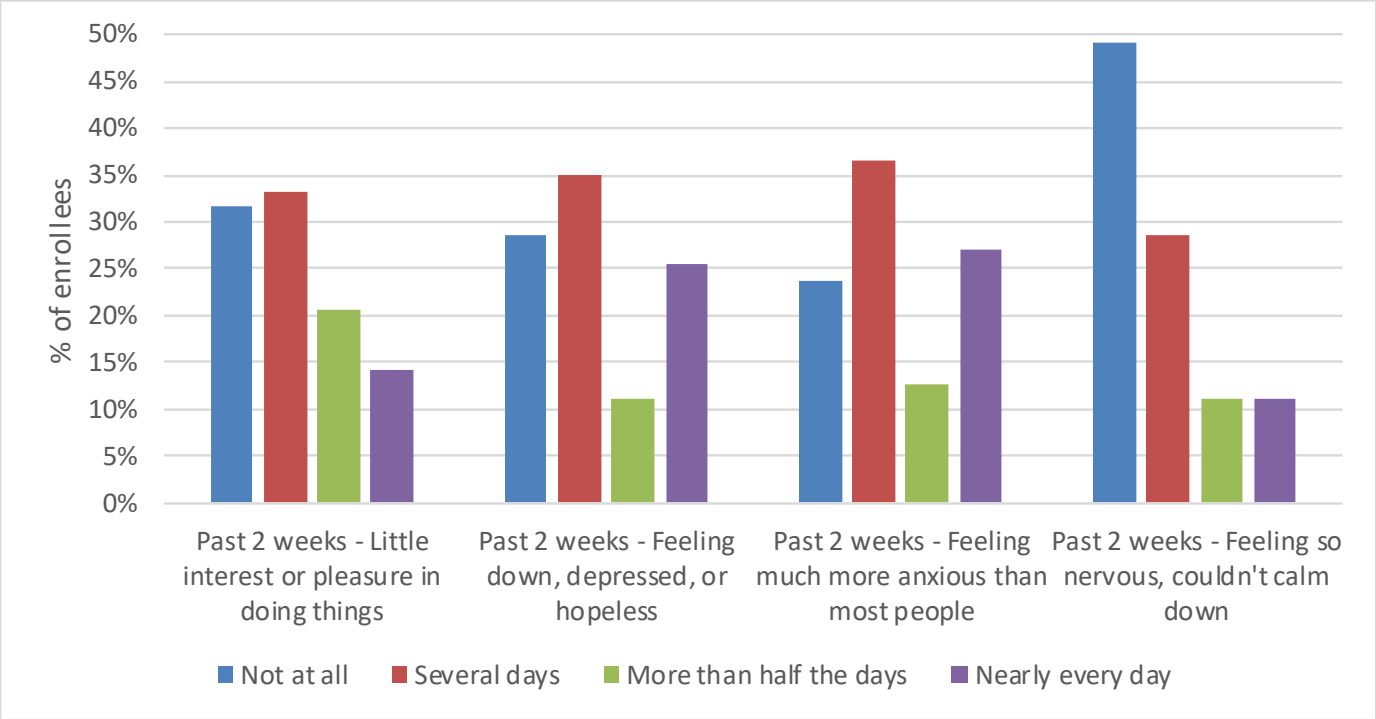
Though these results should be interpreted with caution due to the low recruitment rate, overall, MA-VSEP enrollees who completed the baseline survey rated both their mental and physical health as, on average, between "fair" and "good" (M=2.9, SD=1.1 for physical health; M=2.5, SD=1.1 for mental health). As Figure 17 shows, one third of enrollees rated their physical health as poor or fair, and more than half rated their mental health as poor or fair.

Figure 17: Physical and Mental Health Prior to MA-VSEP Enrollment (n=63)



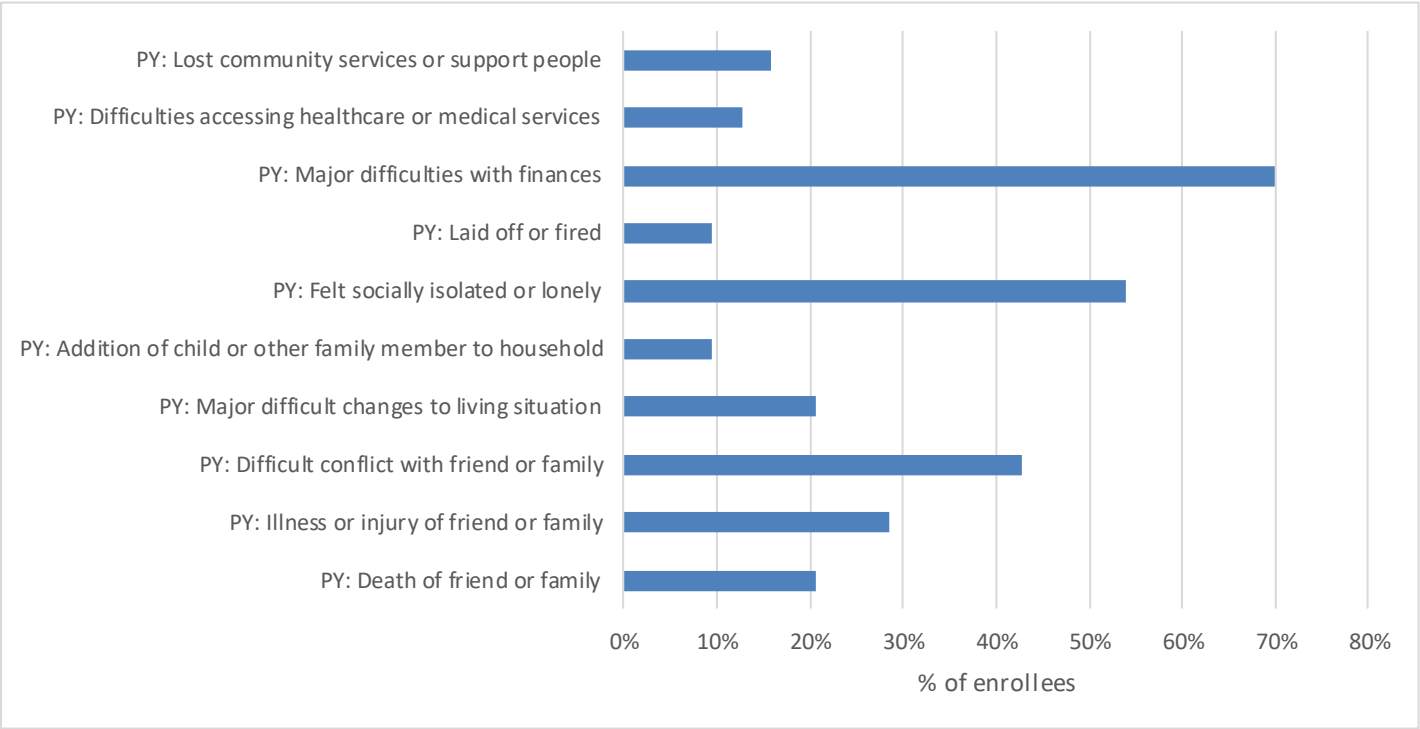
MA-VSEP enrollees who completed the baseline survey also responded to a modified version of the Patient Health Questionnaire-4 assessment for anxiety and depression in the 2 weeks prior to MA-VSEP enrollment (PHQ-4: Kroenke et al., 2009). Figure 18 displays their responses. Enrollees responded to both the depression and anxiety items with average scores ranging from 1.8 to 2.4 on a 4-point scale where 1 indicates "not at all", 2 indicates "several days", and 4 indicates "nearly every day". As shown in Figure 18, the majority of enrollees indicated experiencing each symptom in the past two weeks. Using PHQ scoring practices, in which responses to depression and anxiety items are summed and a score of 5 or greater on either indicates a positive screen, we found that 41.3% of enrollees screened positive for depression and 38.1% screened positive for anxiety.

Figure 18: Depression and Anxiety Symptoms in Two Weeks Prior to MA-VSEP Enrollment (n=63)



To examine potential triggers for mental health issues that might exacerbate gambling issues, the baseline survey asked MA-VSEP enrollees whether they had experienced any of 10 life events in the year prior to MA-VSEP enrollment. As Figure 19 shows, seventy-percent of enrollees who completed the baseline survey indicated that they had major financial difficulties, and more than 50% indicated they felt socially isolated or lonely. More than 40% reported a difficult conflict with a friend or family member. On average, enrollees reported 2.8 stressors (SD=2.0) in the year prior to MA-VSEP enrollment. Number of stressors did not vary by gender, age, or enrollment term.

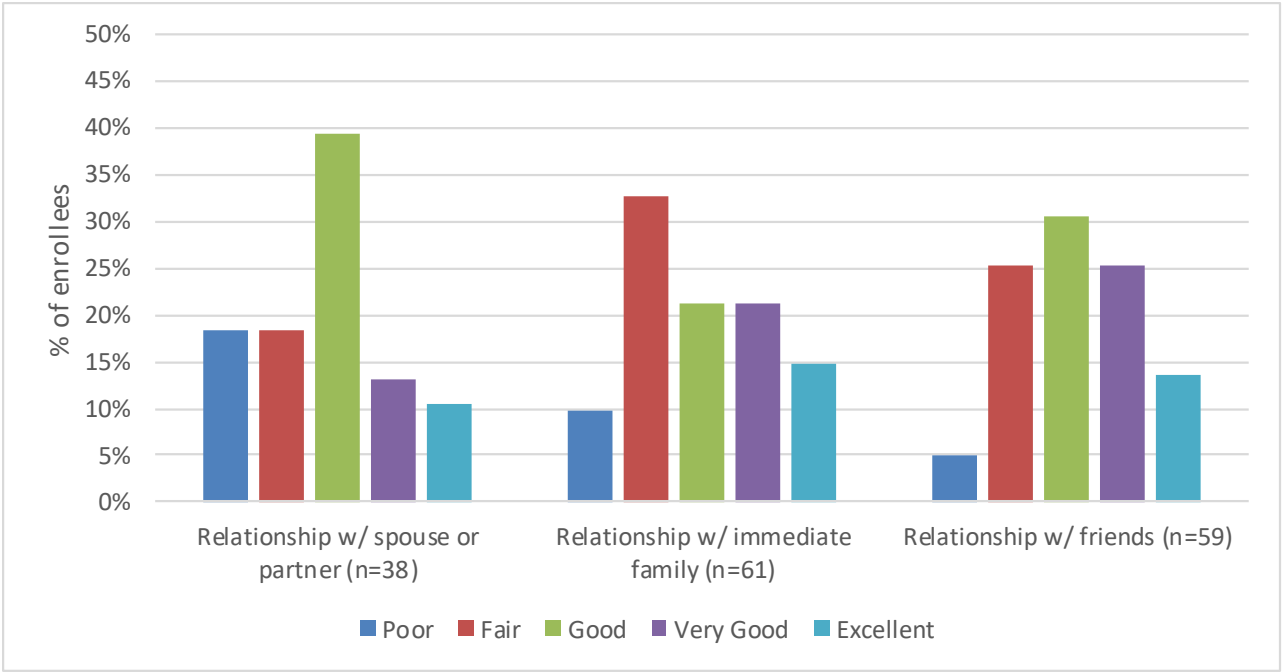
Figure 19: Stressful Life Events in the Year Prior to MA-VSEP Enrollment (n=63)



3.2.8. Relationships and Social Support: Baseline Survey Respondents (n=63)

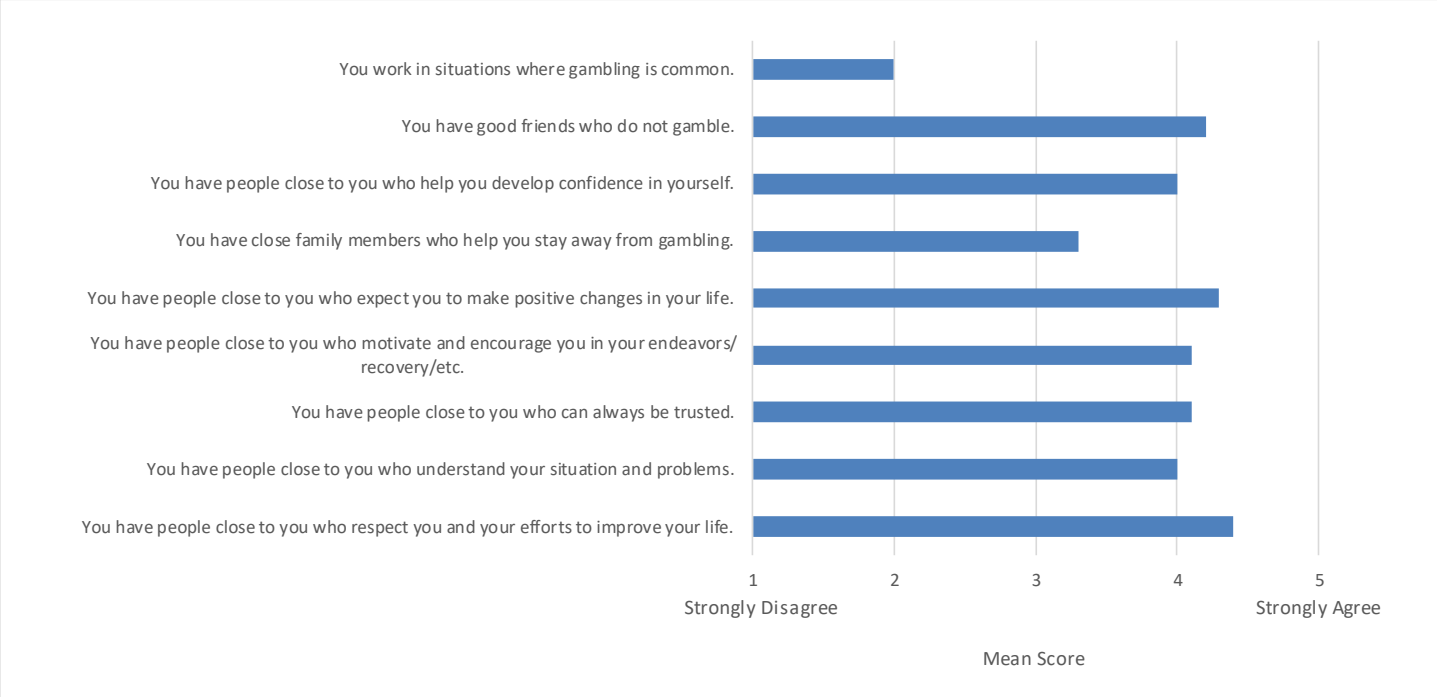
Enrollees who completed the baseline survey rated their relationships on a scale from 1 (poor) to 5 (excellent). Figure 20 illustrates these ratings. Though these results should be interpreted with caution due to the low recruitment rate, almost two thirds of enrollees who answered the question (63.2%) indicated their relationship with their spouse or partner was good, very good, or excellent, 57.4% indicated their relationship with immediate family was good or better, and 69.5% rated their relationship with friends as good or better.

Figure 20: Relationships Prior to MA-VSEP Enrollment



MA-VSEP enrollees who completed the baseline survey also responded to the TCU Social Support Scale (Joe et al., 2002), a 9-item measure of social support from friends and family. Figure 21 displays the items and enrollees' agreement with those items. Enrollees indicated they had generally strong social support networks, scoring an average 36.2 out of a maximum of 45 on the summed scale.

Figure 21: Social Support Prior to MA-VSEP Enrollment (n=63)



3.2.9. Past Treatment: Baseline Survey Respondents (n=63)

Though these results should be interpreted with caution due to the low recruitment rate, a majority of MA-VSEP enrollees who responded to the baseline survey reported having had past experience with treatment-seeking related to gambling. Slightly more than two thirds (68.3%) reported having talked to a doctor or professional about their problems with gambling. Approximately half (47.6%) previously had called a gambling helpline, and 22.2% had done so during the year prior to MA-VSEP enrollment. Approximately half of enrollees who responded to the baseline survey also reported having received treatment for a mental health or substance use problem other than their gambling-related problems. Table 5 summarizes the overlap between these categories. Just over half of enrollees in this sample had sought help specifically for gambling-related problems *and* had treatment for non-gambling mental health or substance use issues.

Table 5: MVEP Enrollee Help-Seeking Behavior Prior to MA-VSEP Enrollment (n=63)

	No prior MH or SU problems	No prior Tx but might have MH or SU problems	Prior treatment for MH or SU problems
No gambling-related help-seeking	10 (66.7%)	1 (6.7%)	4 (26.7%)
Called a gambling helpline or sought help from doctor or professional for gambling-related problems	18 (37.5%)	4 (8.3%)	26 (54.2%)

Note. MH=mental health; SU=substance use; Tx=treatment.

Figure 22 shows the different types of treatment MA-VSEP enrollees who completed the baseline survey had attended prior to MA-VSEP enrollment. Outpatient mental health treatment was the most common, followed by gambling treatment and financial counseling.

Figure 22: Treatment Services Received Prior to MA-VSEP Enrollment (n=63)

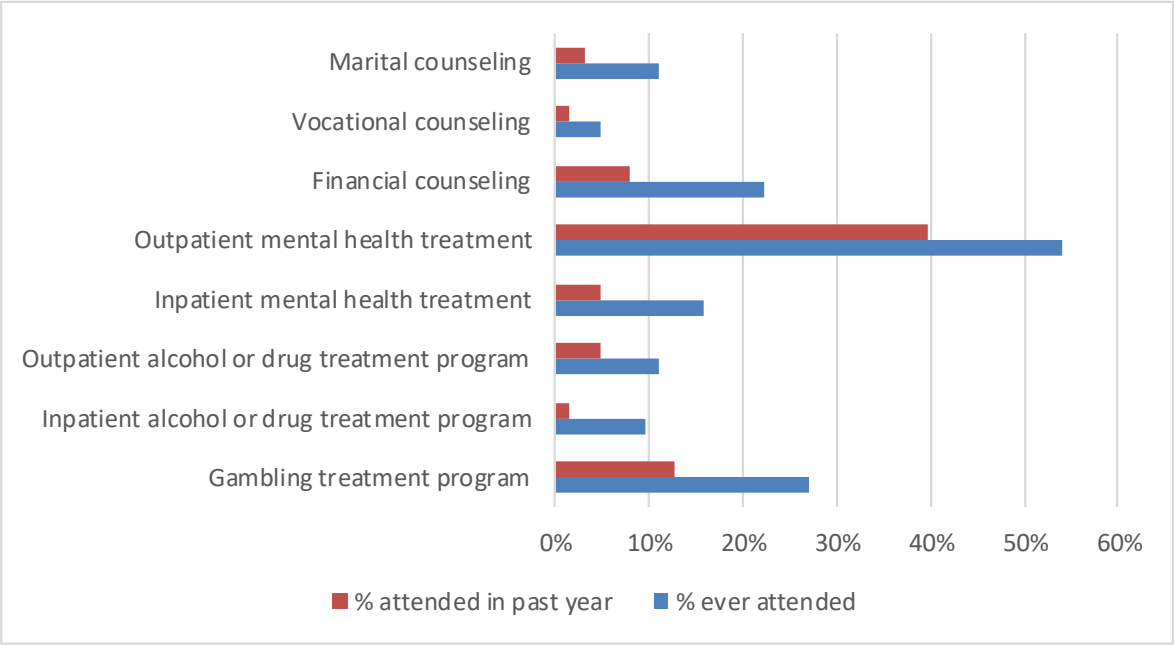
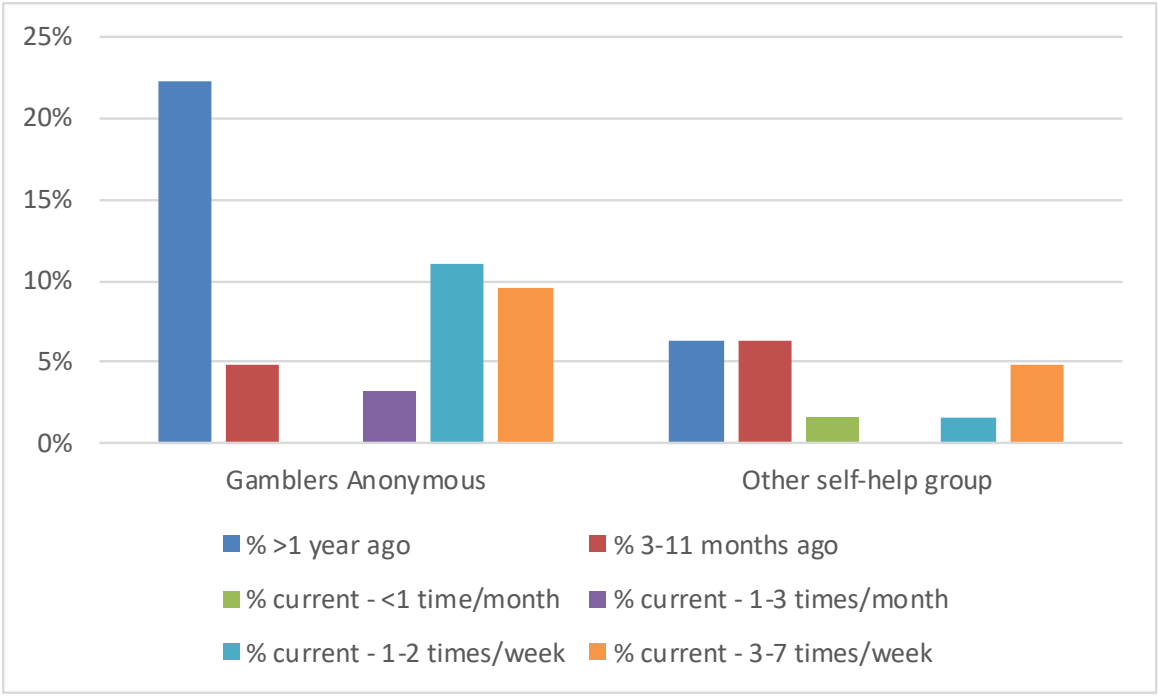


Figure 23 shows Gamblers Anonymous and other self-help group attendance prior to MA-VSEP enrollment among the MA-VSEP enrollees who completed the baseline survey. Half of enrollees (50.8%) had attended Gamblers Anonymous at some point prior to MA-VSEP enrollment, but as the figure shows, only 28.6% had attended Gamblers Anonymous during the past year. However, 11 of the 18 (61%) who had attended during the past year did so within a week before signing up for MA-VSEP. Other self-help groups were less popular. Just over 20.6% of enrollees had participated in other self-help groups prior to MA-VSEP enrollment, 14.3% in the past year.

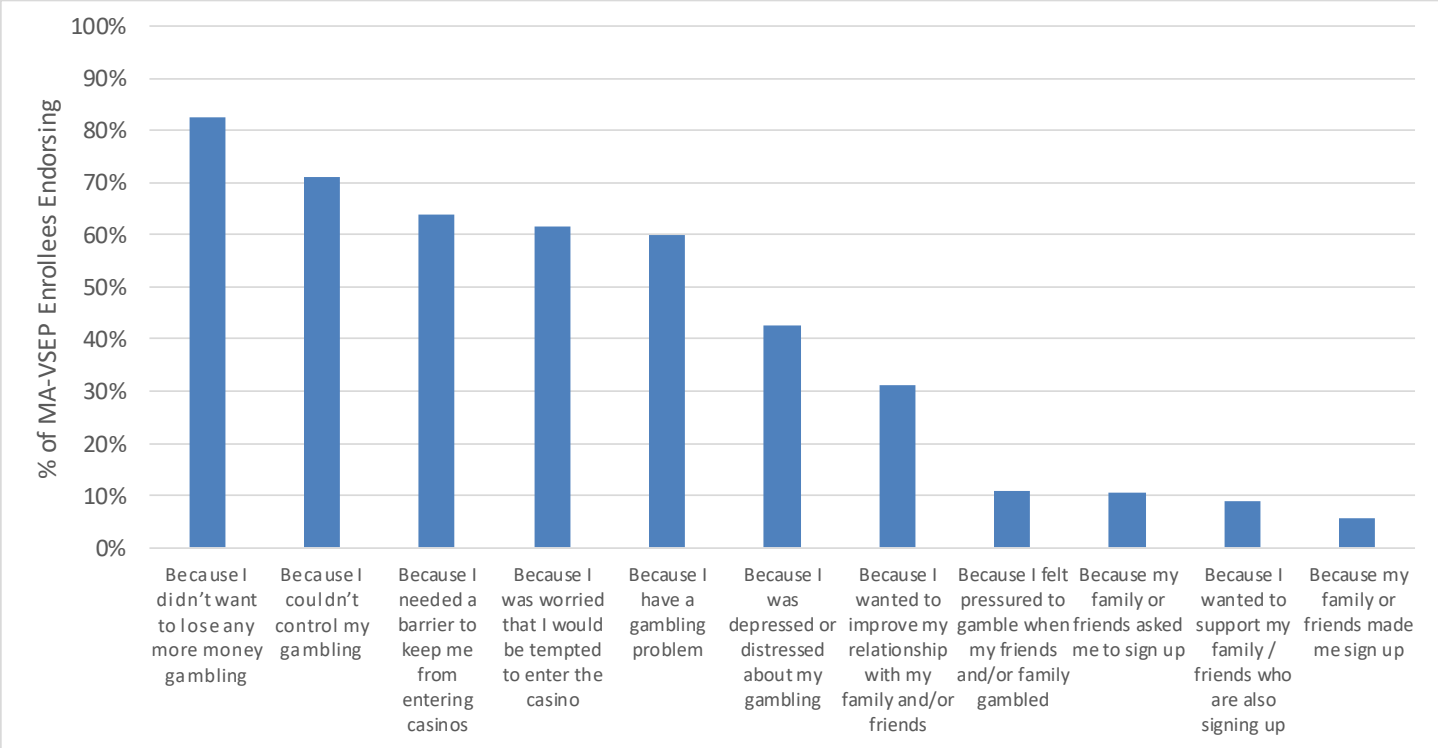
Figure 23: Self-Help Group Attendance Prior to MA-VSEP Enrollment (n=63)



3.2.10. Motivations for Enrollment

Figure 24 displays the reasons MA-VSEP enrollees endorsed for enrolling in MA-VSEP. Enrollees were able to select more than one reason, so the categories are not mutually exclusive. This question was included on both the VSEP application and the baseline survey, so we combined these data sources.[17] One hundred eighty-three MA-VSEP enrollees answered this question, either on their application or the baseline survey.

Figure 24: Endorsed Reasons for MA-VSEP Enrollment (n=183)



Note. Categories are not mutually exclusive.

Most enrollees endorsed individual reasons for MA-VSEP enrollment, as opposed to reasons that indicated being influenced by others or signing up to improve relationships with others. More than 80% of enrollees indicated that they signed up for financial reasons, and more than 70% indicated that they signed up because they were unable to control their gambling.

As Table 6 shows, 26 enrollees also provided other reasons for MA-VSEP enrollment. For the most part, these responses fit within the available categories, but provided more detail. However, multiple open responses indicated that enrollees were enrolling in MA-VSEP proactively, prior to gambling or experience problems at PPC.

We also asked MA-VSEP enrollees why they chose to self-exclude on that day in particular. One hundred fifty-eight enrollees responded on either the VSEP application or the baseline survey. We included their responses as Appendix G. For many enrollees, a large loss at PPC preceded their decision to enroll. For others, as indicated earlier, enrollment was a planned action to prevent them from ever gambling at PPC. Some noted a desire to fix broken relationships, others noted that PPC's proximity to their home or work was problematic. Four individuals specifically mentioned an encounter with a GSA having led them to enroll in VSEP.

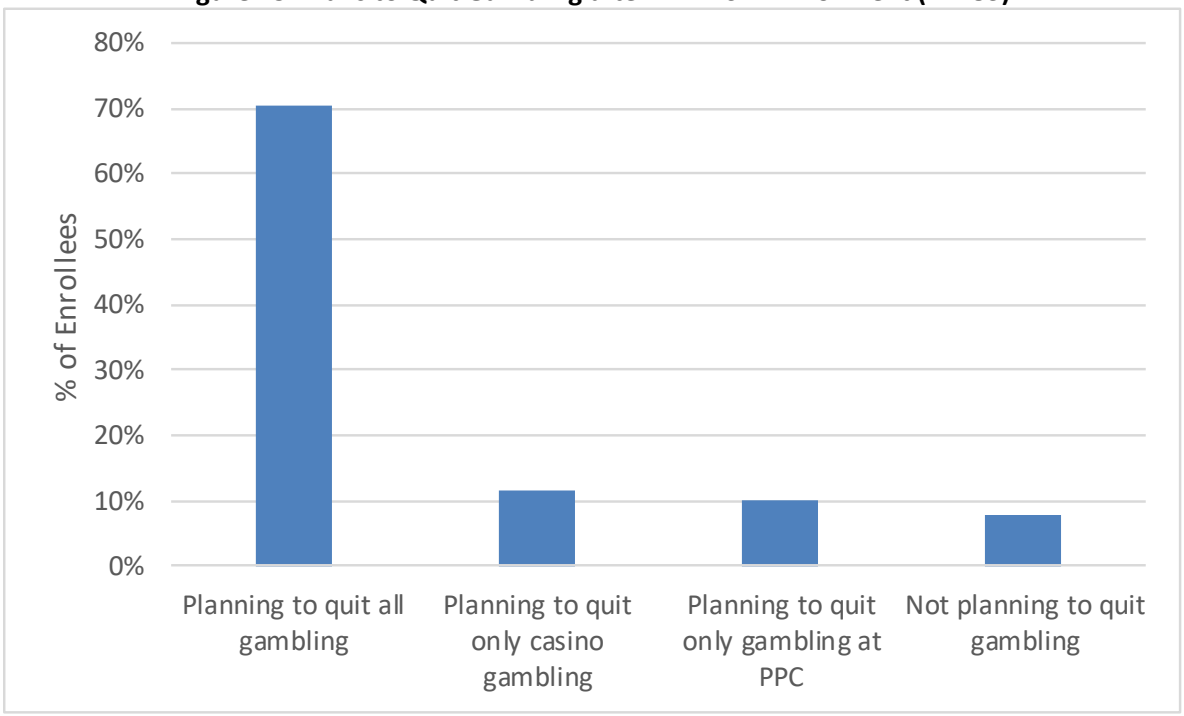
[17] For this question and the question about motivations for MA-VSEP enrollment, if an enrollee endorsed a reason on either their application or the baseline survey, we included their response.

Table 6: MA-VSEP Enrollee Reasons for Enrollment (n=26)

Open Response: "Briefly, why are you signing up for the MA-VSEP? → Other reasons – specify"
A cooling down for local gambling
Because I gamble so much
Because it was available
Bored
Can control my gambling
Career reasons
Come too much
Didn't know my limits
Had a recent big loss
Had to pay bills, gotten out of control
I am already excluded from Twin River and I know I'm a compulsive gambler
I am gambling beyond my means
I have mental illness and my depression would get worse when I gambled. I would stay at the casino for 15 hours straight without eating or taking medication.
I have mental issues
I have self-excluded from another casino
I went every single day since they opened until I signed up for VSE. It was out of control.
It was an intentional exclusion, had planned on signing up whenever MA opened a casino
Losing too much money!
Main reason is my family wanted me to. Started going gambling more and more after husband died (would gamble together)
PPC was convenient to stop at, drove past it frequently. Found that it was hard to not stop when drove past
Recovering addict, jumping to a new addiction
Saw the desk and went on my own
Someone in my life has been helping me and did not want to disappoint them
Stop gambling
Unfair what they are doing; they are controlling the games
Want to stop

As Figure 25 shows, most MA-VSEP enrollees intended to quit all gambling upon MA-VSEP enrollment.

Figure 25: Plans to Quit Gambling after MA-VSEP Enrollment (n=183)



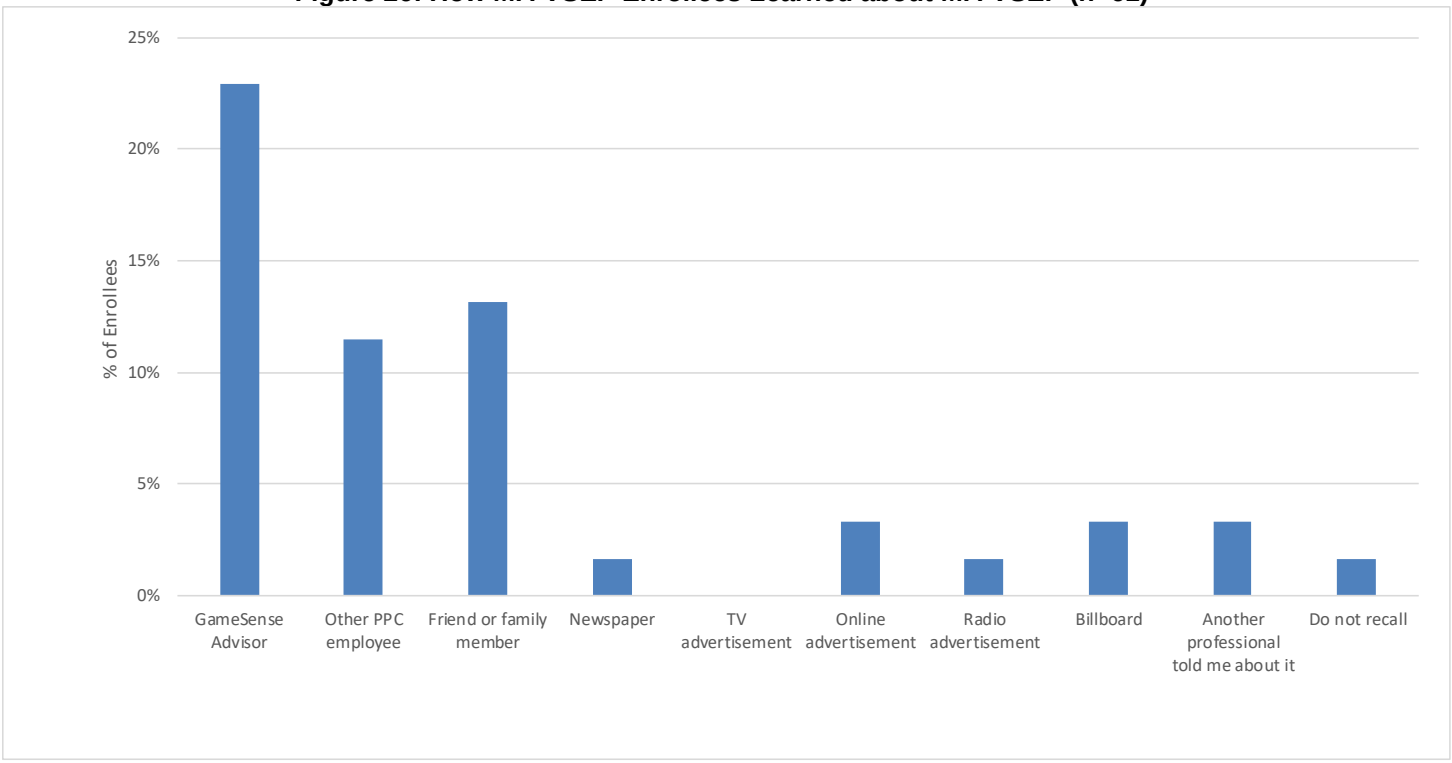
3.2.10.1. Motivations for Enrollment: Baseline Survey Respondents (n=63)

Though these results should be interpreted with caution due to the low recruitment rate, MA-VSEP enrollees who completed the baseline survey expressed both a readiness to change and confidence in their ability to change. On a scale from 0 to 10, enrollees rated themselves an average 8.2 (SD=2.2) on readiness to change, and an average 7.2 (SD=2.8) on confidence in their ability to change. However, confidence ratings varied more widely than readiness ratings.

3.3. MA-VSEP Satisfaction and Experiences: Baseline Survey Respondents (n=63)

MA-VSEP enrollees who participated in the baseline survey indicated how they learned about the MA-VSEP. Though these results should be interpreted with caution due to the low recruitment rate, Figure 26 shows that more than 20% first learned about MA-VSEP from a GSA, and enrollees were more likely to have learned about MA-VSEP from PPC staff, family or friends than through advertisements.

Figure 26: How MA-VSEP Enrollees Learned about MA-VSEP (n=61)



Note. Categories are not mutually exclusive.

More than 65% of enrollees who completed the baseline survey provided their own free response answer to this question; these answers are reported in Table 7. Multiple enrollees noted that they learned about MA-VSEP through signage at the casino, through Gamblers' Anonymous, from other casinos in the area or from the MCCG or the helpline. Of note, among the 46 MA-VSEP enrollees who completed the follow-up survey, 76.1% indicated that they had signed up for VSE in another state or at another casino prior to their MA-VSEP enrollment.

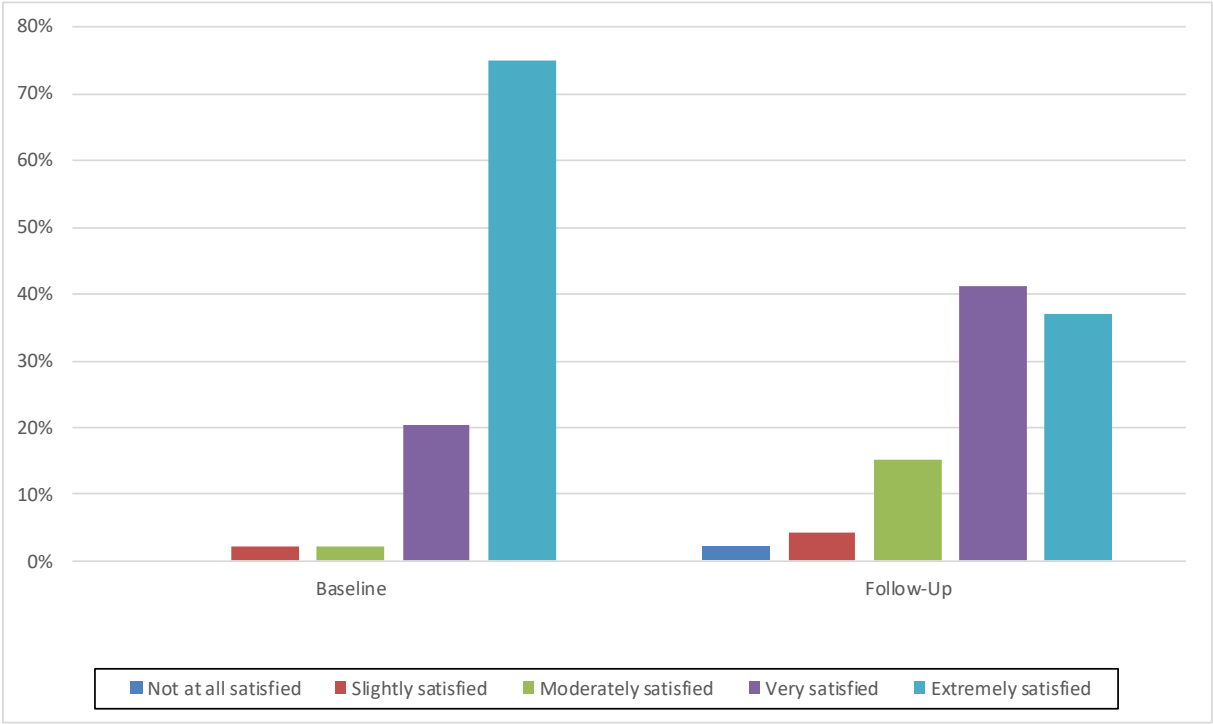
Table 7: How MA-VSEP Enrollees Learned about MA-VSEP (n=40)

Open Response: "How did you hear about the Voluntary Self-exclusion program? → Other – specify"
Ads on-site (before you get on the elevator, in the elevator), you saw the GSA office right as you walk in.
Ads/flyers in the casino
All casino have that
Already knew it was there.
Always known about it
Another gambler at Plainridge
Assumed they had one and asked
Been in and out of places for years, and assumed there was a list
Coworker had signed up
Did it at another casino
Done VSE at other casinos
GA
GA member
Gamblers Anonymous
Gamblers Anonymous
Gamblers Anonymous
Gambling hotline
Gambling hotline
Heard about it at Twin Rivers Casino.
Heard about it from an online support group
I had seen the program at other casinos.
I have done it at other casinos
I walked into the casino looking for help. I have been having a very, very, hard time to be VSE
I was already aware of it because I had used it at other casinos in the past. I saw a pamphlet for it at GA.
It was advertised in Plainridge
Knew about it from other casinos (Twin Rivers has it)
Knew about it through Twin Rivers, called GSAs to figure out how to do it.
Literature given to me, from GA meetings, heard it discussed at a presentation at Mass Council.
Looked it up on the Internet
Looked it up online after seeing GameSense
Mass Council on Compulsive Gambling. I have a good friend over there, I called her to tell me more about Game Sense.
Other casinos
Picked up a brochure at the GameSense Information Center
PPC website
Saw GameSense sign
Saw on website and familiar with it from other casinos
Saw the GameSense center
Saw the office in the casino
Signed up at Connecticut casinos, already aware of the program.
Signed up at other casinos so knew it was available.
When you put your card in the machine, it comes up.

3.3.1. MA-VSEP Satisfaction: Baseline and Follow-Up Survey Respondents (n=63; n=46)

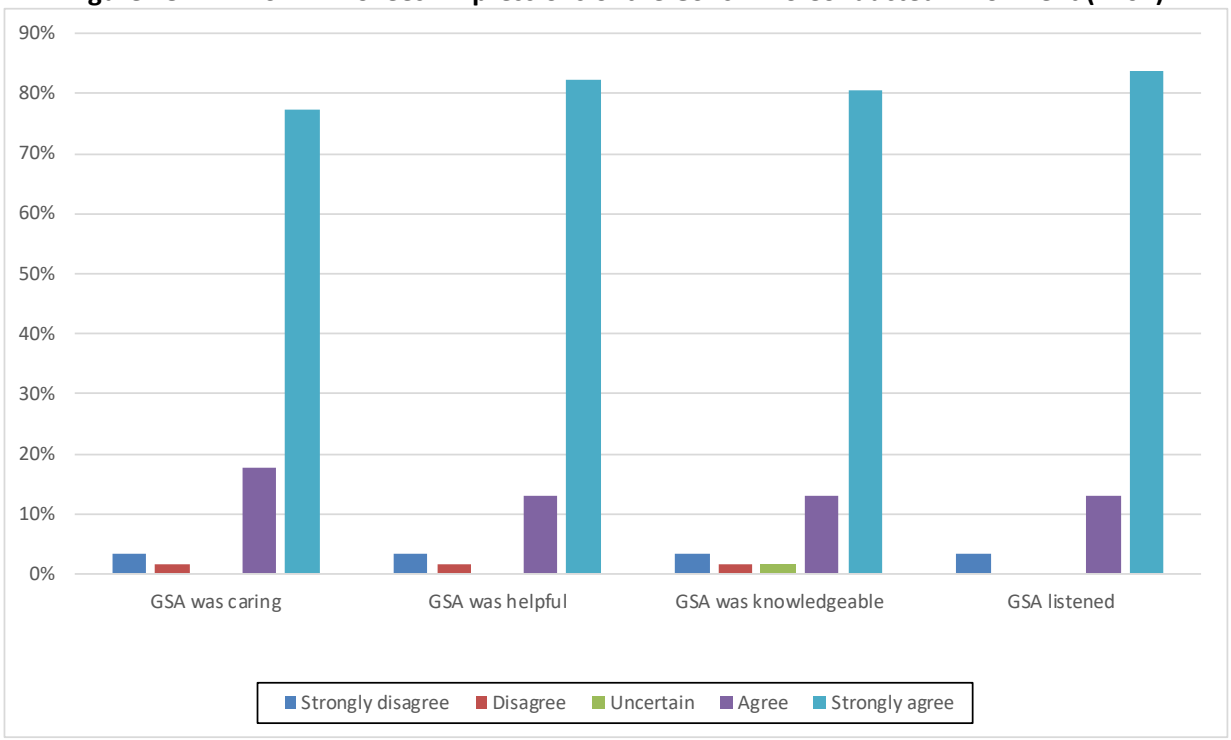
Though these results should be interpreted with caution due to the low recruitment rate, overall more than 75% of MA-VSEP enrollees who completed the baseline interview were extremely satisfied with their MA-VSEP enrollment experience, and another 20% reported being very satisfied. Only 3.3% reported being slightly or moderately satisfied, and no one reported dissatisfaction. At follow-up, these numbers declined somewhat. Thirty-seven percent of the MA-VSEP enrollees who completed the follow-up interview were extremely satisfied, 41.3% were very satisfied, 15.2% were moderately satisfied, 4.3% were slightly satisfied and 2.2% were not at all satisfied. As Figure 27 shows, among the 44 MA-VSEP enrollees who completed the follow-up interview and rated their satisfaction on both surveys, their satisfaction ratings decreased from baseline to follow-up, $t(43)=3.83$, $p<.001$.

Figure 27: Change in MA-VSEP Satisfaction from Baseline to Follow-up (n=44)



MA-VSEP enrollees who completed the baseline survey found the GameSense Information Center to be private (96.8%) and comfortable (95.1%). Figure 27 displays enrollees' impressions of the GSAs who conducted their enrollments. The vast majority of enrollees who completed the baseline survey had favorable impressions of the GSAs.

Figure 28: MA-VSEP Enrollees' Impressions of the GSAs Who Conducted Enrollment (n=62)



Among the 35 MA-VSEP enrollees who completed the follow-up survey and indicated that they had already participated in VSE in another state or at another casino, 82.8% indicated that their experience with MA-VSEP was better than their experience with other program(s), 14.3% indicated it was about the same, and 2.9% did not respond to the question. Table 8 shares additional thoughts these enrollees provided about MA-VSEP compared to other programs.

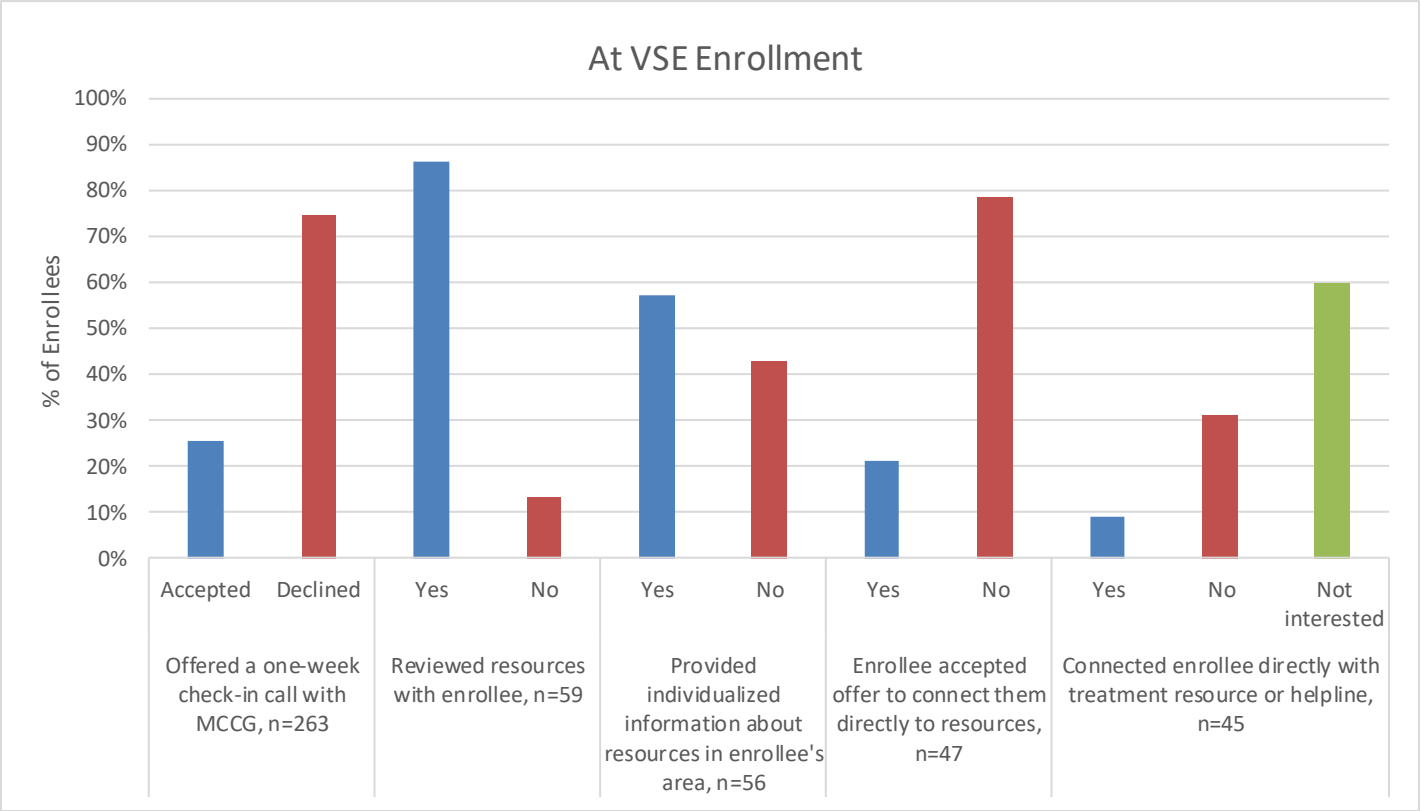
Table 8: Enrollees' Impressions of MA-VSEP Compared to Other VSE Programs (n=35)

Open Response: "Please explain how your experience with MA-VSEP compares to your experience with other self-exclusion programs. If it has been different, how has it been different?"
About the same, did not get any information and took picture
All the other ones are the same, you are treated like a criminal, security brings you in like you are being arrested, they take your photo like you are a criminal and you are run out like a bum. They treat you terrible. Massachusetts was a warm welcome, lets talk , lets see what's going on, comfortable, relaxed, felt like the guy was there to help you. IT was two different worlds. Massachusetts does it write.
At different facilities you are doing the paper work with the security department. In Massachusetts they explain everything, they give you advice, it was very informative, very detailed and a lot of information.
Clean, it's there in the casino and you can see it when you walk in. GSA were very nice, unlike other places. Other places were terrible, it was horrifying and deters her from excluding from other places. Was very humiliating, no privacy.
Considerably better, gamblers interests at heart. More personal. more in depth, more interested in helping. Free to ask questions and have an exchange of ideas.
Don't really remember. Other VSE sign up was at Twin river.
Had someone to sit down and talk to us. At Twin River, you just signed a paper. So basically support or no support.
I don't know yet, I haven't been back to PPC since excluding.
I thought if you went back in there, they would ask you why you are in there. I never would have gone back had I known they don't want you in there. Easier to get back in to a casino in other states than in Massachusetts. Signing up took a lot longer than other states.
In CT, I had to send in confirmation letters. RI was real bad because I had to actually go behind closed doors and I felt very uncomfortable and they weren't too nice. Game Sense advisors are caring and with you.
It felt like help, not a security issue
Major difference - had to go to the casino to do it. I hated it. You have to go to the casino after already deciding to never go back. It's terrible. Other states you can enroll online.
More caring, cares about what's going on. other casinos are more business
More formal, more known and caring.
More thorough, found something about it that was more helpful, maybe more caring
More understanding, less hostile. More medical based than security, cares more about the gambler, very compassionate.
Much better. In others, you sign up and you feel like a criminal, they just take your mugshot. Said he felt like a human being at PPC
No differences I've found. Much nicer (the people who do the interviews)
Other casino was Twin Rivers, they offered no help and was brought out by security. I took it more seriously after the MA-VSEP and began to look for more help. They kept trying to reach out.
Other program felt like they were trying to discourage him from self excluding
Other programs don't follow up and check in, you just self exclude and that's the end of it. I like being contacted and checked on.
Other programs take you in back room and take photo, GameSense was better and more comfortable and more explanation of program
Other VSE programs limit you to just those casinos. Signing up in MA excludes you from other places, other states as well
Rhode Island done by head security guard, very criminal like feeling. No help was offered ,just don't come back until your time is up. Massachusetts was nice, offered help if we needed it, what we needed to do if we wanted to come back. It was 100 times better. I just remember how good it was. I didn't feel belittled or criminalized.
Sat down, explained the process, help was offered. In RI, it was a security guard who told me I would get arrested if I came back. it was amazing, felt less like a criminal.
Some other states did not care about me, the one in MA was kind and understanding, helpful. you don't hear from the other states after you self exclude.
The follow up- they explained everything, walked me through the material. It wasn't just like an automatic check-in. They told me what they expect and they showed care. Other programs felt like just a process.
The GSAs are great, Massachusetts is the best. At other casinos it is just the security who do the exclusions and they just take a picture and escort you out.
The other one was ridiculous, the other casino didn't want to let me exclude because I hadn't gambled there before, I had to explain to them my rights and get a manager. The security lady was a complete boob.
The program is the same, Plainridge really follows the rules and don't let anyone in on the list. The other casinos let you in, they don't care, just want your money, pretend they don't see you.
The same, but mostly positive.
Theres a follow up, it is serious and a good program
They told me straight up what was going to happen if I tried sneaking in; liked that it was a strict policy
They're essentially the same, you can walk in and out, it's only if you hit the jackpot cause then they have to do the identity. All of them are the same. Here's the difference, Massachusetts is forever. In Twin Rivers you could do 5 years. Massachusetts is forever, that feels more serious. But you can still walk in. It's only if you win or if you cause a problem [that they would catch you]
Was treated like a criminal at other casinos, this VSEP was better and a much more positive experience and more personal.

3.3.2. MA-VSEP Utilization

As Figure 29 shows, among the full sample of first-time MA-VSEP enrollees (n=263), 67 (25.5%) agreed to have a one-week check-in call with staff from the MCCG. Among the 67 who agreed to a one-week check-in, GSAs completed forms about interactions at enrollment for 59 of them, but as Figure 29 indicates, did not answer all questions for all of these 59 enrollees.[18] Among the enrollees for whom they answered these questions, GSAs reported that they reviewed resources with 86.4% of them at the time of their initial enrollment. Also, GSAs reported that they provided individualized information about resources in enrollees' areas of residence to 57.1%. Approximately one in five enrollees who agreed to a one-week check-in call accepted offers to connect them directly with resources at the time of MA-VSEP enrollment; however, only 8.9% successfully connected with a treatment resource or the helpline at the time of MA-VSEP enrollment.

Figure 29: Utilization of Resources at MA-VSEP Enrollment

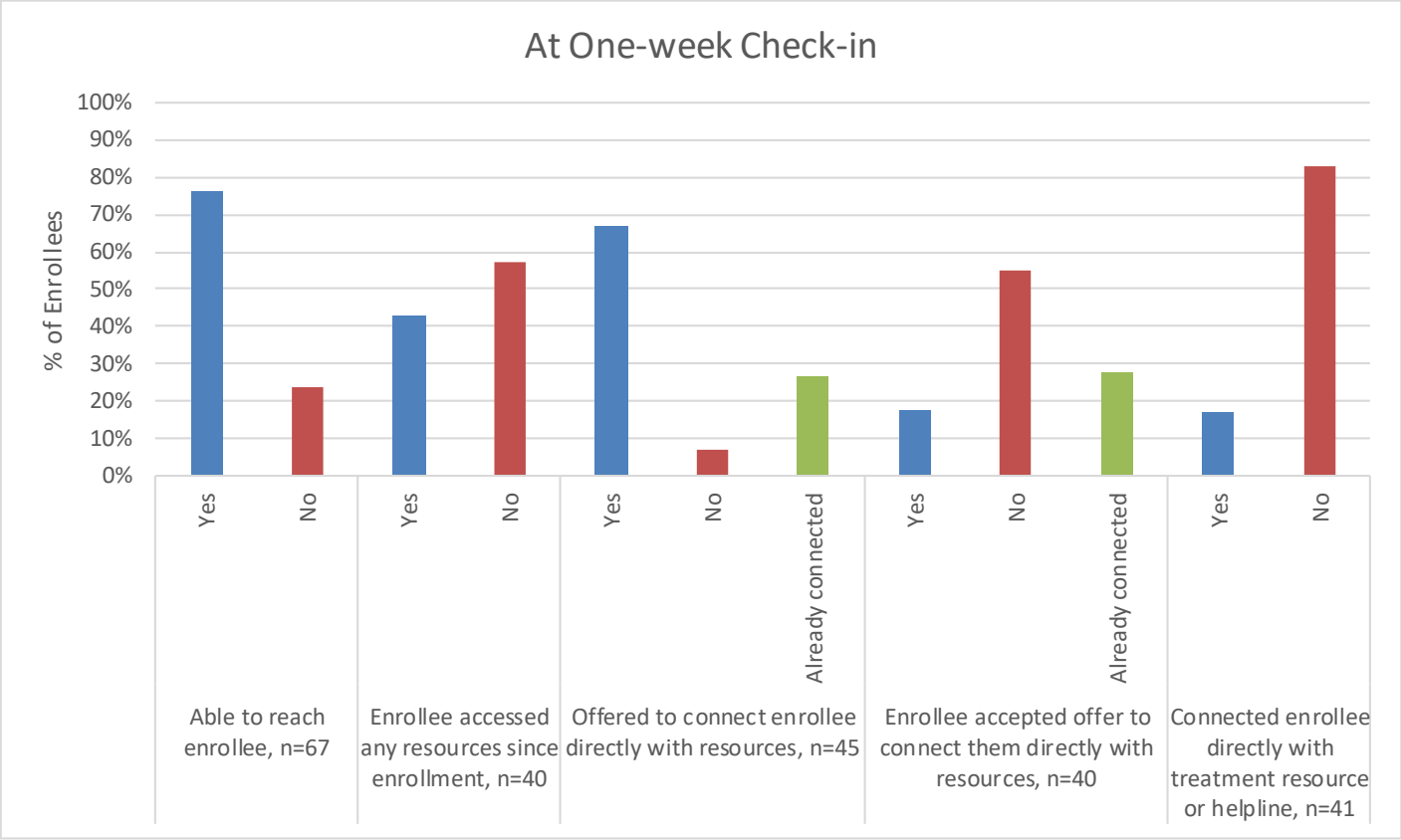


Among the 67 enrollees who agreed to be contacted, MCCG was able to establish contact with 51 (76.1%).[19] As Figure 30 shows, among the enrollees with whom MCCG completed check-in calls, 17 (i.e., 42.5% of the 40 for whom MCCG staff answered the question) reported accessing the resources provided to them at enrollment. During the call, an MCCG staff member offered to connect 30 of 45 enrollees (66.7%) with resources, indicating that 12 were already connected to resources and that they did not make that offer to 3 enrollees. Staff reported that 7 enrollees (17.5% of the 40 for whom they answered this question) accepted their offer to connect them with resources at check-in, 11 (27.5%) indicated they were already accessing resources, and 55.0% refused. Finally, MCCG staff reported that they were able to connect 7 enrollees directly with services at check-in. However, these 7 did not overlap perfectly with the 7 whom MCCG indicated accepted their offer to connect with services.

[18] GSAs were instructed to complete forms about their sharing of resources with enrollees at initial enrollment for all enrollees, but only ended up doing so for enrollees who agreed to a one-week check-in call.

[19] MCCG only completed full one-week check-in records for 39 but indicated through notes that they had made contact with an additional 12. We used those notes to fill in the other fields where possible for those 12 (e.g., whether enrollee had accessed resources since enrollment).

Figure 30: Utilization of Resources at One-Week MCCG Check-In



3.3.2.1. MA-VSEP Utilization: Follow-Up Survey Respondents (n=46)

MA-VSEP enrollees who completed the follow-up survey also reported on their utilization of MA-VSEP resources and their experiences during enrollment. Though these results should be interpreted with caution due to the low recruitment rate, Table 9 summarizes their responses to questions about resources offered during enrollment, check-in calls, and utilization of resources.

Table 9. MA-VSEP Enrollee Self-Reported Experiences with MA-VSEP Enrollment and Utilization of Resources (n=46)

Follow-Up Survey Feedback about MA-VSEP	% Endorsing
Given resource packet at MA-VSEP enrollment	95.7%
GameSense Advisor/Staff reviewed resource packet with enrollee	91.3%
Enrollee used resource packet	18.2%
Received one-week check-in call	54.8%
Signing up for MA-VSEP influenced enrollee to seek further help	41.3%

The 19 enrollees who indicated that signing up for MA-VSEP influenced them to seek further help were asked to explain how their enrollment influenced this action. As Table 10 shows, for some individuals, MA-VSEP enrollment connected them with resources they had not utilized before, while in other cases, the process of enrollment nudged them back toward resources they had utilized previously.

Table 10. How MA-VSEP Enrollment Influenced Additional Help-Seeking (n=19)

Open Response: "[Did signing up for MA-VSEP influence you to seek any kind of treatment or self-help for gambling or other problems?] Briefly, how did it influence you?"
Allowed me to understand my potential for casino-based gambling problems
Gamblers Anonymous
Gave resources to seek out help
Hard to explain, when you sign up you realize that you've lost a lot of money, gives you drive I guess.
I knew I needed help, it was the gateway to help. It didn't bring me to help, but I know I had to go and the first step was exclusion for me.
Inspired me to go to counselling session
It got me to go back to GA, it just made me realize that I just needed to stop.
It influenced me in a positive way and nothing more.
It was okay, it was just explaining what it takes. I didn't review it at all so I didn't know.
Let me know that there is help, didn't pursue it very hard before VSE.
Made me more aware of resources that I can seek out.
Made me see a therapist
Nothing except it is in my head now. I know I shouldn't be doing what I am doing.
Scared me, didn't want to be that kind of person
Struck by the non-security aspect, less intimidating and encouraging. More of an embrace than a shove.
To call the hotline and try to seek additional help, not successful though.
Told therapist about the program. same guy I have seen since 2008
Was able to see that as a support line and doing VSE added to my support group
Went to see therapist

3.3.3. MA-VSEP Enrollees' Impressions of MA-VSEP and Suggestions for MA-VSEP Improvement: Follow-up Survey Respondents

MA-VSEP enrollees who completed the follow-up survey answered two open response questions about whether and how they believed MA-VSEP helped them, and any suggestions for improving the program. These results should be interpreted with caution due to the low recruitment rate. Table 11 includes enrollees' statements about how they believe MA-VSEP helped them. For many, the risk of being caught is a deterrent, but many of the enrollees also mentioned the support provided as particularly important.

Table 12 includes information that MA-VSEP enrollees who completed the follow-up survey provided about how they thought MA-VSEP could be improved. Twenty-nine (63.0%) provided suggestions, and 17 (47.0%) specifically indicated that they had no suggestions or thought the program did not need to improve. Though there were many specific unique suggestions, a few themes emerged. Multiple enrollees indicated they would like to see more follow-up and check-ins from the program. Many enrollees also indicated that they thought the program could be better advertised. A few indicated allowing regional VSE or setting up the program so that an individual did not have to enter the casino or be near the gambling floor to sign up would be helpful.

Table 11. Enrollees' Perceived Benefits of MA-VSEP Enrollment (n=46)

Open Response: "Has the MA-VSEP helped you? If so, how? If not, why not?"
Encouraged me to look for hotline, but also made me go to another casino even more.
Feel as though there is something there to support me
Gives me peace of mind, acts as a barrier
Has helped me, kind of let me know how much I was losing. let me know it's a sickness, it really is, it's like drinking. once you start, you want to keep going.
Has. I went with a group of casino gamblers to exclude, went as a support person and to self exclude as precautionary measure. Program has given a psychological barrier to lean against, I take comfort that exclusion at plainridge extends to other establishments. As identified compulsive gambler, there is potential for relapse in future, the self exclusion gives me a support against that
Haven't been to any of the casinos, just need something that says you can't come here
Helped me by keeping me away from that casino.
Helped me financially and time
Helped me not gamble as much.
Helped with finance, treatment resources and support
Helps by giving a barrier to entry
I can't go gambling in any casinos in MA and RI. and I know if I go I can't gamble so it's a waste of money, so why waste your money.
I guess it's helped because I haven't gone. But again, it's still I guess.
If I want to gamble, I have to drive futrher. I don't know... Where there is a will there is a way. It's made it so I have to travel beyond Plainridge
I'm not going and I'm saving my money. Less stress and headaches.
It did help. while I was on it, I was able to save money and had cash to fall back on when I started gambling again.
It explained a lot about gambling, how the machines work. And now I share that information with other people.
It gives a great deal of support, I use the GameSense wallet and store my credit card in it. It reminds me, gives me subliminal reminders, makes a big difference. However, gambling is not an answer to making more money (either personally or for the state). Casinos aren't built on winners.
It has because even though I can go back in, I have to play differently. I have to limit my playing somewhat, curtail it from my normal addiction, because the way I usually play I can win more than 1200. And I might think twice before going there.
It has helped because it creates a barrier for my gambling. I live very close and now do not spend money to kill time.
It has helped because they spelled out what the program was and how I was able to implement the program into my life and not go back to the casino. Helped me get on the right track.
It has helped because they were interested in helping others, great resource.
It has helped for two reasons. 1.) The follow-up and explanation has been really helpful. 2.) I can't play anymore. If I try and play and get caught I'll get arrested, so this is a very serious offense.
It has helped me because I haven't spent the money. however, I still spend money frivolously
It has helped me stay away from gambling. I feel like there's a big stop sign because I don't want to go in there and risk getting arrested. Or spending money I don't have. And also helping me cope with my depression. Gambling triggered an increase in depression and anxiety. Game Sense has decreased my depression.
It has helped my peace of mind.
It has helped, forced me to have control over my gambling.
it has helped, forced me to not go to the casino as often and helped me control urges
It has helped, I know I can't gamble so that is helpful when I get urges. I like to look at the packet and the dates to celebrate the date I excluded.
It has, helped me see that there is support for people struggling with gambling
It has; gave me resources and help with gambling and started attending GA
It hasn't helped. I'm out of control. It was just another thing I tried to do to help and it didn't. I was homeless for 10 months and now I have had housing for the past 4 months, but I'm stuck in the house for the past 4 days. No one followed up with me.
It helped me because I think a lot more when I go that I shouldn't go gamble. I know I'm not going to get rich I'm only going to get poorer. It makes me give my decisions to gamble more thought. I felt very upset when I did go gambling.
It helped, decrease my gambling
It helps because it provides resources, but it did not stop me from going back
It made it easy for me to be excluded, and them being kind was important to me at the moment. It's the best experience I've had being excluded.
It slowed me down and I'm not as obsessive about it as I used to be. I used to want to go everyday and now I don't. Decreased the obsession.
It was informative and it kept me on course.
It's helped me as long as I can't enter. Other than that I don't know
Keeping me away from the casino. never attempted to go in when excluded
Keeps me from going. It helps. I have to do some traveling if I want to go and gamble
Made me realize what I was doing, and that I was on my way down. Has helped me a lot, and decreased urges.
Not gambling in Massachusetts or RI anymore, so it's allowed me to sign out
Only program where I did not return to the casino, very understanding and it made me feel better about myself
Psychologically it helps, it keeps you out.
The contact and surveys are a very important part of the overall help.

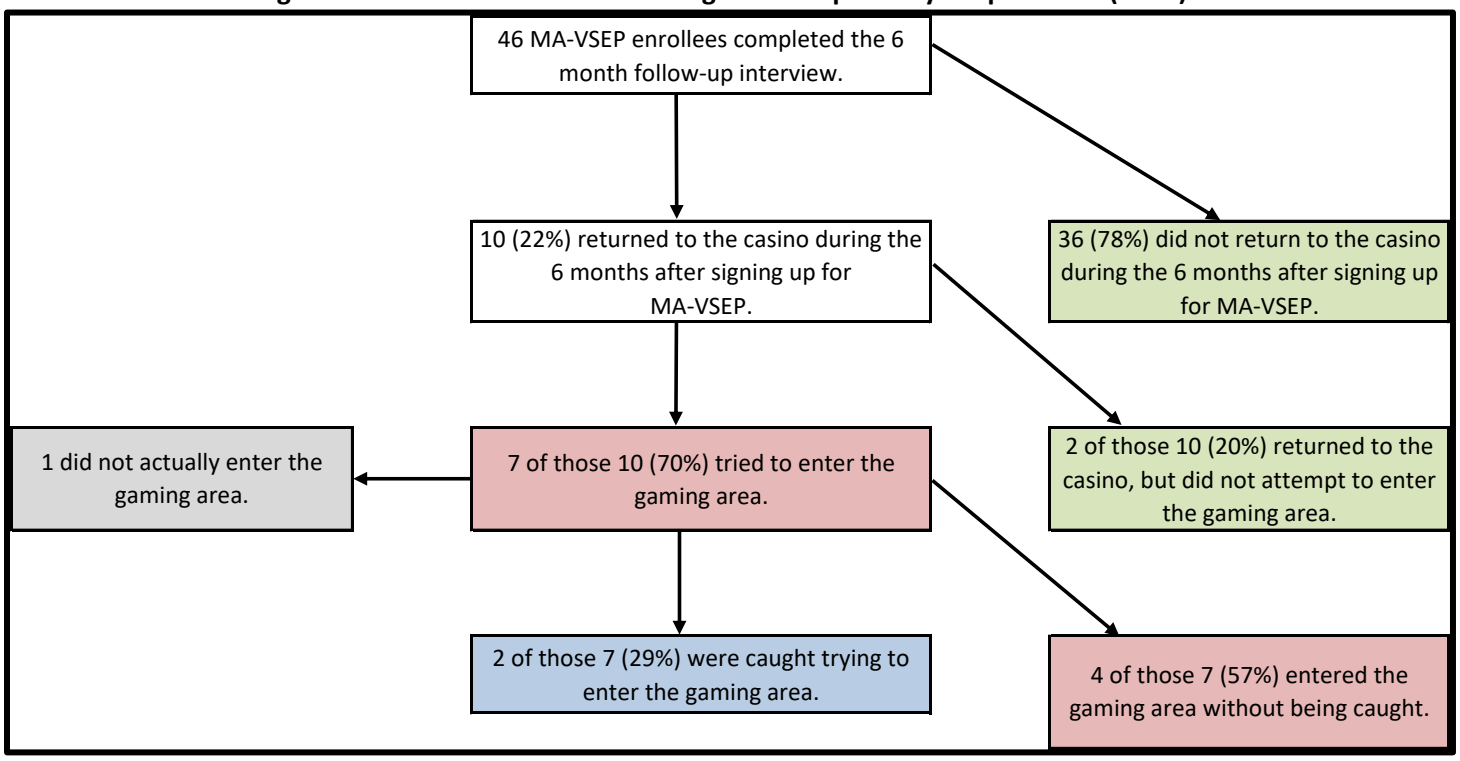
Table 12. Enrollees' Suggestions for Improving MA-VSEP (n=29)

Open Response: "Briefly, how might the MA-VSEP be improved?"
A phone call from the GSA shortly after the meeting would help
As a gambler, I wish you could just walk back in after 6 months but I understand why you cannot do that.
Exclude you from all places in MA, wouldn't have to go to the new casinos to exclude when they open up
Follow up call, check-in
GameSense area surprisingly small, went with a group and only a few could be processed at a time, adjacent to casino floor, makes it triggering when waiting to be processed.
Had to wait a long time when I wanted to sign up because people were in a meeting, there needs to always be someone available
Having it located outside the casino
I don't know yet, you guys are pretty good yet. Actually, you guys don't improve, you only do a year and 6 months or something. You should have a lifetime exclusion. With no takesies-back.
I think the surveys are helpful.
I think they should extend the minimum time past 6 months.
If there was more advertisement it would be better, because some people might not know they can exclude. There should also be some sort of networking so people can support each other.
If they built a website. Sometimes people are not comfortable enough to talk over the phone or being grouped together. An online tool where people could access it, share experiences, and make friends. I don't see any online presence for it. There's no alternative. Social options like a soccer team or something.
If they called or sent email to check in
It is important for them to reach out and keep reaching out.
Make it easier to go back once thier time is up. Make someone available at the casino to do the exit interviews at PPC.
MGC should talk about VSE more, advertise it more. All you hear about it as Wynn and the drama with the new casino. They should make it more visible, haven't seen many advertisements. While watching people at PPC, noticed that they were all compulsive gamblers
More awareness that it's an option.
More follow up interaction after a period of time
More proactive with follow up.
More specificity about the evaluation calls, possibly including more details in a mailing.
People like myself, I think the only way to help improve the system is to have the person arrested for coming back to the casino. Arrested for trespassing. Its the only thing that's going to stop someone. once, they are arrested, they'll be exposed to everyone. So that they will come out of the darkness into the light. It could also kill someone if they are exposed. Follow-up with people who sign up.
Self-exclusion led to me traveling further to Twin River. I didn't really miss PPC. Its only a bandaid because I can still get into other regional casinos. A regional self-exclusion would be hlelpful
Setting up more like workshops or different programs make people more aware of the resources that are out there. I think a lot of people go to GA a couple of times and leave. If there were more explanation or why to do it or a speaker telling about what self-exclusion did for them.
Someone to follow up and check in.
They should advertise it more.
To let me gamble a couple of times without being arrested.
Tough to say right now, it's still new. Plainridge just has... I'm more of a blackjack program, I'm not tempted to go there. It's not really a temptation program for me at this time.
With periodic check-ins. An option to write your email, can we send you period check-ins, emails every couple of months, for accountability, can be a little kicker that someone needs to get help.
Work even closer with the casinos.

3.3.4. MA-VSEP Violations: Follow-Up Survey Respondents (n=46)

Forty-six MA-VSEP enrollees completed the follow-up survey 6-12 months after enrolling in MA-VSEP. Figure 30 includes information about MA-VSEP violations among these enrollees. As before, these results should be interpreted with caution due to the low recruitment rate for this sample.

Figure 31: MA-VSEP Violations among Follow-Up Survey Respondents (n=46)



Ten of those 46 (21.7%) reported having returned to PPC during the exclusion period, and seven (15.2% of the 46 and 70.0% of the 10) reported trying to enter the gambling floor. Of those seven, one did not end up entering, two entered once, two entered twice, one entered three times, and one entered six times. Two were caught: one was told to leave the first and only time he tried to enter; the other was identified by a GSA on one of the two occasions he tried to enter and removed by PPC staff. Section 3.4.2 includes information about player card use after MA-VSEP enrollment.

3.4. Changes in Behavior and Well-Being after MA-VSEP Enrollment: Follow-Up Survey Respondents (n=46)

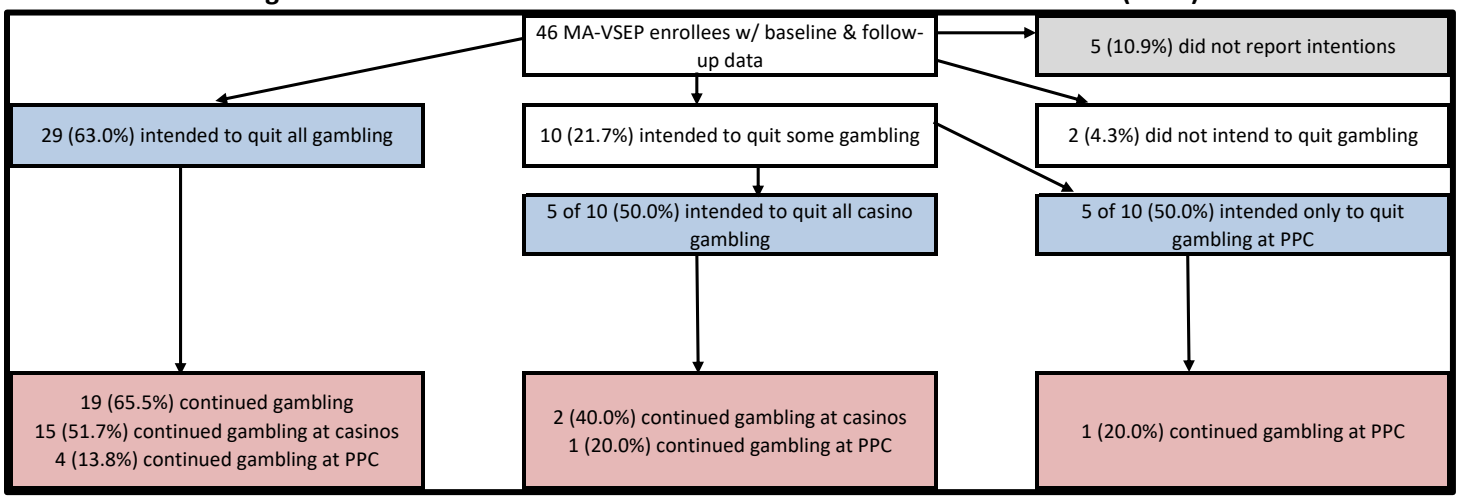
For this set of analyses, we focus on the 46 MA-VSEP enrollees who completed the follow-up survey, examining both their baseline and follow-up data to assess change across time. As before, these results should be interpreted with caution due to the low recruitment rate for the baseline survey sample. However, the 73% retention rate of that sample for the follow-up survey provides confidence that these results are generalizable to that sample of 63 individuals who joined the study.

3.4.1. Gambling Behavior

More than 70% (71.7%) of MA-VSEP enrollees who completed the follow-up survey continued to gamble after enrolling in MA-VSEP, and 17.4% did so at PPC.[20] Close to 30% (28.9%) of enrollees had gambled within the last week when interviewed at follow-up. Figure 32 shows how MA-VSEP enrollees' post-enrollment gambling behavior relates to their intentions upon enrolling. More than 60% of enrollees intended to quit all gambling upon enrollment, but only about one third of those succeeded (i.e., 10 of the 29). Enrollees who intended to quit either just casino gambling or just gambling at PPC had more success. Two of the five who intended to quit all casino gambling continued casino gambling after MA-VSEP enrollment, and only one of the fie who intended to quit gambling at PPC returned to gamble at PPC after their enrollment.

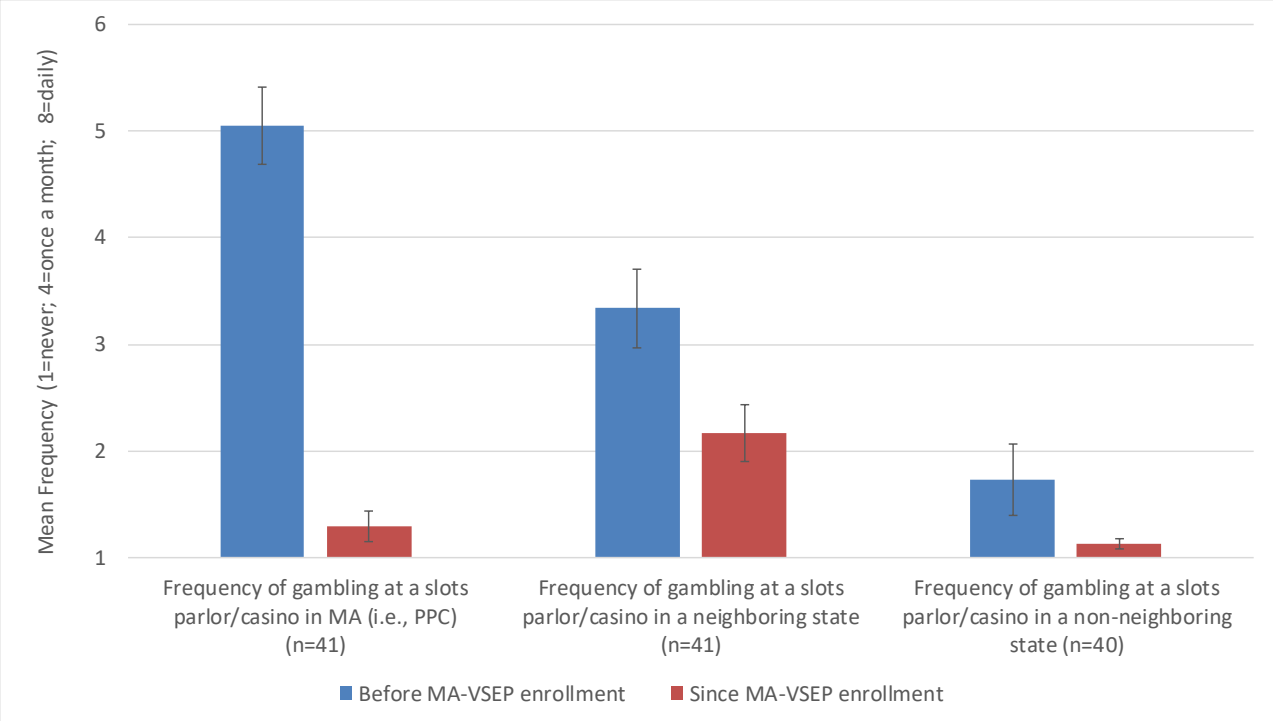
[20] This number does not match up to the number of individuals who reported entering the game floor at PPC after MA-VSEP enrollment. Investigation of these cases indicates that two individuals indicated that they never entered the gaming floor at PPC after MA-VSEP enrollment, but in the later question indicated that they had gambled there since enrollment.

Figure 32: MA-VSEP Enrollees' Intentions and Post-Enrollment Behavior (n=46)



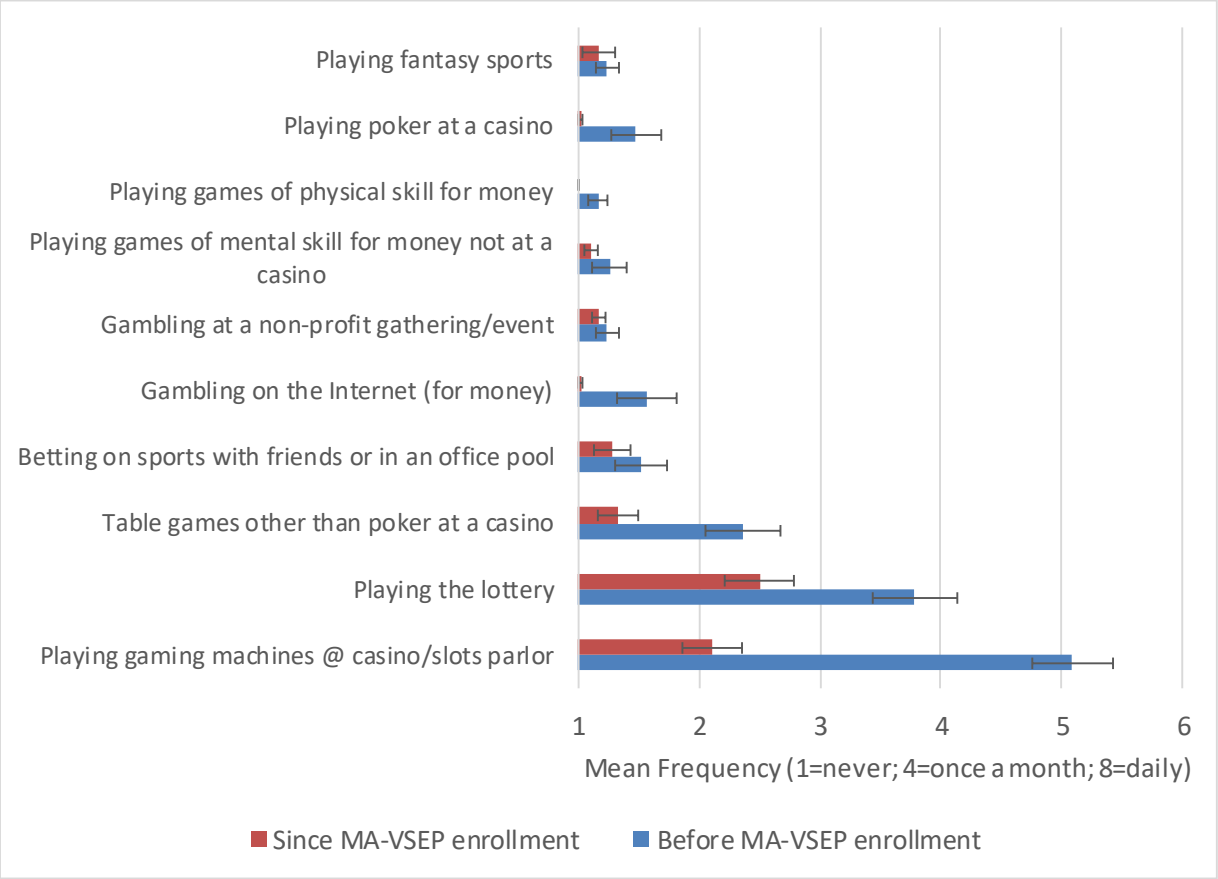
As Figure 33 shows, across enrollees who completed the follow-up survey, frequency of gambling at PPC and other casinos decreased from baseline to follow-up. Gambling at PPC had the greatest decrease; at follow-up enrollees were gambling more frequently at neighboring casinos than at PPC. However, all frequency decreases were significant: $t(40)=10.8$, $p<.001$ for gambling at PPC, $t(40)=3.2$, $p<.01$ for gambling at neighboring casinos, and $t(39)=2.4$, $p<.05$ for gambling at casinos in states or other locations that do not neighbor MA.

Figure 33: MA-VSEP Enrollees' Pre- and Post-Enrollment Frequency of Gambling at Casinos



We also examined changes in frequency of gambling on different game types for the 10 game types engaged in by more than 10% of the baseline sample. As Figure 34 shows, MA-VSEP enrollees who completed the follow-up survey decreased gambling on almost all game types, but evidenced the greatest decreases in playing electronic and table games at casinos, $t(45)=9.7$, $p<.001$, and $t(45)=3.9$, $p<.001$, respectively, and playing the lottery, $t(45)=3.4$, $p<.01$.

Figure 34: MA-VSEP Enrollees' Pre- and Post-Enrollment Frequency of Gambling on Different Game Types



The number of game types MA-VSEP enrollees who completed the follow-up survey engaged in after signing up for MA-VSEP decreased from 3.4 in the year before MA-VSEP to 1.7 since enrollment, t(45)=4.6, p<.001. When only the 33 enrollees who continued gambling after MA-VSEP were included, the reduction was less (i.e., from M=3.4 to M=2.3), but still significant, t(32)=3.9, p<.01.

More than half of MA-VSEP enrollees who completed the follow-up survey *and* reported continued gambling reported casino gambling machines as the type of gambling on which they lost the most money, but, as Table 13 shows, among the 35 who had reported gambling machines as the game on which they had lost the most money at baseline, a quarter were no longer gambling, and close to another quarter were no longer losing the most money on casino-related games.

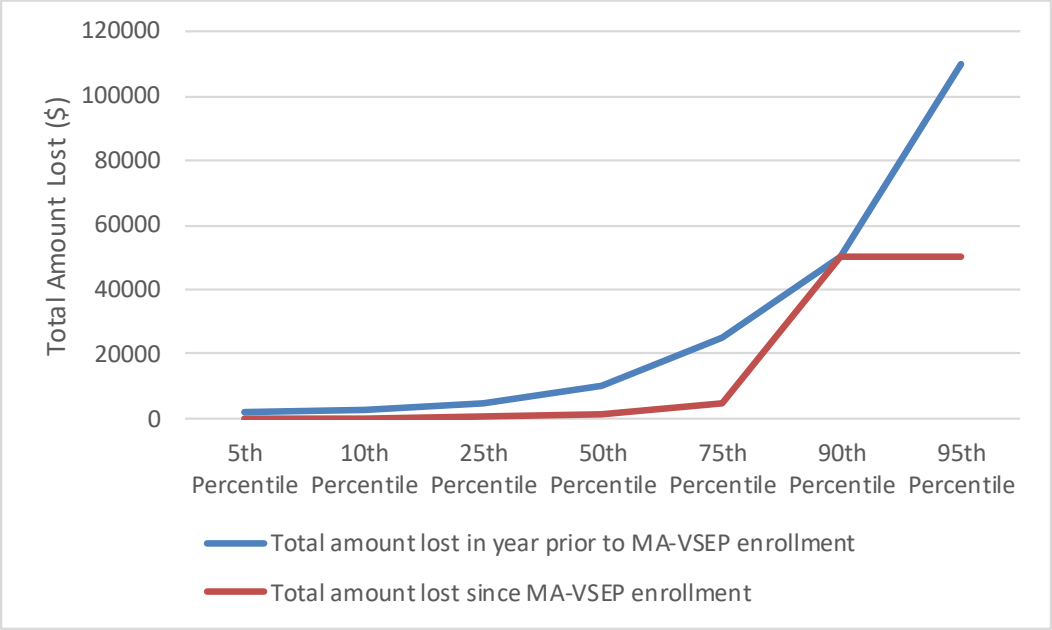
Table 13: Game Type on Which Enrollees Lost the Most Money Before and After MA-VSEP Enrollment (n=46)

	Post-MA-VSEP Enrollment				
Pre-MA-VSEP Enrollment	Casino gaming machines	Casino table games (other than poker)	Lottery / scratch cards	Other Non-Casino Games	No Gambling at Follow-Up
Casino gaming machines	**14 (40.0%)**	4 (11.4%)	5 (14.3%)	3 (8.6%)	9 (25.7%)
Casino table games	0 (0.0%)	**1 (33.3%)**	0 (0.0%)	0 (0.0%)	2 (66.7%)
Lottery / scratch cards	0 (0.0%)	0 (0.0%)	**0 (0.0%)**	0 (0.0%)	0 (0.0%)
Other Non-Casino Games	0 (0.0%)	0 (0.0%)	0 (0.0%)	**0 (0.0%)**	3 (100.0%)
Not Reported at Baseline	4 (80.0%)	0 (0.0%)	1 (20.0%)	0 (0.0%)	**0 (0.0%)**

Among the 33 who continued gambling after MA-VSEP enrollment, average total losses (M=6,963.6 [SD=14,601.1]) and maximum lost in one day (M=1,204.0 [SD=1,743.3]) since enrollment continued to be high. However, median total lost (Median=1,000.0) and median maximum lost (Median=600.0) were considerably lower than the means, suggesting positive skew. For those who continued gambling, both total losses, and the maximum lost in one day were significantly lower than prior to baseline, t(26)=2.2, p<.05, and t(26)=2.3, p<.05, respectively.[21] Figures 35 and 36 show these distributions for enrollees who continued gambling before and after MA-VSEP enrollment.

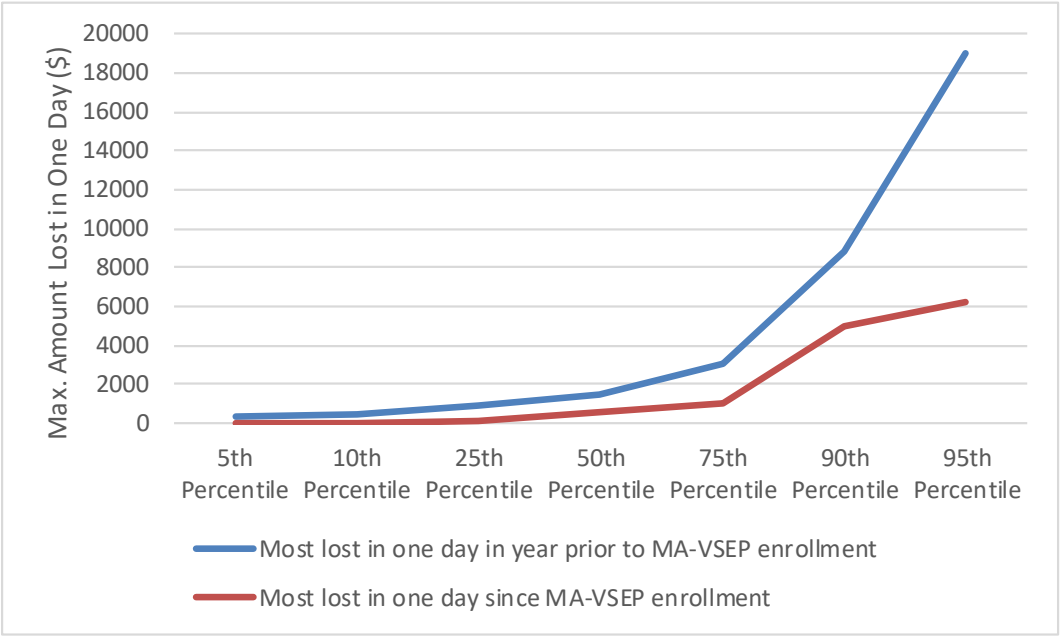
[21] For these analyses, 6 enrollees did not provide this information at baseline, so the sample was limited to 27 instead of 33.

Figure 35: Total Lost in Year Prior to MA-VSEP Enrollment and Since MA-VSEP Enrollment – Percentiles (n=27)



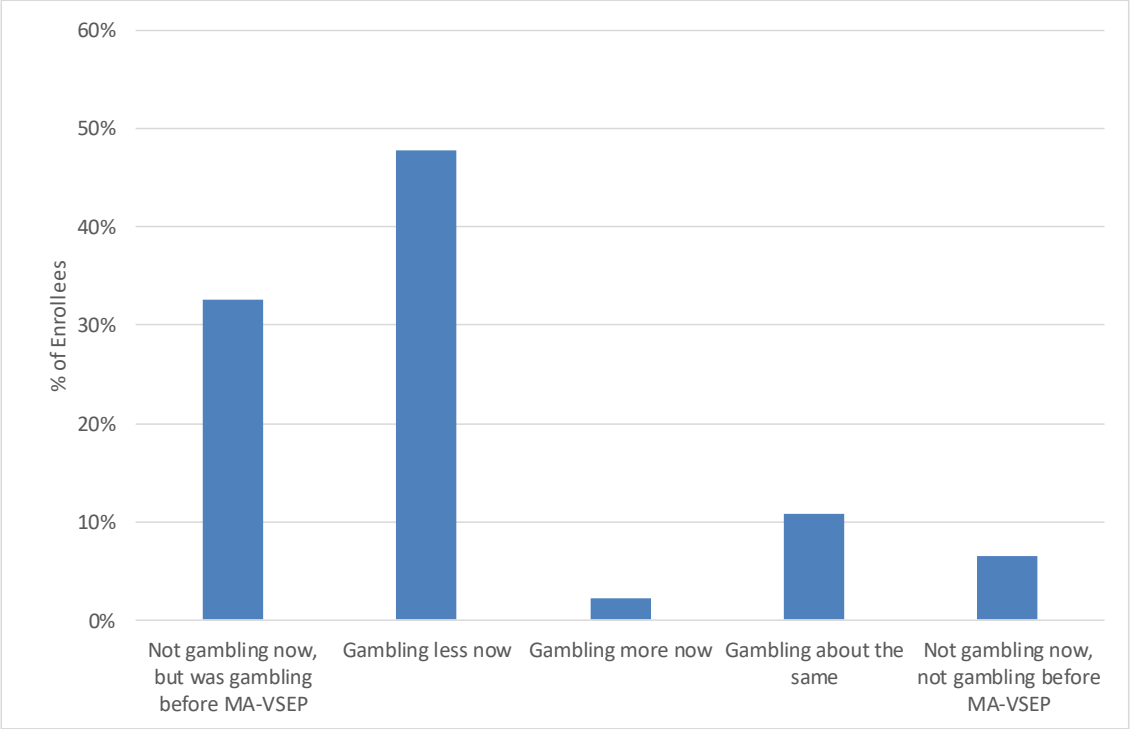
The figures demonstrate that despite the decreases, a small proportion of enrollees continued to gamble and lose disproportionately large amounts of money. More than 70% of the 33 enrollees who continued gambling after enrollment (71.9%) still reported needing to get more money in the middle of a gambling outing at some point since MA-VSEP enrollment. A McNemar test showed that this was a significant decrease ($p<.05$) from the percent who reported this behavior prior to MA-VSEP enrollment.

Figure 36: Maximum One Day Loss in Year Prior to MA-VSEP Enrollment and Since MA-VSEP Enrollment - Percentiles



When asked to report their own perceived changes in gambling from before MA-VSEP enrollment to after, as Figure 37 shows, 32.6% indicated that they were not gambling now but had been gambling prior to MA-VSEP, and an additional 47.8% indicated that they were gambling less now than when they enrolled. About 2% indicated they were gambling more now than before, and 6.5% indicated they gambled neither directly before nor after MA-VSEP enrollment.

Figure 37: MA-VSEP Enrollees' Self-Reported Changes in Gambling Behavior Since MA-VSEP Enrollment



3.4.2. Gambling Behavior at PPC after MA-VSEP Enrollment – Player Card Data

Among the 91 enrollees in our sample who had player card data available, one individual used his player card after enrolling in MA-VSEP. However, the card usage was within two weeks prior to his official removal from the MA-VSEP list, occurring two days after his term was due to expire and eight days before his formal removal. None of the other 90 enrollees had player card activity after their MA-VSEP enrollment date.

3.4.3. Gambling Motivations

Figure 38 illustrates the reasons MA-VSEP enrollees who completed the follow-up survey and continued to gamble after enrollment endorsed for gambling. According to McNemar tests, enrollees were less likely to endorse gambling to get money or gambling for excitement after MA-VSEP enrollment than they were before enrollment. Endorsement of other reasons did not vary from before to after enrollment.

3.4.4. Gambling Problems

MA-VSEP enrollees who completed the follow-up survey were less likely to endorse each of the DSM-5 criteria for gambling disorder at follow-up than at baseline, as displayed in Figure 39. Forty-one of the forty-six enrollees who completed the follow-up (89.1%) qualified for gambling disorder (i.e., endorsed 4+ DSM-5 criteria) at baseline, and 18 enrollees qualified for gambling disorder at follow-up: 39.1% of the sample and 43.9% of those individuals who qualified at baseline.

Figure 38: MA-VSEP Enrollees' Pre- and Post-Enrollment Reasons for Gambling

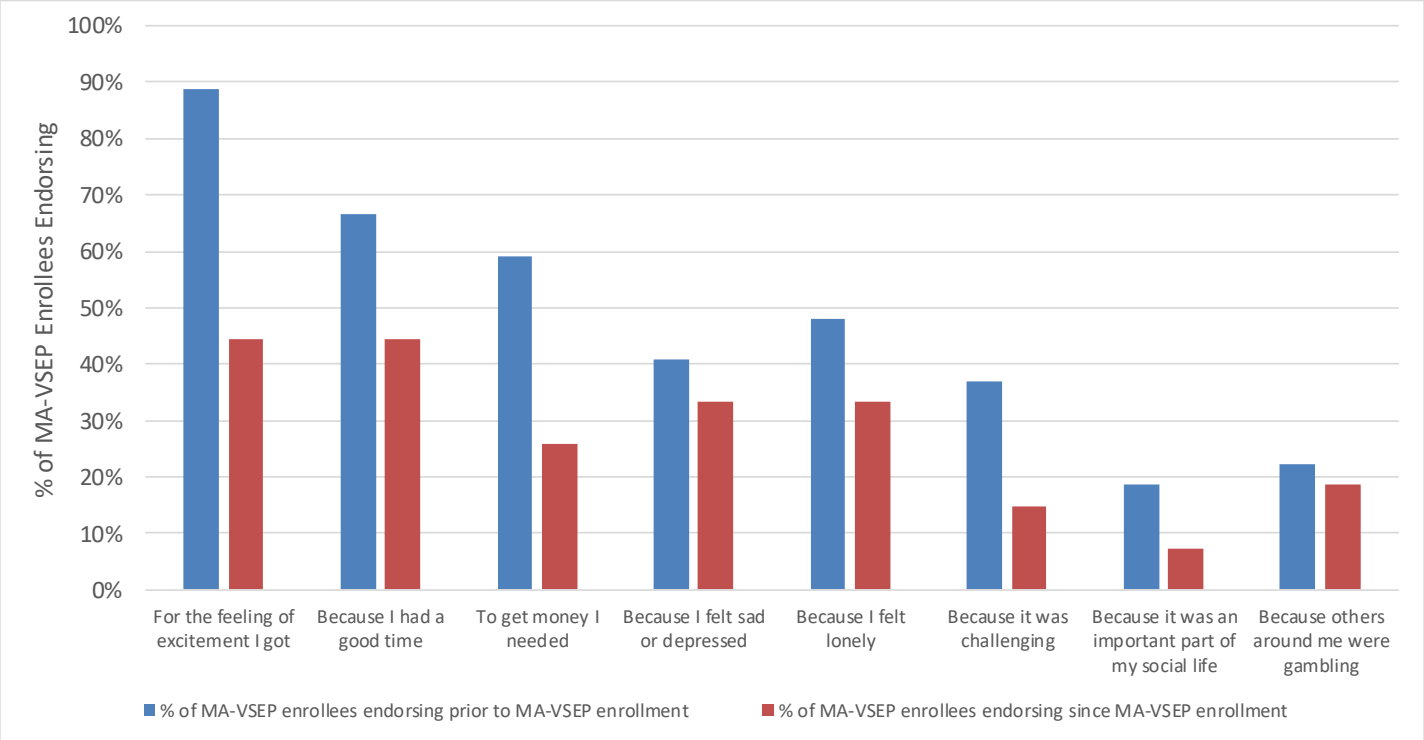
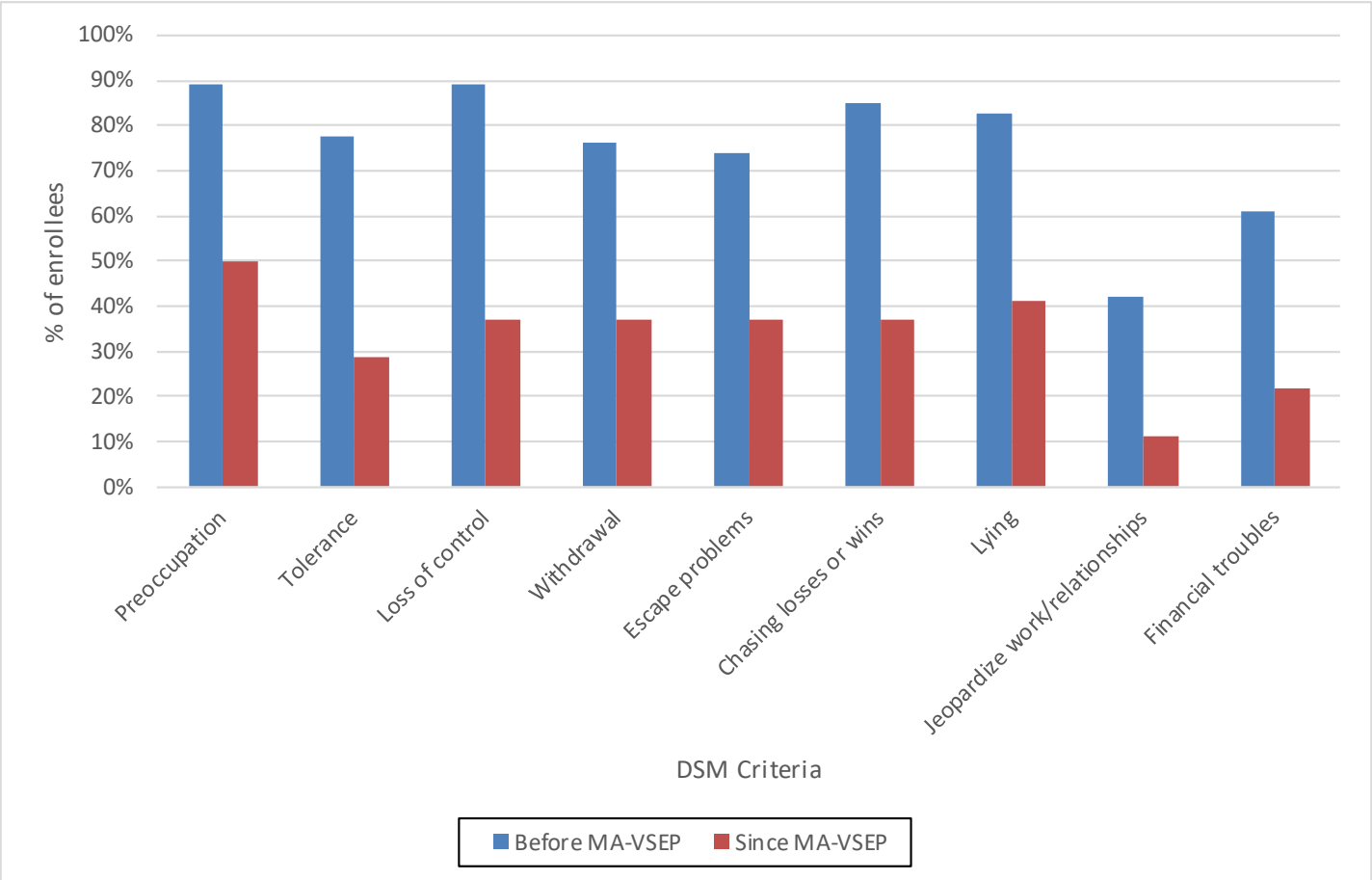


Figure 39: MA-VSEP Enrollees' Pre- and Post-Enrollment DSM-5 Criteria Endorsement for Gambling Disorder



Note. All reductions significant at the p<.05 level according to McNemar tests.

As Table 14 shows, the five enrollees who endorsed fewer than 4 DSM-5 criteria for gambling disorder at baseline reported no gambling problems at follow-up. The average number of DSM-5 criteria endorsed by enrollees decreased from 6.7 at baseline to 3.0 at follow-up, t(45)=8.4, p<.001.

Table 14: DSM-5 Gambling Disorder Before and After MA-VSEP Enrollment (n=46)

	Post-MA-VSEP Enrollment				
Pre-MA-VSEP Enrollment	No reported gambling problems	1-3 reported problems: Subclinical	4-5 reported problems: Gambling disorder - mild	6-7 reported problems: Gambling disorder - moderate	8-9 reported problems: Gambling disorder - severe
No reported gambling problems	**4 (100.0%)**	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
1-3 reported problems: Subclinical	1 (100.0%)	**0 (0.0%)**	0 (0.0%)	0 (0.0%)	0 (0.0%)
4-5 reported problems: Gambling disorder - mild	1 (100.0%)	0 (0.0%)	**0 (0.0%)**	0 (0.0%)	0 (0.0%)
6-7 reported problems: Gambling disorder - moderate	6 (33.3%)	8 (44.4%)	2 (11.1%)	**2 (11.1%)**	0 (0.0%)
8-9 reported problems: Gambling disorder - severe	6 (27.3%)	2 (9.1%)	2 (9.1%)	6 (27.3%)	**6 (27.3%)**

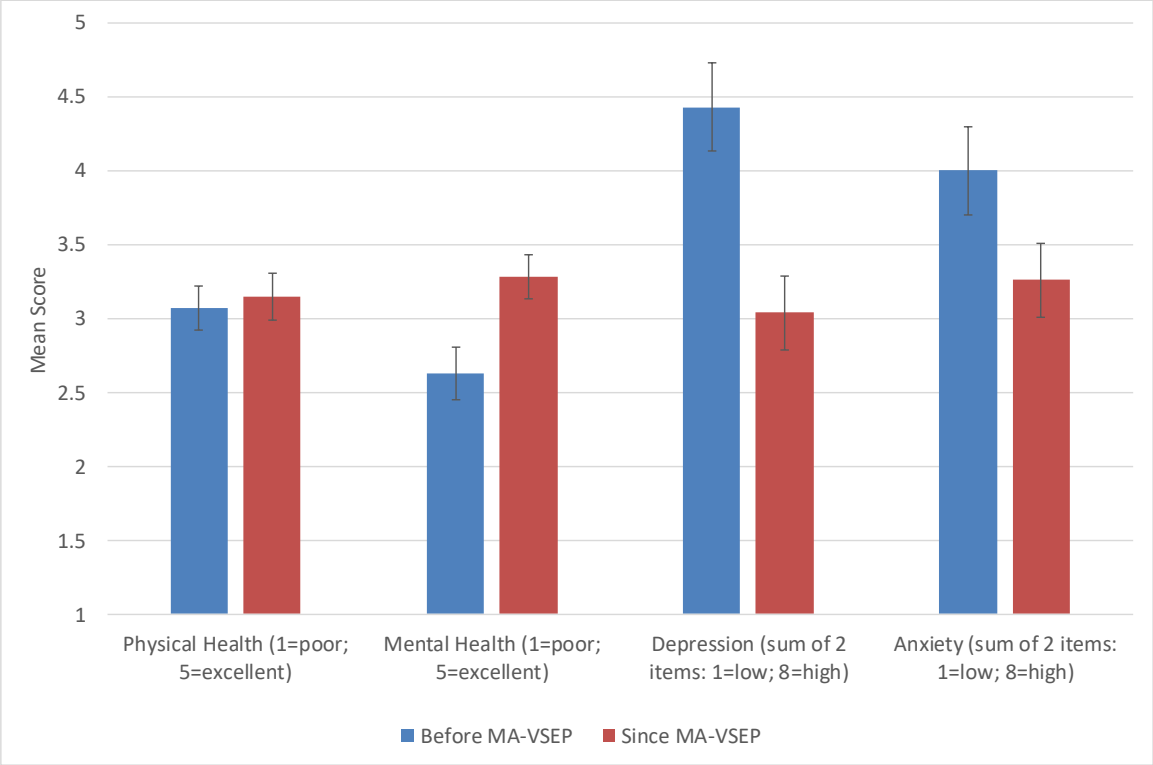
Some of these reductions are attributable to the fact that 13 MA-VSEP enrollees reported successfully stopping all gambling after enrollment. However, even when we included only those 33 who continued gambling in analyses, 13 of the 31 (41.9%) who qualified for gambling disorder at baseline no longer qualified for gambling disorder at follow-up. Among those 13, 3 reported no gambling problems at follow-up, and 10 met 1-3 gambling disorder criteria (i.e., subclinical problems). For these 33 who continued gambling after enrollment, the average number of DSM-5 criteria endorsed decreased from 7.1 at baseline to 4.2 at follow-up, t(32)=6.9, p<.001.

Among the 33 MA-VSEP enrollees who completed the follow-up survey and continued gambling after enrollment, 18.2% reported drinking or using drugs while gambling since enrollment. This practice did not decrease significantly from baseline.

3.4.5. Physical and Mental Health

MA-VSEP enrollees who completed the follow-up survey again responded to questions about physical and mental health, as well as the modified version of the Patient Health Questionnaire-4 assessment for anxiety and depression in the 2 weeks prior to follow-up (PHQ-4: Kroenke et al., 2009). Figure 40 shows changes in their responses from baseline to follow-up. Enrollees reported no improvements in physical health, but significant improvements in mental health, t(45)=-3.9, p<.001. Enrollees also evidenced significant reductions in depression and anxiety, t(45)=5.2, p<.001, and t(45)=2.8, p<.01, respectively.

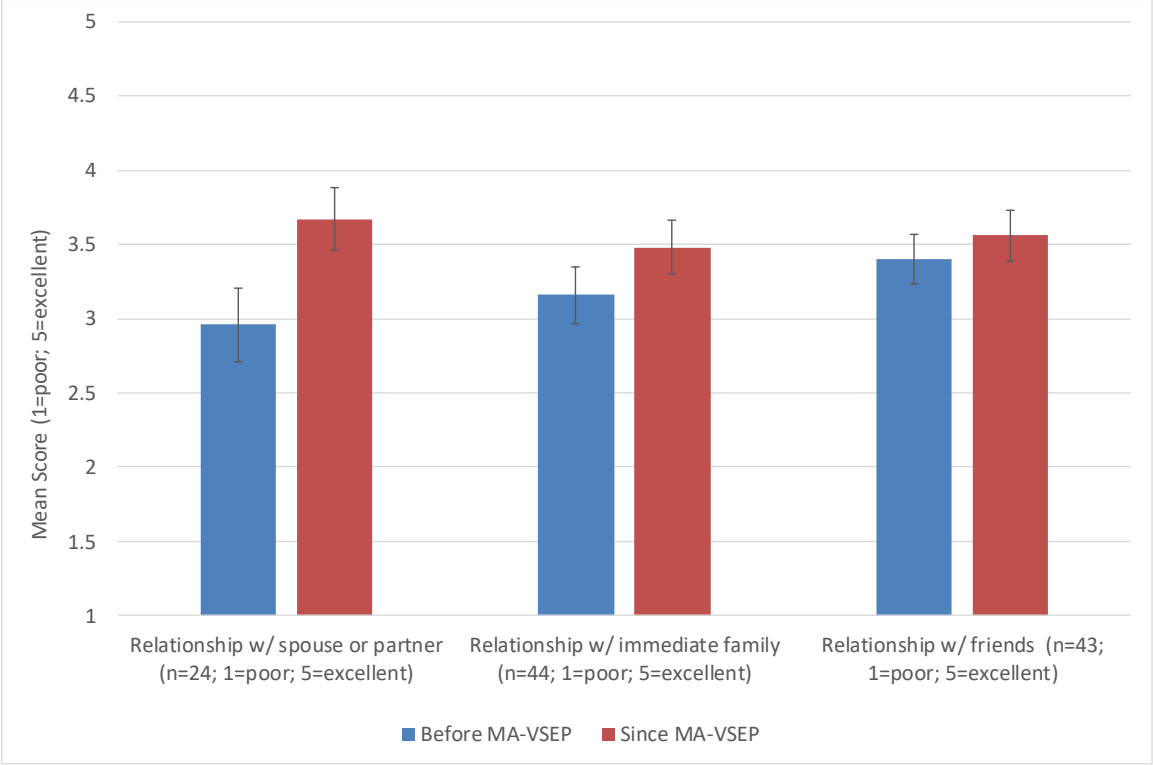
Figure 40: MA-VSEP Enrollees' Pre- and Post-Enrollment Physical and Mental Health



3.4.6. Relationships & Social Support

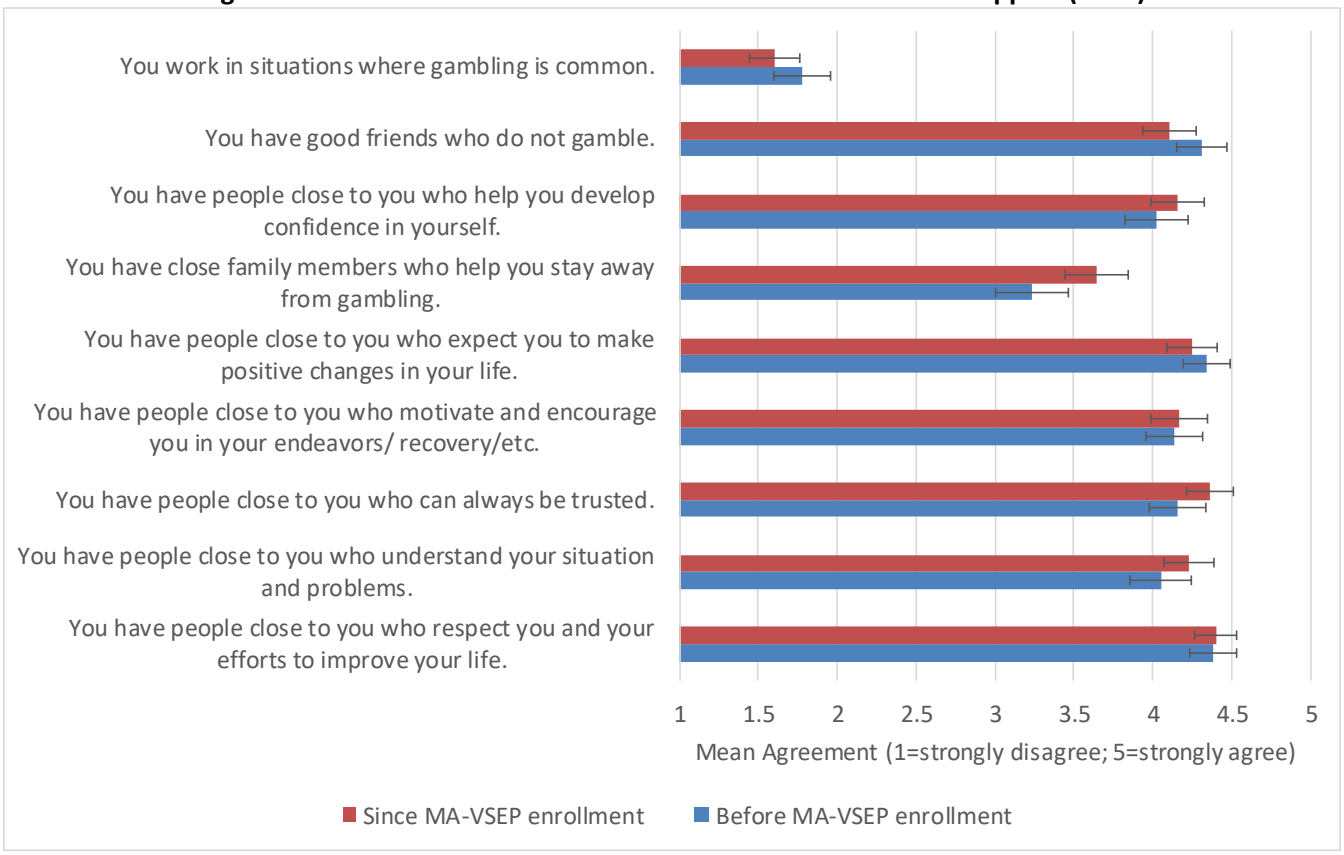
MA-VSEP enrollees who completed the follow-up survey responded to the same questions about their relationships with family and friends and social support (i.e., the TCU Social Support Scale (Joe et al., 2002), a 9-item measure of social support from friends and family) as at baseline. Figures 41 and 42 display changes in their responses from baseline to follow-up.

Figure 41: MA-VSEP Enrollees' Pre- and Post-Enrollment Relationship Quality



Enrollees reported significant improvements in the quality of their relationships with their spouse or partner, t(23)=-2.4, p<.05, and their relationships with their immediate family, t(43)=-2.1, p<.05, but no improvement in their relationships with friends. In terms of social support, enrollees did not experience significant changes overall. On one of the nine items, having close family members who help the enrollee avoid gambling, enrollees indicated significantly greater agreement at follow-up compared to baseline. Endorsement of all other items did not change from baseline to follow-up. Enrollees continued to indicate they had generally strong social support networks at follow-up, scoring an average 37.6 out of a maximum of 45 on the summed scale. This score did not vary significantly from enrollees' baseline score.

Figure 42: MA-VSEP Enrollees' Pre- and Post-Enrollment Social Support (n=45)



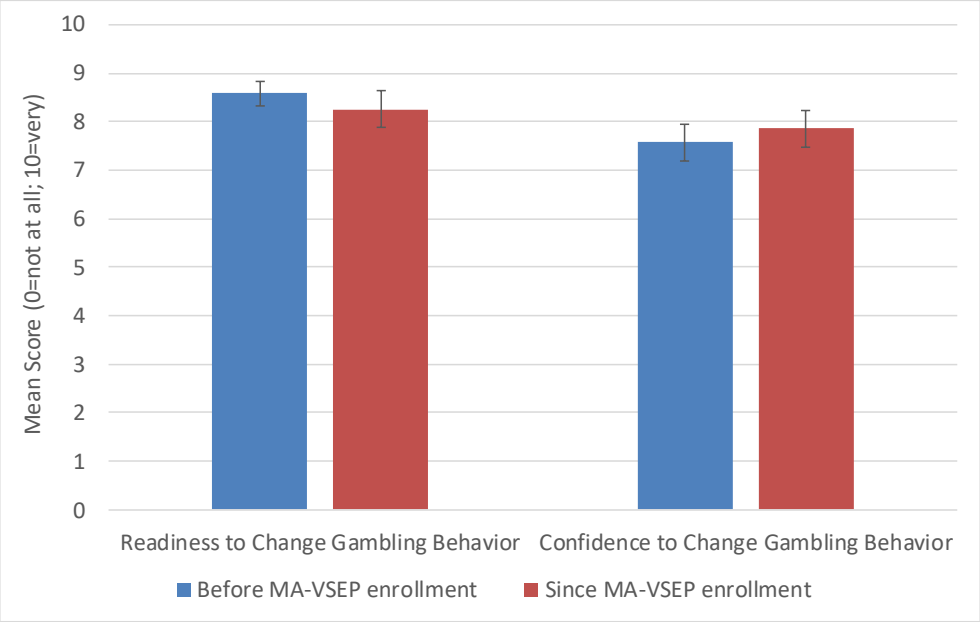
3.4.7. Treatment Readiness Before and After MA-VSEP Enrollment

MA-VSEP enrollees' readiness to and confidence in their ability to change their gambling behavior did not change significantly from baseline to follow-up. At both time points, MA-VSEP enrollees who completed the follow-up survey scored high on the readiness and confidence to change, as shown in Figure 43. Description and analysis of changes in treatment involvement follow in Section 3.5.

3.4.8. Intent-to-Treat Analyses

One way to provide more conservative estimates of change among our sample is to assume individuals who dropped out of the sample prior to follow-up did not demonstrate any improvements in their behavior. For these analyses, all 63 baseline survey respondents are retained; for those who did not respond to the follow-up survey, their baseline responses are carried forward. We re-ran the change analyses presented in Sections 3.4.1 through 3.4.7 using this approach. There were no differences between the two sets of analyses.

Figure 43: MA-VSEP Enrollees' Pre- and Post-Enrollment Readiness and Confidence to Change Gambling Behavior



3.4.9. Factors that Influence Positive Change among MA-VSEP Enrollees

To examine factors that predict positive change among MA-VSEP enrollees, we conducted a series of multiple linear regression and logistic regression analyses predicting outcomes from demographics, enrollment characteristics, gambling behavior, gambling problems, attitudes, motivations, and intentions at enrollment, physical and mental health, social support and relationships, and MA-VSEP experiences. Because these analyses were highly exploratory, had small n's, and involved samples limited by low recruitment rates, we only provide these analyses in Appendix J, not the body of the report. All of these analyses should be interpreted with caution.

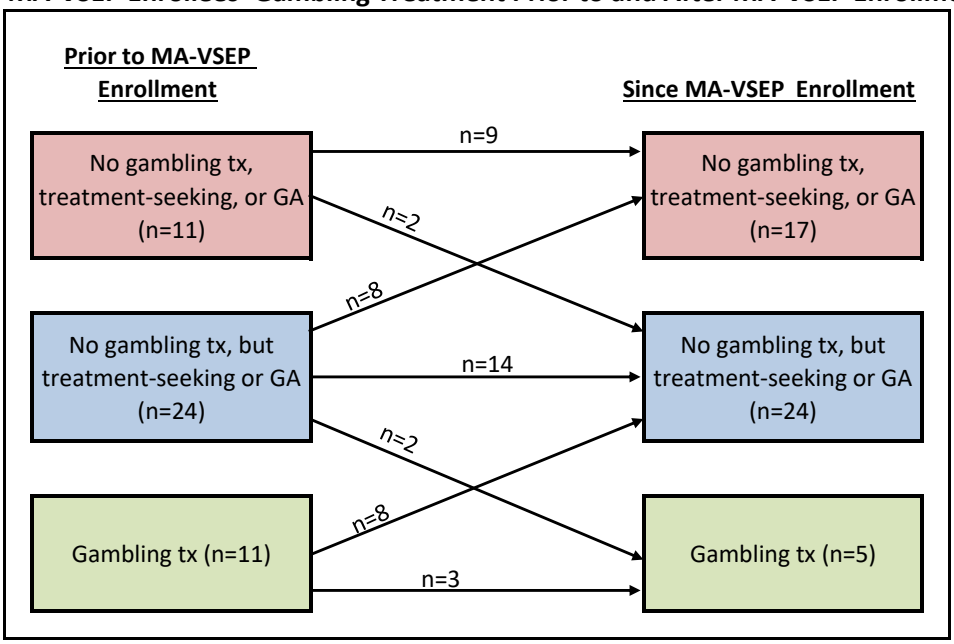
3.5. Resource and Treatment Access Before and After MA-VSEP Enrollment: Follow-Up Survey Respondents (n=46)

As reported in Section 3.2.8, two thirds of MA-VSEP enrollees who responded to the baseline survey reported having talked to a doctor or professional about their problems with gambling, half had previously called a gambling helpline, half had attended Gamblers Anonymous, and half had received treatment for a mental health or substance use problem other than their gambling-related problems.

3.5.1. Changes in Access after MA-VSEP Enrollment

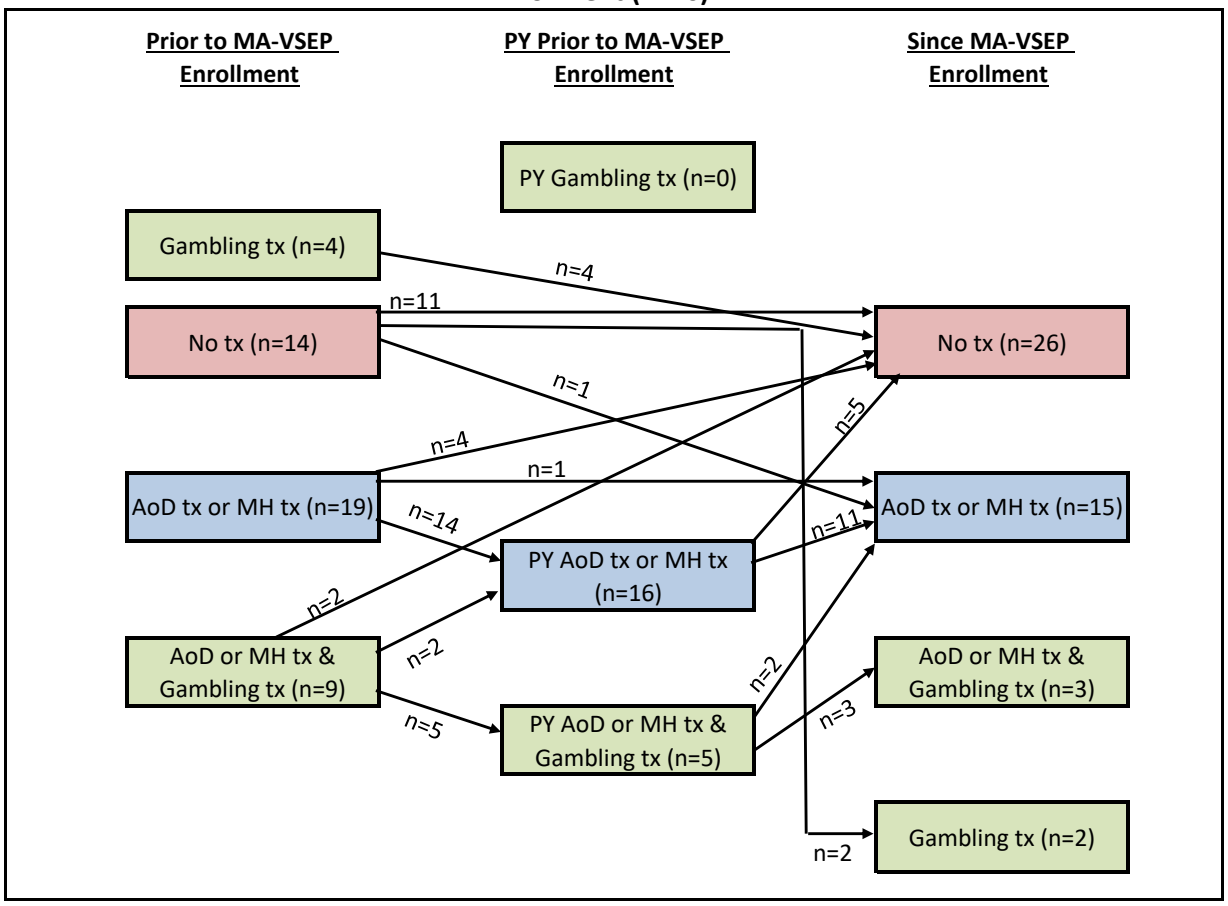
Appendix H includes a flowchart that illustrates the gambling-related treatment, treatment seeking, and self-help that each MA-VSEP enrollee who participated in the study (n=63) received before and after enrollment in MA-VSEP. As the flowchart shows, among the 14 enrollees who reported no gambling-related treatment, treatment seeking, or self-help upon enrollment to MA-VSEP, 9 (i.e., 64.3% of the 14, and 81.8% of the 11 who completed the follow-up survey) continued to report none, 3 did not complete the follow-up survey, one reported speaking with a professional about their gambling problems, and one reported newly attending Gamblers Anonymous. Among the 49 who reported some form gambling-related treatment, treatment seeking, or self-help prior to MA-VSEP enrollment, 8 (i.e., 16.3% of the 49, and 22.9% of the 35 who completed the follow-up survey) reported none at follow-up, 14 did not complete the follow-up survey, and 27 reported some form of continued treatment, treatment-seeking, or self-help at follow-up. Figure 44 illustrates the movement between levels of gambling treatment (i.e. no treatment, treatment-seeking or self-help, and treatment) from enrollment to follow-up.

Figure 44: MA-VSEP Enrollees' Gambling Treatment Prior to and After MA-VSEP Enrollment (n=46)



Note. Tx=treatment; GA=Gamblers Anonymous.

Figure 45: MA-VSEP Enrollees' Substance Use, Mental Health, & Gambling Treatment Prior to and After MA-VSEP Enrollment (n=46)



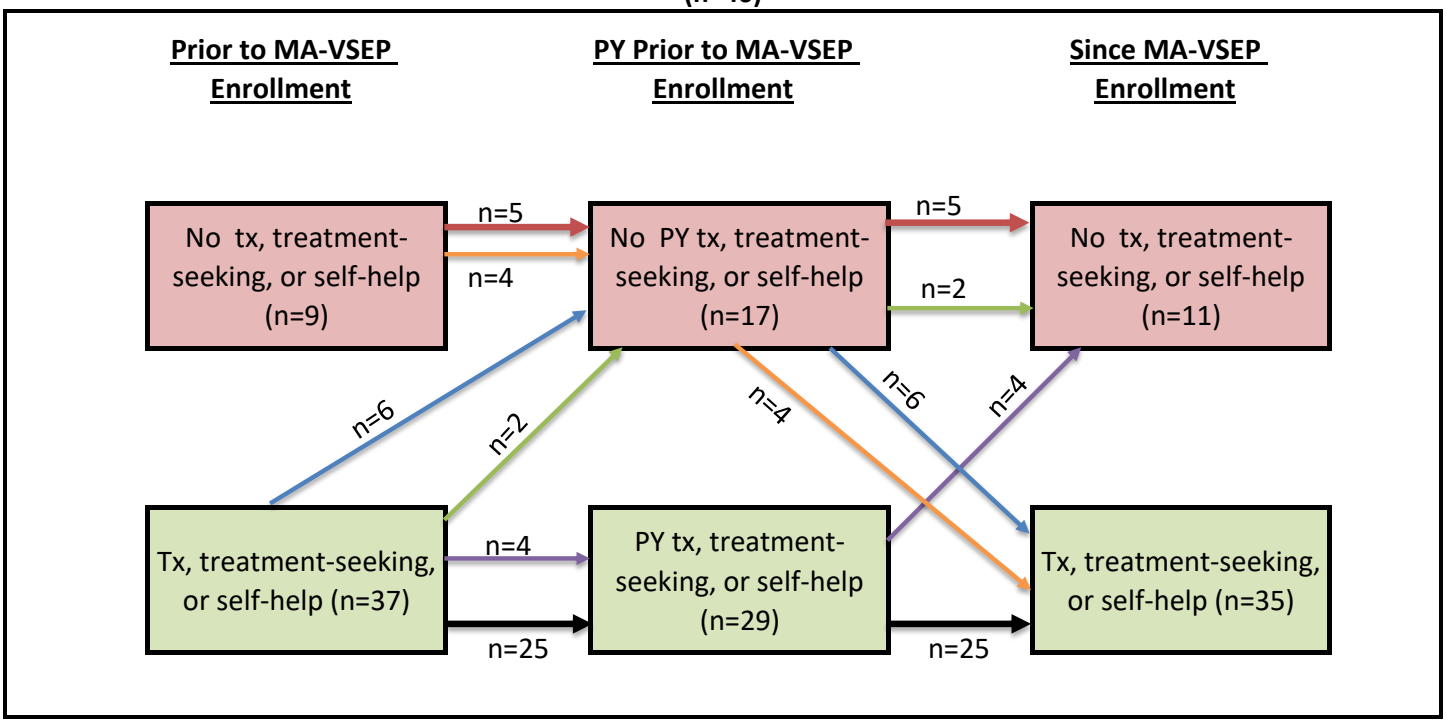
Note. Tx=treatment; PY=past year; AoD=alcohol or drug; MH=mental health.

As Figure 45 shows, at follow-up 43.5% of MA-VSEP enrollees who completed the follow-up survey were attending some kind of treatment, compared to 54.3% in the year prior to MA-VSEP enrollment, and 69.6% at any point during their lives

prior to MA-VSEP. Figure 45 also shows that the majority of enrollees who received gambling treatment after MA-VSEP enrollment received treatment for both gambling problems and other mental health or substance use issues, and that the majority of these individuals had received services for both issues prior to MA-VSEP enrollment.

Finally, Figure 46 illustrates any treatment-seeking (e.g., talking to a medical professional about problems), treatment, or self-help (e.g., Gamblers Anonymous) behavior for gambling problems, substance use problems, or mental health prior to MA-VSEP enrollment, during the 12 months prior to MA-VSEP enrollment, and after MA-VSEP enrollment. As the Figure shows, most MA-VSEP enrollees who completed the follow-up survey (80.4%) had engaged with mental health or addiction-related services in some way prior to MA-VSEP enrollment, and 63.0% had been engaged in some way in the year prior to MA-VSEP enrollment. Just over three quarters (76.1%) were engaged in some way after MA-VSEP enrollment, and just more than half were engaged with services both in the year prior to MA-VSEP enrollment and after enrollment. Among those who had not been engaged with services at all prior to MA-VSEP enrollment, 44.4% (i.e., 4 of the 9, and 8.7% of the sample) were engaged after enrollment. An additional 6 (i.e., 13.0%) who had engaged with services in the past but not in the year prior MA-VSEP enrollment became engaged after enrollment.

Figure 46: MA-VSEP Enrollees' Treatment Seeking, Self-Help, & Treatment Prior to and After MA-VSEP Enrollment (n=46)



Note. Arrows are color coded to follow cases that move from one bin to another. Tx=treatment; GA=Gamblers Anonymous.

4. DISCUSSION

4.1. Purpose of this Evaluation

Policymakers often turn to responsible gambling programs as a strategy to mitigate harm that might result from gambling or expanded gambling opportunities. Responsible gambling programs provide gamblers with strategies to limit gambling-related harms by reducing the frequency or duration of their gambling behavior (Ladouceur et al., 2017). Voluntary self-exclusion programs, in particular, target individuals who have gambling-related problems and provide them with a "contract" and set of resources meant to help those individuals control their behavior. In Massachusetts, the Responsible Gaming Framework (Massachusetts Gaming Commission, 2014) specifies that operators will make available to patrons three opportunities for VSE: (1) removal of patrons from marketing lists; (2) preventing patrons from using check cashing or house credits; and, (3) VSE from casinos state-wide.

The current study provides an objective evaluation of the MA-VSEP by assessing the gambling behaviors, gambling problems, mental health, and well-being of MA-VSEP enrollees across time and providing evidence-based recommendations for program improvements. To that end, this discussion reviews our goals and findings and provides specific recommendations for the MA-VSEP program tied to those findings.

4.2. Evaluation Goal 1: Understand Enrollment Trends Across Time and Place

During the course of this study, across the first 29 months of operation of PPC, MA-VSEP enrollments occurred steadily from month to month with cumulative enrollments reflecting a linear trend. The enrollment rate was approximately 11 per month, with the vast majority of enrollments occurring at PPC and guided by GSAs. The lack of observable adaptation in this enrollment curve is notable; in our previous work evaluating the Missouri Voluntary Exclusion Program, we observed a leveling off of enrollments across time (LaBrie et al., 2007). We posited that this curve reflected an exposure and adaptation effect in which increased exposure to gambling opportunities resulted in initial increases in disordered gambling among the most vulnerable, evidenced by self-exclusion rates, followed by individual and population-level adaptation to the novelty of the gambling opportunities. However, the Missouri data spanned a longer time period than the current MA-VSEP data; six years as opposed to less than one year. It is possible that the MA-VSEP data will mirror this exposure and adaptation trend in the years to come, evidencing increased MA-VSEP enrollment rates with the opening of the MGM Springfield and Encore Boston Harbor casinos before showing a gradual levelling off of those rates across time. If Massachusetts does not observe this predicted levelling off of enrollments, that might be an indicator that gamblers are failing to adapt to these new opportunities and more prevention or intervention efforts are needed. It is important to note that while few individuals with gambling problems choose to participate in VSE programs, most VSE program enrollees qualify for gambling disorder (e.g., Ladouceur et al., 2007; Nelson et al., 2010; current report), making VSE enrollments a good indicator of temporal trends in gambling disorder and gambling problems.

Our previous work suggested that MA-VSEP enrollments would be geographically clustered around the MA casino(s) (LaBrie et al., 2007). For MA-VSEP enrollees, this clustering occurred at a macro level, with enrollees more likely to reside in the eastern half of the state than in central or western regions. However, *within* eastern MA, there was no evidence of clustering around PPC. Enrollees were just as likely to reside in cities and towns bordering Boston as cities and towns bordering PPC. No MA-VSEP enrollees lived in Plainville, where PPC is located. However, because PPC is within 35 miles of Boston, the largest urban area in MA, it is not surprising that many MA-VSEP enrollees lived in Boston and its close suburbs. A large proportion of MA-VSEP enrollees lived outside the state, primarily in Rhode Island. Plainville, where PPC is located, is one of the closest towns to the Rhode Island border. Twin River casino, Rhode Island's largest casino, is located only 18 miles from PPC, and many MA-VSEP enrollees, some from Rhode Island, reported signing up for VSE at both casinos. These findings suggest that a regional VSE program, including Rhode Island, Massachusetts, and Connecticut, where two more large casinos are located, could be a valuable resource for these individuals, possibly allowing for a more streamlined process. It is also possible that a regional program of this type could lead to better deterrence, but we are aware of no research comparing regional program to other VSE programs.

MA-VSEP enrollees selected a range of enrollment terms. Though 12-month and 60-month terms were most common, all term length options were selected by at least 10% of those who enrolled in the program. Few enrollees had any complaints

about the term length options, suggesting that current options are reasonable and adequate. A small proportion (13%) of MA-VSEP enrollees fulfilled the required steps to formally remove themselves from the MA-VSEP list once their term expired, and one third of those (n=11) re-enrolled at a later time point. Most MA-VSEP enrollees whose terms expired had not formally removed themselves from the MA-VSEP report at the time of this report.

Some of the first enrollees in the MA-VSEP reported enrolling preventatively, before they ever gambled at PPC. Others reported enrolling in PPC as well as other casinos in Connecticut and/or Rhode Island within the same week or several days. First-time VSE enrollees, on the other hand, often reported enrolling after large losses at PPC. The presence of both of these MA-VSEP enrollee types (i.e., those who enroll as part of a larger planned effort to engage in VSE and those who enroll in response to negative outcomes at the casino) highlight the importance of offering MA-VSEP enrollment both at the casino, as is done in the GameSense Information Center, and in non-casino locations. Though very few individuals enrolled in MA-VSEP at locations other than PPC, this could be due to a lack of awareness and advertising about other potential enrollment locations.

4.3. Evaluation Goal 2: Understand Who Signs Up for MA-VSEP and Why

The surveys MA-VSEP enrollees completed provided a wealth of information about enrollee characteristics, gambling behavior and attitudes, gambling-related problems, mental health, treatment history, and relationships. We adapted these surveys from a survey we administered as part of a study of an Internet panel of adult Massachusetts residents distributed across the state (Nelson et al., 2013; Nelson et al., 2018). Though the initial recruitment rate for this Massachusetts "Knowledge Panel" was not sufficiently high to consider the sample representative, the panel was recruited using random address-based household sampling and matches the demographic profile and geographic distribution of the general adult population in Massachusetts. Because of the overlap among items, we can consider how MA-VSEP enrollees compare to Massachusetts residents on many of the domains we assessed in both studies. In the sections that follow, we explore these differences and similarities, and then review how MA-VSEP enrollee characteristics compare to those reported by other studies of self-excluders. These are not comparable samples or studies, so we consider the following discussion an attempt to place our findings in context, not draw direct comparisons.

4.3.1. MA-VSEP Enrollees and Massachusetts Residents

An informal comparison with an internet sample of Massachusetts residents surveyed prior to gambling expansion (MA sample) suggests that this MA-VSEP sample was of similar age, more likely to be male, more likely to be employed, less likely to be married, and had a lower household income (Nelson et al., 2013).[22]

Overall, MA-VSEP enrollees appeared to have stronger concerns about the dangers of gambling than did the MA sample. This might be explained by the majority of MA-VSEP enrollees who reported financial problems and a lack of control over their gambling as motivations for their signing up for VSE. MA-VSEP enrollees' experience with significant gambling-related problems likely shaped their current beliefs. On the other hand, MA-VSEP enrollees also seemed more likely to think of gambling as a fun or acceptable form of entertainment, suggesting they might have had conflicting attitudes toward gambling as a result of their experiences. MA-VSEP enrollees also appeared to have greater misperceptions about luck and probability than the MA sample.

Compared to MA sample members who reported gambling in the past year, MA-VSEP enrollees were more likely to play electronic gambling machines and other casinos games in the past year and more likely to report weekly or more frequent play on those games. The two samples reported similar rates of weekly play of the lottery. This lottery finding suggests that MA-VSEP enrollees could have been supplementing, not substituting the types of gambling typically engaged in by MA residents.

[22] We selected this sample for comparison because we used a very similar set of questions in our survey of this internet sample. The sample is derived from a Knowledge Panel (http://www.knowledgenetworks.com/ganp/), which is distributed throughout the state and has demographics that match US Census demographics for Massachusetts. Comparisons with the SEIGMA baseline sample (Volberg et al., 2017) yield similar results, but the questions asked were not directly comparable.

MA-VSEP enrollees not only endorsed more gambling problems than the MA sample, but also appeared to have poorer mental health, and higher levels of anxiety and depression. Encouragingly, MA-VSEP enrollees also seemed more likely than the MA sample to report having sought help for their mental health or substance use problems.

These informal findings suggest that MA-VSEP enrollees represent a population with elevated levels of both gambling-related problems and other mental health issues, and that, as a group, they are aware of and ready to seek help for these comorbid issues.

4.3.2. MA-VSEP Enrollees and Other Samples of VSEs

MA-VSEP enrollee demographics seem consistent with other studies of VSE samples. Similar to previous studies of VSE samples, MA-VSEP enrollees tended to be middle-aged, white, and male (Kotter, Kraplin, & Buhringer, 2018; Ladouceur et al., 2007; McCormick et al., in press; Nelson et al., 2010). Rates of gambling disorder also were similar. Previous studies of VSE populations reported that 79-89% qualified for gambling disorder at baseline (Nelson et al., 2010; Pickering et al., 2018; Tremblay et al., 2008); 92% of MA-VSEP enrollees qualified for gambling disorder at baseline. Our current results support previous findings that this population is at high-risk and experiencing significant problems with their gambling.

MA-VSEP enrollees' reasons for enrolling were similar to those reported by VSEs in previous studies. Feelings of loss of control, and a desire to curb financial losses were prevalent in the current study and past studies (Ladouceur et al., 2007; Pickering et al., 2018).

Unlike previous studies where participants were more likely to choose terms of exclusion of one year or less (Ladouceur et al., 2007; Tremblay et al., 2008), the MA-VSEP enrollee population were more likely to enroll for terms greater than one year; 40% selected a 5-year term. The fact that many MA-VSEP enrollees also had enrolled in VSE programs in other states might partially explain this difference. These enrollees might have been more willing to commit to a longer term because of those other experiences.

Previous studies of VSE programs have shown that enrollees significantly reduce both gambling behavior and resulting problems after VSE enrollment (Hing et al., 2015; Kotter, Kraplin, & Buhringer, 2018; Ladouceur et al., 2007; McCormick et al., in press; Nelson et al., 2010; Townshend, 2007). The current study was no exception. Rates of gambling abstention after MA-VSEP enrollment were higher than in other recent studies, and among those MA-VSEP enrollees who continued to gamble, a large percentage reported reductions in their gambling frequency and losses since signing up for self-exclusion. Endorsement of gambling disorder criteria and qualification for gambling disorder declined significantly between baseline and follow-up, both among those who abstained from gambling and those who continued gambling. It is important to note, however, that these findings are constrained to the minority of MA-VSEP enrollees who completed the follow-up interview. We do not have information about the gambling behavior or problems of other MA-VSEP enrollees after enrollment.

Among MA-VSEP enrollees, 17% reported breaching their self-exclusion contract during the follow-up period. That breach rate is similar to rates reported by VSEs in our evaluation of Missouri self-excluders (Nelson et al., 2010) and a more recent study in Canada (McCormick et al., in press), but lower than rates reported in a number of other studies (i.e., 26-46%)(i.e., 26-46%: Hing et al., 2015; Kotter, Kraplin, & Buhringer, 2018; Ladouceur et al., 2007; Pickering et al., 2018; Tremblay et al., 2008). It is possible that because MA-VSEP enrollees were more likely to have participated in VSE elsewhere and were also more likely to have experienced treatment for gambling, mental health, or substance use prior to enrollment than other samples of VSEs (e.g., Nelson et al., 2010), they were further along in their recovery processes and less likely to violate their VSE contracts as a result.

4.4. Evaluation Goal 3: Evaluate MA-VSEP Satisfaction and Experiences of Enrollees

As evidenced by both their ratings and open response comments, MA-VSEP enrollees were satisfied with their MA-VSEP experience. In particular, enrollees highlighted their interactions with the GSAs as important and positive. Those who had participated in VSE elsewhere noted that the MA program seemed more caring and supportive, whereas other program enrollments occurred with security personnel and felt punitive. In some cases, enrollees first learned about MA-VSEP from the GSAs and commented that these initial interactions with GSAs were crucial to their decisions to enroll. These initial

impressions are important because for many enrollees these interactions occur at a time of crisis. The supportive environment created by the GSAs might help potential enrollees use the crisis as a turning point.

Overall satisfaction with MA-VSEP at follow-up was lower than satisfaction with the enrollment process. However, satisfaction levels were still high, with more than three quarters of MA-VSEP enrollees who completed the follow-up interview very or extremely satisfied with the program. To understand any lack of or reduction in satisfaction with the MA-VSEP, it is helpful to consider enrollees' suggestions for improvement. As with other programs (Nelson et al., 2010), for some enrollees lack of satisfaction is due to regretting the decision to enroll in the first place. However, MA-VSEP enrollee comments about the program indicate that some enrollees would like to see the program adopt *more* restrictions, not fewer. Similarly, most enrollees who commented reported that they wanted more follow-up from the program. Multiple enrollees suggested having GSAs or other program staff follow up or check in. This is notable because MA-VSEP procedures include the offer of a one-week check-in call. It appears that some MA-VSEP enrollees were not aware of this option or did not understand what was being offered at the time of their enrollment. In addition, results from the one-week check-in calls suggest that GSAs did not review resources or point out resources specific to the enrollee's region of residence with all MA-VSEP enrollees upon enrollment. There are many reasons this might have occurred but given that the commonly perceived strength of the MA-VSEP is the caring, supportive environment it provides, ensuring fidelity to this part of the MA-VSEP protocol appears particularly important.

When it comes to breaching their VSE contract, less than 20% of MA-VSEP enrollees who completed the follow-up survey attempted or made it on to the gambling floor to gamble. These findings are similar to breach rates seen in Nelson et al.'s study (2010) with lifetime excluders in Missouri and a more recent study by McCormick, Cohen, & Davies (in press). However, the breach rate is much lower than what has been reported in a number of previous studies where breach rates ranged from 30% to 50% (Hing et al., 2015; Ladouceur et al., 2007; Pickering et al., 2018; Tremblay et al., 2008). Regardless, as noted in our earlier evaluation of the Missouri VSE program (Nelson et al., 2010), because of the difficulty of detecting breaches, enforcement is likely less important to successful outcomes than the enrollment process and accessibility of the program. On the other hand, MA-VSEP violations might be opportunities to reinforce the program's commitment to connecting enrollees with resources and should not be ignored entirely. Just as lapses and relapses are to be expected during recovery from other expressions of addiction, MA-VSEP violations might be part of the recovery process for some individuals with gambling problems and used as an opportunity to provide further help.

4.5. Evaluation Goal 4a: Examine Outcomes for MA-VSEP Enrollees 6-12 Months After Enrollment

We examined two primary types of MA-VSEP outcomes for this study: (1) gambling-related behaviors and problems, and (2) other corollary outcomes related to well-being, mental health, and relationships. Both relied on a sample limited by low recruitment rate and finding should be interpreted with caution. For the first type, two different subsets of MA-VSEP enrollees influenced the results – those who stopped gambling and those who continued gambling. We examined these outcomes for both groups.

In both cases, the MA-VSEP enrollees experienced significant decreases in frequency of gambling. MA-VSEP enrollees who continued gambling also experienced decreases in the amount of money lost gambling. Overall, more than three quarters of MA-VSEP enrollees who completed the follow-up interview also self-reported reductions in their gambling when they considered how they thought their behavior had changed since MA-VSEP enrollment. These findings support previous work that has shown similar decreases in gambling behavior across time (Hing et al., 2015; Kotter, Kraplin, Pittig, et al., 2018; Townshend, 2007; Tremblay et al., 2008). MA-VSEP enrollees, both the full follow-up sample and those who continued gambling, also experienced significant reductions in the number of DSM-IV criteria they qualified for from baseline to follow-up. This finding is similar to what has been reported in a majority of previous longitudinal VSE studies (Hing et al., 2015; Ladouceur et al., 2007; McCormick et al., in press; Nelson et al., 2010; Townshend, 2007; Tremblay et al., 2008).

An important observation related to gambling outcomes is that these outcomes did not necessarily match MA-VSEP enrollees' intentions upon enrollment. Only about one third of those who intended to quit all gambling succeeded. Further, MA-VSEP enrollees who intended to quit all gambling reported poorer mental health at follow-up, controlling for their mental health at enrollment, than others. This suggests that many of these individuals might have set overly ambitious goals and not received the support they needed to fulfill those goals. In contrast, those who intended to quit only casino

gambling or quit only gambling at PPC had more success fulfilling their goals. The MA-VSEP might consider asking about enrollees' goals and providing some brief motivational interviewing to help enrollees set manageable goals and recognize and access the support they need to take steps toward those goals. The relationship between quit intentions and mental health at follow-up also suggests that abstinence goals, compared to harm-reduction goals, did not lead to better outcomes. We included quit intentions in all models predicting follow-up outcomes, and the negative relationship between intention to quit all gambling and mental health was the only relationship we found.

Overall, outcomes related to well-being, mental health, and relationships also were positive for MA-VSEP enrollees who completed the follow-up interview. Enrollees reported improvements in mental health and were less likely to screen positive for depression and anxiety at follow-up than at enrollment. Though the subgroup n's were small, there was some evidence, presented in Appendix I, that younger female enrollees did not evidence these same improvements, a finding that should be examined further with larger samples.

Very few of the predictors that we examined in exploratory analyses presented in Appendix J related to MA-VSEP enrollee outcomes, and even fewer did so consistently. One notable and strong positive relationship emerged between social support upon MA-VSEP enrollment and reductions in gambling problems at follow-up. Often, individuals recovering from addiction struggle because their social networks are inextricably linked to their substance-using or gambling behavior. Changing that behavior often involves removing oneself from those social networks and dealing with the isolation and loneliness that follow. On the other hand, individuals who have people in their lives who support their behavior changes might have more confidence in their ability to make those changes, more motivation to do so, and fewer negative side effects from those changes.

All of these improvements and positive outcomes for MA-VSEP enrollees suggest the program has a positive effect on enrollees. Certainly, enrollees' open response comments about the program indicate that they perceive the program to be beneficial. However, as discussed more fully in the limitations section, with the current study design it is not possible to determine with any certainty the causes of these outcomes. We do not have a control group, so it is possible, though not likely, that these changes might have occurred whether individuals enrolled in the MA-VSEP or not. More interesting, and worthy of further exploration in future studies, is the question of whether it is simply the act of signing up for a program of this type versus specific aspects of the program itself that instigates behavior change. It might be that individuals willing to sign up for MA-VSEP are already in a place where they are ready to change their behavior and would do so without the program. Alternatively, the act of entering a VSE contract might be a concrete step that individuals can take that motivates them to change. Finally, the actual external controls imposed by the program, coupled with the support it provides might be a key element of MA-VSEP enrollees' success.

4.6. Evaluation Goal 4b: Examine whether MA-VSEP Enrollment Is a Gateway to Treatment

Unlike VSE enrollees in our previous work (Nelson et al., 2010), many MA-VSEP enrollees already had received both gambling treatment and other forms of mental health and substance use treatment prior to MA-VSEP enrollment. Almost half of those who completed the baseline survey had received mental health or substance use treatment, and a quarter had been in a gambling treatment program. Very few enrollees who were involved with gambling services weren't also involved with mental health or substance use services. Potentially because of this pre-existing treatment history, there was no evidence that MA-VSEP enrollment served as a gateway to treatment in this population. There was some evidence that some individuals who had not accessed services in the year prior to MA-VSEP enrollment returned to treatment-seeking or self-help groups after enrollment, so MA-VSEP enrollment might have nudged these individuals to re-engage with services. However, given that many enrollees specifically expressed a desire for the MA-VSEP to check in with them after enrollment, it seems that the program could further its efforts to make sure enrollees have access to the resources they want and need. Taking a basic treatment history at enrollment can help program staff better tailor the resources they offer and any follow-up. In addition, given the high comorbidity in this population, the program could consider connecting enrollees with resources for mental health treatment, not just gambling-specific services, depending on their needs.

4.7. Limitations

The primary limitation of the current work, and most VSE studies, is the absence of a control or comparison group. Though we were able to assess MA-VSEP enrollee experiences across time, because of the absence of a comparison group, we were unable to determine whether the changes we observed were due to the program, to the act of signing up for the program, or neither. Our original design, which involved comparing a standard version of MA-VSEP to an enhanced version, would have allowed us to determine whether specific program features (i.e., personalized introduction to treatment resources, offers to connect enrollees directly with treatment, and one-week check-in calls) led to improvements in behavior and well-being among MA-VSEP enrollees. However, as noted earlier, it was difficult to maintain fidelity to these two program conditions and recruit individuals to participate in the study, so the experimental design element was not included in this study. Future research needs to include these kinds of experimental components to determine whether VSE programs play a causal role in enrollee improvements, and which aspects of these programs influence change.

A second limitation of the current work is the recruitment rate into the study component of the evaluation. We were only able to recruit 24% of MA-VSEP enrollees to participate in the baseline survey component of the study; only 11% were willing to participate when invited by GSAs during their MA-VSEP enrollment. Among the enrollees who released their information but did not sign up for the study during enrollment, 56% were willing to participate when contacted by Division staff. Our use of multiple sources for data about MA-VSEP enrollees alleviates some of the concern about this low study recruitment rate – we were able to report about some information for *all* MA-VSEP enrollees during the study period. However, information from the baseline survey is limited to the 24% of MA-VSEP enrollees who were willing to participate. Our retention rate of 73% means that we only have follow-up outcomes and information for 17% of MA-VSEP enrollees who enrolled during the study period. It is quite possible that the same qualities that made these individuals more amenable to the research and more willing to be contacted for follow-up also helped them succeed in the program.

A third limitation of the current work is the amount of missing data. As Appendix F demonstrates, MA-VSEP enrollees did not consistently complete all sections on the MA-VSEP applications or the baseline surveys completed at PPC. In addition, problems with the fillable forms for the MA-VSEP applications resulted in lost data. For the MA-VSEP applications, the section that included questions about past gambling behavior and other characteristics originally was presented as optional to MA-VSEP enrollees, and then was removed during the first few months of the study on the assumption that most enrollees would complete the baseline survey. It was returned as a required component to the last version of the application. It is not clear why baseline surveys were not consistently and fully completed by enrollees who participated in the baseline component of the study at PPC. However, because GSAs were not reviewing study participant responses, it is possible that some participants skipped sections to complete the survey as quickly as possible. GSAs also only completed information about sharing resources and connecting MA-VSEP enrollees with those resources for enrollees who agreed to a one-week check-in call even though the protocol indicated that these forms should be completed for all enrollees. Finally, limitations in the availability of player card data affected the player card information available for MA-VSEP enrollees. We were provided with only player card information from June 2016 forward instead of June 2015 forward. Therefore, our sample of MA-VSEP enrollees with player card data was restricted. We also only had enough confidence in summary data from one of the tables provided to include it in the report because of problems and anomalies that have arisen in the data sets that have been provided for us (Tom et al., forthcoming).

5. RECOMMENDATIONS

Based on the current MA-VSEP evaluation, we provide three sets of recommendations: (1) Program recommendations – suggestions to improve aspects of the MA-VSEP program; (2) Data systems recommendations – suggestions to improve the way data are collected and maintained; and (3) Continued evaluation recommendations – suggestions to better integrate program evaluation into the program and data systems.

5.1. Program Recommendations

Based on the results of this evaluation, we have eight primary program recommendations.

Many MA-VSEP enrollees reported first learning about the MA-VSEP through conversations with the GSAs or by seeing signs for it at the casino. We also know that at least half of MA-VSEP enrollees have accessed treatment services related to gambling, substance use, or mental health. Therefore, we make the following two recommendations:

1) Publicize MA-VSEP more widely throughout the state.

2) Specifically collaborate with substance use and mental health treatment organizations to publicize MA-VSEP.

Though many MA-VSEP enrollees did not check the box on their applications agreeing to be contacted by MCCG staff for a check-in in the weeks after enrollment, it appears that enrollees were not fully aware of the purpose of these calls. In fact, many enrollees, including those who did not agree to or receive check-in calls, indicated a desire for more follow-up by the MA-VSEP program. Therefore, we make the following recommendation:

3) Consider making one-week check-in calls a standard part of MA-VSEP, not optional. At the very least, make sure to offer these calls and describe their purpose explicitly to every MA-VSEP enrollee.

The evaluation provided some evidence that MA-VSEP enrollee mental health outcomes differed depending on their intentions to quit gambling at enrollment, and that enrollees' intentions did not predict their future behavior. In addition, many enrollees already had some history of treatment-seeking related to gambling and other substance-related and mental health issues. Given that a strength of the MA-VSEP appears to be its supportive approach and that MA-VSEP enrollees appear to desire more contact with GSAs, it is possible that more targeted discussion about enrollee goals and possible resources could be beneficial. Therefore, we make the following two recommendations:

4) Include motivational interviewing training for program staff.

5) Conduct an assessment of treatment history and enrollment goals (e.g., abstinence vs. harm reduction) with enrollees at the time of enrollment.

Because MA-VSEP enrollees evidence comorbid mental health and substance-related issues, and because enrollees and more generally individuals with gambling problems rarely seek treatment just for gambling-related issues, the MA-VSEP could serve as an access point not just for gambling services, but for other behavioral health services. In addition, close to a quarter of MA-VSEP enrollees were residents of Rhode Island. Therefore, we make the following two recommendations:

6) Provide resources for gambling treatment <u>and</u> other forms of mental health and substance use treatment in enrollees' regions.

7) Include Rhode Island as a region for which resources are provided.

At least three major casinos are available to enrollees within neighboring states (i.e., Twin Rivers in Rhode Island, and Foxwoods and Mohegan Sun in Connecticut), as well as a handful of other smaller casinos. A subset of MA-VSEP enrollees elected to enroll in MA-VSEP as part of a larger endeavor to ban themselves from all regional casinos. Some of these enrollees noted their desire for a regional VSE program. In addition, at follow-up, MA-VSEP enrollees were gambling more frequently at casinos in neighboring states than at PPC. Finally, for individuals with gambling problems who are already in recovery and wish to enroll in MA-VSEP, entering a casino has the potential to be a triggering event. Though MA-VSEP

enrollment also can occur at MGC or MCCG, these locations are not necessarily convenient to most enrollees. Therefore, we make the following recommendation:

8) Consider offering regional VSE and making VSEP enrollment available through gambling, substance use, and mental health treatment providers.

5.2. Data Systems Recommendations

Throughout this evaluation project, we worked closely with the MGC to connect the various sources of records we utilized. Throughout this process, it became evident that better integration of data collection and data storage systems and processes could improve both the program and the ability to evaluate the program. In addition, problems with the electronic version of the MA-VSEP application led to several data anomalies that yielded unreliable application data for individuals who enrolled during the time period that version of the application was active. Therefore, we make the following four recommendations related to data systems:

1) Utilize a relational database to link application data with enrollment terms, one-week check-in data, player card data, and exit interview information.

2) Set up the MA-VSEP electronic application in a way that allows the information to feed directly into the relational database described above and does not default to specific answer options if a question is unanswered.

3) For any data important to the program, do not allow "optional" response within the MA-VSEP application.

4) Create a data system that can generate reports automatically detailing program enrollment, treatment resource access, program removal, and program violation, split by gender, age group, and length of enrollment term.

5.3. Continued Evaluation Recommendations

Two of the major limitations of the current evaluation, discussed earlier, involved the low recruitment rate and missing data. One way to address both of these issues is to include evaluation components within the standard MA-VSEP enrollment and exit process. This was done, to some extent, during the evaluation by including some application questions about enrollee characteristics. However, for much of the study, GSAs portrayed this section of the evaluation as optional to enrollees. This resulted in a self-selection effect for these data whereby only those sufficiently invested in the program completed that section of the application. Instead, requiring these elements and conveying to enrollees the integral role evaluation plays in MA-VSEP and its improvement will allow for more consistent, representative data for evaluation. Integrating evaluation components into all contacts with enrollees will allow for continuous evaluation. Therefore, we make the following three recommendations:

1) Formalize the information collected during check-in calls and the exit interview for the MA-VSEP, collecting a standardized set of information about outcomes for all enrollees who complete these calls and/or an exit interview. This information should include gambling behavior, gambling problems, mental health, treatment access, MA-VSEP satisfaction and suggestions for improvement, and other domains of interest to the MA-VSEP.

2) Include key domains of interest as mandatory components of the MA-VSEP application, including gambling behavior (i.e., amount, frequency, and type) prior to enrollment, treatment history, enrollment goals and quit intentions, other substance use and mental health issues, and social support.

3) Track information about resources shared with enrollees upon enrollment, information discussed during the check-in call, and enrollee access to these treatment resources.

Finally, as noted earlier, the only way to fully understand the effect of the MA-VSEP and its features is to conduct scientific experiments. Even though conducting a randomized controlled trial of MA-VSEP compared to no program might not be feasible or ethical, there are other ways to test program features. In particular, the features that are most unique to the MA-VSEP and show promise could be varied systematically, for example, by making check-in calls mandatory for a

randomly selected proportion of MA-VSEP enrollees and comparing outcomes for these enrollees compared to those for whom these calls are optional. Therefore, we make the following recommendation:

4) Examine MA-VSEP program features that might be particularly effective at facilitating change by conducting controlled experiments, randomly assigning half of MA-VSEP enrollees to each of two different program conditions and assessing outcomes.

6. CONCLUDING THOUGHTS

Overall, MA-VSEP enrollees had generally positive experiences with the MA-VSEP, demonstrated improvements in their gambling behavior, problems, mental health, and relationships after enrollment, and experienced the program as more caring and supportive than other VSE programs. In addition, for several individuals, the GSAs and the MA-VSEP appear to have been a lifeline in a time of crisis. The Massachusetts' program goal of offering a non-punitive, supportive model of VSE appears to be clear to enrollees and positively received. Based on feedback, program staff can improve this model by offering more check-ins after enrollment, and better targeting of resources that apply to both gambling and other associated behavioral health issues. In addition, program staff can elicit and recognize enrollees' intentions related to their gambling. Finally, better integration of data crucial to evaluation into existing data systems (i.e., adding baseline interview questions as mandatory components of the MA-VSEP application, recording treatment access for all MA-VSEP enrollees, adding follow-up interview questions to the exit interview), will allow for continuous evaluation of the program in real time.

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APPENDICES

1. Appendix A: Resource Packet Provided to Enrollees at MA-VSEP Enrollment
2. Appendix B: Informed Consent and Telephone Scripts
3. Appendix C: Baseline Survey and Follow-Up Interview
4. Appendix D: MA-VSEP Application Forms
5. Appendix E: MA-VSEP One Week Check-In Form
6. Appendix F: Analysis of Missing Data by Instrument and Item
7. Appendix G: MA-VSEP Enrollees' Specific Reasons for Enrolling in MA-VSEP on That Day
8. Appendix H: MA-VSEP Enrollees' Gambling-Related Treatment and Self-Help Before and After MA-VSEP Enrollment
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APPENDIX A: RESOURCE PACKET PROVIDED TO ENROLLEES AT MA-VSEP ENROLLMENT

[Packet includes materials distributed to MA-VSEP enrollees living in each of three regions within Massachusetts.]

Congratulations,
You have enrolled in
the VSE program.

Term of Exclusion:

_____

Term Expiration:

_____

If you have any questions,
call your VSE coordinator at
(617) 533-9737

To maintain confidentiality,
you will be required to prove
your identity before any
information is disclosed

GameSense

Your first step to change.

If gambling is affecting your life and you are thinking about change, you've already taken the first step. This guide will help you understand gambling, figure out if you need to change, and decide how to deal with the actual process of change. If you're at all concerned about your gambling, this guide is for you.

Your First Step to Change

Should you decide to change, this guide can help you begin your journey. You can use the guide in the way you feel most comfortable. Complete it all at once, a little at a time, or keep it as a reference that you can read whenever you want. The guide is divided into the following three sections:

Section 1: *Facts About Gambling,*
will explain how gambling works and how it can become a problem for some people.

Section 2: *Understanding Your Gambling,*
will help you think about how you gamble and your reasons for gambling.

Section 3: *Thinking About Change,*
will lead you through the process of change.

The first step of your journey is to figure out if you need or want to change. Try to answer the following questions:

1. Have you often gambled longer than you had planned? Yes____ No____
2. Have you often gambled until your last dollar was gone? Yes____ No____
3. Have thoughts of gambling caused you to lose sleep? Yes____ No____
4. Have you used your income or savings to gamble while letting bills go unpaid? Yes____ No____
5. Have you made repeated, unsuccessful attempts to stop gambling? Yes____ No____
6. Have you broken the law or considered breaking the law to pay for your gambling? Yes____ No____
7. Have you borrowed money to pay for your gambling? Yes____ No____
8. Have you felt depressed or suicidal because of your gambling losses? Yes____ No____
9. Have you been remorseful after gambling? Yes____ No____
10. Have you ever gambled to get money to meet your financial obligations? Yes____ No____

If you answered "yes" to any of these questions, then you may want to consider making a change. The following sections of this guide can help. Section 1 will explain some interesting things about gambling you might not know.

Section 1: *Facts About Gambling*

Understanding Gambling

Gambling is simply putting something at stake on the outcome of an event before it happens. People usually gamble because they hope to gain something of larger value. Gambling includes everything from buying a lottery or a scratch ticket to playing Bingo to betting on the outcome of a sports event.

"What is problem gambling?"

Problem gambling is gambling to the extent that it causes emotional, family, legal, financial or other problems for the gambler and the people around the gambler. Problem gambling can get worse over time, and gambling problems can range from mild to severe.

STREAKS

Every time you flip a coin your chance of getting heads is 50% and your chance of getting tails is 50%. This means that if you flip the coin 10 times and it comes up heads all 10 times, the chance of getting heads or tails on the 11th flip is exactly the same: 50-50. The outcome of each coin toss does not affect the next. The coin does not have a memory. Although many people think that losing streaks are more likely to be followed by wins, you are never "due" to win.

LUCK

People who have a problem with gambling often believe that things like "luck" can affect their chances to win. For example, some people who play slot machines believe that playing one specific machine for a long time, or that wearing their lucky shirt, can favorably affect their chance of winning. These things have no effect on chance. Chance is chance.

"What are some signs of problem gambling?"

When people have a problem with gambling, many times they feel like they need to bet more money more frequently, feel irritated when they try to stop, and think that they can "chase" their losses to recover money. This can lead to more gambling, despite financial loss and the trust of friends and loved ones. In general, people with gambling problems usually spend a large portion of their income on gambling.

"Do a lot of people have problems with gambling?"

If gambling is becoming a problem for you, you are not alone. Research shows that 1.1% of the adult population in the U.S. and Canada has had severe problems with gambling in the past year. Also, another 2.2% of that same population has had at least some problems with gambling in the past year. Based on a recent U.S. Census, in total these estimates represent 7 million people in the U.S. alone.

"What if it's my turn to win?"

Sometimes people who gamble tend to think that eventually it will be their turn to win, but it's probably not. Here's why: gambling is based on chance, probability, and randomness. If you have a 50-50 chance at winning a game, it doesn't matter how many times you have won or lost in the past. The next time you play, your chances of winning are still 50-50.

"Are certain games more likely to lead to gambling problems?"

All gambling is risky to some degree. Games that have a quick turnaround, such as video lottery, slot machines, and scratch tickets, are typically more risky. However, gambling problems can develop by playing any type of game.

SYSTEMS AND STRATEGIES

Many problem gamblers believe either that they have found a way to "outsmart" the system or that they have an ability to beat the odds. Even if you were able to handicap a race or count cards, there are still many factors that could change the outcome of an event. As a result, it is not likely that you have turned the odds in your favor or even affected them in any substantial way. Gambling is gambling—the outcome is always unknown, and there is no way for a gambler to affect the odds of the game.

Section 2: *Understanding Your Gambling*

Understanding how gambling works and the dangers that are associated with gambling is an important step in your journey. This part of the guide will help you to understand your gambling patterns. Complete the questions below to see if you should examine your gambling patterns more closely:

1. Have you ever tried to cut down on your gambling? Yes____ No____
2. Are others annoyed by your gambling? Yes____ No____
3. Do you ever gamble alone? Yes____ No____
4. Do you ever feel guilty about your gambling? Yes____ No____
5. Do you ever gamble to feel better? Yes____ No____

If you answered "yes" to one or more questions, then you may want to consider looking at your gambling more closely. Many people are not aware of all the ways that gambling can affect their lives. The exercise on the following page will help you to identify difficulties you may be facing. Answering these questions can alert you to problems that you might not have thought about before.

1. Have you spent a great deal of your time during the past 12 months thinking of ways to get money for gambling? Yes____ No____

2. During the past 12 months, have you placed bigger and bigger bets to experience excitement? Yes____ No____

3. Did you find during the past 12 months that smaller bets are less exciting to you than before? Yes____ No____

4. Has stopping gambling or cutting down how much you gambled made you feel restless or irritable during the past 12 months? Yes____ No____

5. Have you gambled during the past 12 months to make the uncomfortable feelings that come from stopping or reducing gambling go away? Yes____ No____

6. Have you gambled to forget about stress during the past 12 months? Yes____ No____

7. After losing money gambling, have you gambled to try to win back your lost money? Yes____ No____

8. Have you lied to family members or others about how much you gambled during the past 12 months? Yes____ No____

9. Have you done anything illegal during the past 12 months to get money to gamble? Yes____ No____

10. During the past 12 months, have you lost or almost lost a significant relationship, job, educational or career opportunity because of your gambling? Yes____ No____

11. Have you relied on others (e.g. family, friends, or work) to provide you with money to cover your gambling debts? Yes____ No____

12. During the past 12 months have you tried to quit or limit your gambling, but couldn't? Yes____ No____

These questions point out different problems you might have had because of gambling. Each question identifies a very serious problem. If you answered "yes" to one or more of these questions, you might want to think about reducing or stopping gambling.

Money Problems

Another way to understand your gambling is to consider the financial impact it has on you. Many problem gamblers experience various kinds of money problems. For example, some problem gamblers are always short of cash despite adequate income, and others will borrow, pawn, or even steal to get some quick cash to gamble. Answer the following questions to see if you have found yourself in some of the same money situations as problem gamblers:

1. Have you ever been denied credit? Yes____ No____

2. Have you ever taken money out of savings, investments, or retirement accounts to gamble? Yes____ No____

3. Do you find yourself frequently bothered by bill collectors? Yes____ No____

4. Have you ever used grocery money or other money for necessities to gamble? Yes____ No____

5. Have you ever delayed paying household bills in order to get more money for gambling? Yes____ No____

6. Have you ever taken cash advances from credit cards to use for gambling? Yes____ No____

If you answered "yes" to any of these questions, it may be a sign that your gambling has affected your financial situation. Money problems, such as these, are usually symptoms, not the causes, of problem gambling. At this point you still may not know if you want to change. What's important is that you have a better understanding of your gambling. The next section of this guide will help you to think about the reasons you gamble and how to change, should you decide a change is right for you.

Section 3: *Thinking About Change*

"Do I really want to change?"

Before you make a decision, it's good to think about the costs and benefits of each choice. Filling in the boxes below will help you see the costs and benefits of your gambling:

Here's an example:

Benefits of Not Gambling • I would have more money to spend on other things. • I would have more time to spend with people I care about.	Benefits of Gambling • I have fun when I gamble. • I love the feeling of excitement when I gamble.
Costs of Not Gambling • I will have to face responsibility. • I will have to somehow fill up my time.	Costs of Gambling • I am heavily in debt. • I am depressed and anxious.

Now you try by filling in your own answers.

Benefits of Not Gambling	Benefits of Gambling
Costs of Not Gambling	Costs of Gambling

Which box has the most answers? _____

What does this mean to you? _____

_____

_____

Do the benefits of continuing to gamble outweigh the costs? _____

If you think the costs of continuing to gamble are greater than the benefits, you may want to consider changing your gambling behavior. This is your decision.

Deciding on Goals

The next step in the process of change is deciding on your goals. For example:

- When do you want to change?
- Do you want to stop gambling or just gamble less than you do now?

Remember that change is a process and it will take time. The first three months are usually the most difficult. The period after that will be hard too, but not quite like when you began to change. Although getting through this process may seem very difficult, the experience of many people shows that you can change your gambling patterns.

SOMETHING TO THINK ABOUT

Some people simply cut down on gambling, while others try to stop completely. Research suggests that cutting down on gambling can be a goal. However, a lot of people find that just cutting back on gambling is a difficult goal to keep because it can easily lead back to problem gambling. If reducing your gambling is too hard for you, you may choose to stop gambling completely. Obviously, neither option will be easy, but just reducing your gambling might be more risky.

To change these patterns, you must first make a decision. Think about what changes you would like to make. For example, you may decide that you want to completely stop gambling in the next year, or that you want to limit your gambling activity over the next six months.

Which of the following options would you choose?
Check the box that applies:

☐ **Stop Completely** ☐ **Limit Gambling**

Now write down some details about how you will accomplish the goal you just chose. For example, when are you planning to start? What specific things will you begin to do differently?

_____

_____

_____

_____

This is your goal for change. Sign your name as a promise to yourself:

Signature_____ Date: _____

"What can I do to handle an urge to gamble?"

Urges are normal for a person who is reducing the amount that they gamble. Urges are often very difficult to deal with, but with practice you will be able to let these feelings pass without giving in to them. You might notice that after stopping or cutting back your gambling you get more urges to gamble than you did before. This is normal. What's important is that you recognize that these urges are temporary and they will pass.

If you do feel an urge to gamble, it is important to acknowledge the urge—do not ignore it. Think, "I am having an urge to gamble right now. But I know it will pass and I don't have to act on it." When this happens, do something from your list of activities as soon as possible.

Here are a few suggestions. Focus on doing other things. Replace the things in your life that you associate with gambling with other activities that will help to keep your mind off gambling. Find new enjoyable ways to spend your time. Most importantly, think about the things that you liked to do before gambling became a part of your life.

Make a list of those things you enjoyed before gambling became a part of your life.

_____

_____

_____

_____

Get involved with these old activities again; you might have forgotten just how much you enjoyed doing them. Keep this list with you at all times so that you can refer to it should you get an urge to gamble.

If your urge is so great that you cannot focus on your new way of thinking or an activity on your list, say, "Okay, maybe I'll gamble in 10 minutes." Then wait 10 minutes. If the urge is still there, keep telling yourself to just wait 10 minutes. Find other things to do from the list you made for each 10-minute interval. The urge to gamble *will* pass with time.

Now, call or visit a friend or family member that you can trust. Talk about your urges to gamble and how you are dealing with these feelings. Friends and family who support your decision to change will play a big role in helping you achieve your goals. Some people in your life, however, might not want you to change, and these people could potentially encourage you to gamble. If you know someone who may do this, avoid contacting that person—especially when you are experiencing an urge to gamble.

It might also help to try some of the following:

- Attend self-help meetings such as Gamblers Anonymous (see Website listing).
- Avoid going in or near places where gambling is available.
- Spend less time with people who gamble to avoid being pressured into gambling.
- Carry only the minimum amount of money that you need for the day.
- Have your paycheck direct-deposited, if possible.
- Destroy your credit, debit, and ATM cards.

"What if I gamble and I really don't want to?"

If you find that you gamble even though you are trying to quit, you are not alone. Many people find that it takes several attempts to quit or cut down on gambling. Stopping or reducing gambling is a very difficult thing to do and you may not be able to do it the first time you try. Remember, however, that a lot of people don't even get this far. By asking for information and thinking about change, you have already begun your journey to a safer, happier, and healthier life.

If you do gamble and you don't want to, that does not mean that you will never be able to stop. Keep trying, keep talking to people you trust, and keep asking for help. Going back to gambling doesn't make your goals any less valuable or possible.

Hopefully this guide has helped you think about change. It is a starting point, as well as a roadmap for the process of change. Thinking about change is not always easy. Should you decide a change is right for you, you will encounter many obstacles along the way. Expect them and be prepared. Your journey may be difficult at times, but it will be well worth it.

ADDITIONAL RESOURCES

Reading this guide may have helped you to notice new things about yourself. Some of these things can be hard to deal with. Some may even be life problems that don't have anything to do with gambling. If you think that you have some other types of problems (or even some gambling problems that you need more help with), you should consider getting additional support or treatment. Some of the resources in the envelope in the back of the guide will help you, should you decide to seek additional information or counseling.

Problem Gambling Related Website Information

This list of Websites has been compiled to help you better understand the issue of problem gambling. Some of these sites refer to research on problem gambling, some refer to self-help groups, and others are sites of organizations that focus on raising the awareness and education level of the general public around problem gambling.

Bettors Anonymous - www.bettorsanonymous.org

Debtors Anonymous - www.debtorsanonymous.org

Gam-Anon - www.gam-anon.org

Gamblers Anonymous - www.gamblersanonymous.org

Harvard Medical School, Division on Addictions - www.hms.harvard.edu/doa

Massachusetts Council on Compulsive Gambling - www.masscompulsivegambling.org

Massachusetts Department of Public Health/Bureau of Substance Abuse Services (includes state compulsive gambling treatment centers) - www.state.ma.us/dph/bsas/

National Council on Problem Gambling - www.ncpgambling.org

Responsible Gambling Council - www.responsiblegambling.org

University of Minnesota Gambling Research - www.cbc.med.umn.edu/~randy/gambling

The WAGER - www.thewager.org

Additional Reading

If you would like to read more about problem gambling, you might find the following resources useful and interesting:

Berman, L., & Siegel, M. E. (1998). Behind the 8-ball: A guide for families and gamblers. New York: Kaleidoscope Software, Inc.

Blaszczynski, A. (1998). Overcoming compulsive gambling: A self-help guide using cognitive behavioral techniques. London: Robinson Publishing Ltd.

Chin, J. (2000). A way to quit gambling for problem gamblers. Lincoln, NE: Writers Showcase.

Custer, R. L., & Milt, H. (1985). When luck runs out: Help for compulsive gamblers and their families. New York: Warner Books.

Dostoevsky, F. (1981). The gambler. New York: W. W. Norton & Co.

Federman, E. J., Drebing, C. E., & Krebs, C. (2000). Don't leave it to chance. Oakland, CA: New Harbinger Publications, Inc.

Heineman, M. (1992). Losing your shirt. Minneapolis, MN: Comp Care Publishers.

Horvath, T. A. (1998). Sex, drugs, gambling, & chocolate: A workbook for overcoming addictions. San Louis Obispo, CA: Impact Publishers, Inc.

Humphrey, H. (2000). This must be hell: A look at pathological gambling. New York: Writers Club Press.

Lesieur, H. R. (1984). The chase: The career of the compulsive gambler. Cambridge, MA: Schenkman Publishing.

Moody, G. (1990). Quit compulsive gambling: The action plan for gamblers and their families. Wellingborough, England: Thorsons Publishers.

National Endowment for Financial Education. (2000). Personal financial strategies for the loved ones of problem gamblers. Denver, CO: Author. (This booklet can be ordered through the National Council on Problem Gambling at 1-202-547-9204.)

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). Changing for good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward. New York: Avon.

Svendsen, R., & Griffin, T. (1998). Gambling: Choices and guidelines. (booklet). Anoka, MN: Minnesota Institute of Public Health. (This booklet can be ordered through The Gambling Problem Resource Center at the Minnesota Institute of Public Health at 1-800-782-1878.)

ACKNOWLEDGMENTS

Your First Step To Change was developed as a public service project by the Massachusetts Council on Compulsive Gambling and the Institute for Research on Pathological Gambling and Related Disorders. The design was developed by **cause**media, inc. and Bennett+Dunne and funded by the Massachusetts Department of Public Health.

Workbooks that were developed by David Hodgins et al. and Linda and Mark Sobell et al. provided substantial background and information for Your First Step to Change.

Additional resources used for this project included:

Blaszczynski, A., McConaghy, N., & Frankova, A. (1991). Control versus abstinence in the treatment of pathological gambling: A two to nine year follow-up. British Journal of Addiction, 86, 299-306.

Ciarrocchi, J. W. (2002). Counseling problem gamblers. New York: Academic Press.

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Gamblers Anonymous. (2001). Suggestions for coping with urges to gamble.

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Sobell, M. B., & Sobell, L. C. (1993). Problem drinkers: Guided self-change treatment. New York: Guilford.

The following individuals provided advice and assistance to this project:

Doug Bennett
Paul Carey
Richard Earle
Dana Forman
Judi Haber
Richard LaBrie
Debi LaPlante
Melissa Pleschakow
Christine Reilly
Sarah Ruiz
Kathleen Scanlan
David Shaffer
Howard Shaffer
Chrissy Thurmond
Laura van der Leeden
Marlene Warner

Additional notes:

REGION A

Congratulations

We deeply respect your decision to enroll in the MA Voluntary Self-Exclusion (VSE) Program. VSE is intended to offer you one means of addressing problem gambling behavior, as well as an opportunity to make a positive change in your life.

Enrolling in the Voluntary Self-Exclusion Program was no doubt a difficult decision. Please know that we are here to support you by providing information, as well as referrals to resources and treatment providers.

Enclosed in this package are::

- Materials to aid in your understanding
- Help you understand the VSE process
- Answer commonly-held questions about VSE

If you still have questions after reading the enclosed materials, do not hesitate to call a VSE coordinator or designated agent at:

VSE Enrollment & Information Line: (617) 533-9737

The Problem Gambling Helpline: (800) 426-1234

Frequently Asked Questions about VSE Enrollment

"Where exactly am I excluded from?"

During the period of your exclusion, you will not be allowed to enter the gaming floor of any Massachusetts casino. The information you have provided will be given to casino personnel, MGC Agents, as well as our GameSense Advisors. If you enter a gaming area and are identified, you may be asked to leave or be escorted from the building by security personnel.

"What happens if I am in a gaming area and win while enrolled in a Self-Exclusion Program?"

If you are in the casino gambling and win while on the Self-Exclusion list, you will not be eligible to collect your winnings. If you attempt to claim a prize, it will not be paid.

"Can I keep my rewards points?"

To reduce the temptation to return to the casino, your reward points will be forfeited and marketing materials directed to you will be suspended as well.

"When does my Self-Exclusion expire?"

The Self-Exclusion period begins the moment you meet with a designated agent, complete and submit the enrollment form. Depending on the term of exclusion you selected, your period of Self-Exclusion would expire 6 months, 1 year, 3 years, or 5 years from the day you completed the form.

"Do I need to re-enroll after the date of expiration?"

If you wish to remain in the program: You can, but it is not necessary to re-enroll. Your name will remain within the Voluntary Self-Exclusion database the Massachusetts Gaming Commission shares with its Gaming Licensees until you submit a petition for removal.

If you wish to un-enroll from the Voluntary Self-Exclusion Program: You will need to participate in an exit session with a designated agent from the Massachusetts Council on Compulsive Gambling, or another authorized agent. The exit session will include discuss: Risks and Responsibility Factors; Responsible Gaming Tips; and Access to Resources should you feel you need them at any time in the future.

"I've changed my mind. Can I opt out of the Voluntary Self-Exclusion Program before my term expires?"

Unfortunately, you cannot opt out of the term of Self-Exclusion that you selected before it is set to expire. This is intended as a service to help you honor the commitment you made to the VSE program.

"Where can I find more information about getting help?"

Please call the Problem Gambling Helpline at 800-426-1234.

"Who can I talk to about my Self-Exclusion application?"

You may call the VCS Coordinator at 617-533-9737.

MASSGAMING COMMISSION

Massachusetts Council on COMPULSIVE GAMBLING

We understand the problem. We can help.

GameSense

Region A
Essex, Middlesex, Norfolk, Suffolk and Worcester Counties

Department of Public Health Counseling Services

Counseling is available to anyone concerned about gambling; those who gamble, their families and/or significant others. Treatment is made available regardless of insurance coverage. Many outpatient counseling centers are able to offer other services through programs offered in the center. Translation services should be available upon request. For translation requests please first contact the center or you may contact Omar Cabrera at the Department of Public Health at 617-624-5089.

Boston ASAP
29 Winter Street, 2nd fl., **Boston**, MA 02108
Referral Contact: Matt Hoffman
(617) 482-5292

Mt. Auburn Hospital Prevention & Recovery Center
Clark Building (located to the right of the Main Hospital;
use door on extreme left of Clark Bldg.)
330 Mt. Auburn St. **Cambridge**, MA 02238
Referral Contact: Monique Willett
(617) 499-5051

North Suffolk Mental Health Services*
301 Broadway, **Chelsea**, MA. 02150
Referral Contact: Meredith Johnson
(617)912-7578
Intake in Chelsea, services at East Boston location
Clinicians available who are fluent in Spanish and Asian languages

LUK, Inc.
545 Westminster Street, **Fitchburg** MA 01420
Referral Contact: Lisa Pineo
(978) 829-2248

NFI Ambulatory Services
76 Winter Street, **Haverhill**, MA 01830
Referral Contact:Intake Coordinator
(978) 373-1181 x11

The Psychological Center
11 Union Street, **Lawrence**, MA 01840
Referral Contact: Moheb Faltas
(978) 685-1337

Lowell House, Inc.
555 Merrimack Street, **Lowell**, MA 01852
Referral Contact: Linda Cunha
(978) 459-8656

Clinicians in Private Practice

Private practice clinicians operate independently of any counseling organization. Services are rendered in a private office setting and focus primarily on the individual but may also incorporate family into treatment.
Each clinician offers different payment methods. Contact the private practitioner to discuss what insurances they accept or if they provide services on a sliding scale of payment. All private practice clinicians have been trained in gambling disorder and other addictions.

Shelly Watson, MSW,LICSW, MA PGS
210 Highland St.
Worcester, MA 01609
(P) 508-887-2735

David Alpert, LMHC, LADC, CADC, NCC, MA PGS
Enlightened Care
1177 Washington St., 1st floor
West Newton, MA 02465-2121
(P) 617-332-5523
(F) 781-942-5886

Denise Sullivan, MSW, LICSW, MA PGS
275 Turnpike St.
Canton, MA 02021
(P) 781-724-5439
(F) 781-821-1743

Melanie Barbarisi MA, LMHC, CPC, MA-PGS
207 Hagman Road
2nd Floor
Winthrop, MA 02152
(P) 617-285-2642 (F) 617-846-1281

James Bresnahan
LMFT,LMHC,LADC1,CADC,CEMDR,CSAT,MA PGS
50 ELM St.
Worcester, MA 01609
(P) 508-752-1170
(F) 508-752-1800

Joanne Bresnahan-Ball, CADAC MLADC, LADCI, SAP, LCS, MA-PGS
1) 1 Branch St., Suite 204
Methuen, MA 01844
2) 66 Prospect St.
Manchester, NH 03104
603-965-6477 for both offices

Janice F. Chiaradonna, Ed.D. LMHC, CADAC, MAPGS
Chiaradonna Consultations
7 Essex Green Dr., Suite 65
Peabody, MA 01960
781-596-3315

Deborah J. Colucci, LMHC, CADC-II, MA PGS
162 Park St., Suite 202
North Reading, MA. 01864
781-820-4575

Mary Grady, LADC1,CADC1,MA PGS
76 Norcross St.
Lowell, MA 01851
(P) 978-937-5917
mary_grady@comcast.net

Financial Resource Referrals:

General Information
http://www.massresources.org/credit-counseling.html

Self-Management of Finances:
Mint.com
https://www.mint.com/

Moneywise
http://www.moneywise.com/

Credit Counseling Agencies:

American Credit Counseling Service, Inc. **
Community Service Since 1988
4 Taunton Street, Suite 5 Plainville, MA 02762
Toll Free (800) 729-0551 -- Fax: (508) 695-0148
http://www.accs.org/

American Consumer Credit Counseling
130 Rumford Ave #202
Auburndale, MA
(617) 559-5700
http://www.consumercredit.com

Money Management International
Main number: (866) 226-0278
Massachusetts Branches -Boston
31 Milk St.
Boston, MA 02109
http://www.moneymanagement.org/About-Us/Locations.aspx

Legal Resources:

Boston Bar Association
Lawyer Referrals
(617) 742-0625 or Toll Free: (800) 552-7046
http://www.bostonbarlawyer.org/
Monday through Thursday, 8:30 am to 5:30 pm;
Friday from 8:30 am to 5:00 pm

Massachusetts Justice Project
Worcester: toll-free: 1-888-427-8989;
local: 508-831-9888

Greater Boston Legal Services
Toll-free: 1-800-323-3205
Boston: 617-371-1234

Merrimack Valley North Shore Legal Services
Toll-free: 1-800-336-2262
Lowell: 978-458-1465

Community Legal Aid Services
Worcester: 1-800-649-3718 or 508-752-3718

Metro-West Legal Services
Toll-free: 1-800-696-1501
Framingham: 508-620-1830

Consumer Hotline (MA Attorney General)
617-727-8400

Harvard Legal Aid
Harvard Legal Aid provides services to low-income people in civil (non-criminal) matters in order to ensure equal access to justice and to remove legal barriers to economic opportunity.

Harvard Legal Aid Bureau
23 Everett St.
Cambridge, MA 02138
Tel.: (617) 495-4408
Fax: (617) 496-268-mail
Contact by telephone during ordinary business hours, 9am to 5pm, Monday through Friday. Please do not email requests for legal help;

http://www.harvardlegalaid.org/

Trial Court Law Libraries
Librarians will assist pro-se litigants with legal research.
(617) 878-0339
(800) 445-8989

Peer Recovery Centers:

STEPRox
9 Palmer Street
Roxbury, MA 02119
Phone: 617.442.7837
Fax: 617.445.3573

Devine Recovery Center
70 Devine Way
South Boston, MA 02127
Phone: (857) 496-1384

Everyday Miracles
25 Pleasant Street
Worcester, MA 01601
Phone: (508) 799-6221
Fax: (508) 756-1928
www.everydaymiraclesprsc.org

Quincy Recovery Center
85 Quincy Avenue
Quincy, MA 02169
Phone: (617) 302-3287
baystatecs.org

New Beginnings
487 Essex Street Lawrence,
Massachusetts 01840
Phone: (978) 655-3674
Fax: (978) 258-4355
www.newbeginningsprc.org/

Stairway to Recovery
142 Crescent Street
Brockton, MA 02301
Phone: (774) 888-8562

Region A
Essex, Middlesex, Norfolk, Suffolk and Worcester Counties
List of Self-Help Meetings

Time	Location	Address	City	Notes	Day
8:00 AM	East Boston Social Center, 2nd Floor	68 Central Square	East Boston, MA 02128	GA. Non-Smoking. Friends & Families	Sunday
8:00 AM	East Boston Social Center, 3rd Floor	68 Central Street	East Boston, MA 02128	Gam-anon Only. Non-Smoking	Sunday
12:00- 1:30 PM	Knights of Columbus Hall	25 Teed Drive	Randolph, MA	GA. Non-Smoking. Open Meeting last meeting of month.	Sunday
5:00-6:30 PM	First Church of the Nazarene	529 Eastern Ave.	Malden, MA 02148	GA. WOMENS topic meeting.Regular. H. Non-Smoking	Sunday
7:00 PM	Church of the Nazarene	529 Eastern Ave.	Malden, MA 02148	GA. Open.	Sunday
7:00 PM	All Souls Universalist Church	196 Elm Street (Corner Church and Elm)	Braintree, MA 02184	GA. Open Meeting. Non-Smoking	Sunday
8:00 AM	Life Care Center of Stoneham	25 Woodland Rd. (The Fellsway)	Stoneham, MA 02180	BA. Closed. Non-smoking	Sunday
7:30 PM	Congregational Church of Newton Highlands	54 Lincoln Street	Newton Highlands, MA 02461	GA. Regular. Non-smoking	Monday
7:00 PM	Beth Isreal Deaconess Health Care Center	1000 Broadway	Chelsea, MA 02150	GA. Regular. Non-Smoking. No meeting on Holidays	Monday
12:00 PM - 1:15 PM	Mass. Council on Compulsive Gambling	190 High Street - 6th Floor	Boston, MA 02110	GA. Open Meeting. H. Non-smoking	Tuesday
7:30 PM	Trinity Episcopal Church	1 Blue Hill River Rd (at 1st traffic light north of Rt.128/I95 on Rt. 138	Canton, MA 02021	GA. Open Meeting. Non-smoking. Handicapped Accessible	Tuesday
7:30 - 9 PM	Wesley United Methodist Church	100 Wintrhop St.	Medford, MA 02155	GA. Regular. H. Non-Smoking. Open Meeting last meeting of month.	Tuesday
7:30 - 9:15 PM	Wesley United Methodist Church	100 Winthrop St.	Medford, MA 02155	Gam-anon. Non-Smoking. H	Tuesday

Gamblers Anonymous: 855-222-5542
Bettors Anonymous: 978-988-1777 or 781-662-5199
Gam-Anon: 888-644-8482

Time	Location	Address	City	Notes	Day
7:00 PM	Beth Isreal Deaconess Health Care Center	1000 Broadway	Chelsea, MA 02150	GA. Regular. Non-Smoking. No meeting on Holidays	Wednesday
7:00 PM	All Saints Episcopal Church	79 Central Street	Stoneham, MA 02180	BA. Closed. Non-smoking.	Wednesday
7-8:30 PM	All Saints Episcopal Church	79 Central Street	Stoneham, MA 02180	Families & Friends of Compulsive Gamblers Anonymous. BA Affiliated. Contact: Sis M at 781-933-3842 or Janet T. at 617-569-3214	Wednesday
12:00 PM - 1:15 PM	Mass. Council on Compulsive Gambling	190 High Street - 6th Floor	Boston, MA 02110	GA. Open Meeting. H. Non-smoking	Thursday
7:30 PM	Mary Immaculate of Lourdes Church	270 Elliot Street	Newton, MA 02459	GA. Open.Non-smoking. No meetings when BC Law is closed for Holidays	Thursday
7 - 8:45 PM	First Church of Christ Congregational	678 Lynnfield Street	Lynn, MA 01904	GA. Regular. Non-smoking	Friday
7:15 AM	Beth Israel Deaconess	1000 Broadway	Chelsea, MA 02150	BA Regular. Non-Smoking	Friday
7:30 PM	St. John's United Methodist Church	80 Mt. Auburn Street (RT 16, basement,left rear)	Watertown, MA 02472	GA. Regluar. H. Open Meeting 3rd meeting of month. Non-smoking	Friday
10:00 AM-Noon	Quincy Comm. Methodist Church	40 Beale Street	Quincy, MA 02184	GA. Regular. Topic discussion. Non-Smoking. H	Saturday
10:00 AM - Noon	Quincy Comm. Methodist Church	40 Beale Street	Quincy, MA 02184	Gam-anon. Non-Smoking. H	Saturday
8:15 AM	Sterling Services	589 Concord St. (Rt. 126)	Holliston, MA 01746	GA. Regular. H. Non-smoking	Sunday
7:30 PM	Our Lady of Assumption	10 Waters St.	Millbury,MA	GA. Non-smoking	Monday
7:30 PM	St. Ann's Church	124 Cochituate Rd. (Rt. 27)	Wayland, MA 01778	GA. Regular. H. Non-Smoking	Tuesday
8:00 PM - 9:30 PM	St. Mark's Church Thrift Shop	60 West Street	Leominster, MA 01453	GA. Open.	Tuesday

Gamblers Anonymous: 855-222-5542
Bettors Anonymous: 978-988-1777 or 781-662-5199
Gam-Anon: 888-644-8482

Time	Location	Address	City	Notes	Day
7:30 PM	St. Lukes Parish (Parish Hall Basement)	1 Ruggles St. (Route 30 & Ruggles Street)	Westborough, MA 01581	GA. Regular. H. Non-smoking	Wednesday
8:00 PM	The United Methodist Church	104 South Main Street (Rt 122)	Orange, MA 01364	GA. Regular. Non-smoking	Wednesday
7:30 PM	Greendale People's Church	25 Francis St. (Just off West Boylston Street)	Worcester, MA 01606	GA. Regular. Non-smoking	Friday
7:30 PM	Greendale People's Church	25 Francis St. (Just off West Boylston Street)	Worcester, MA 01606	Gam-anon	Friday
7:15 PM	1st United Methodist Church. Room 101	57 Peters Street (rear)	North Andover, MA 01845	GA. 12 Step Meeting	Tuesday
7:15 PM	1st United Methodist Church. Room 101	57 Peters Street (rear)	North Andover, MA 01845	Gam-Anon	Tuesday
7:00 pm - 8:30 pm	Union Congregational Church	350 Main Street	Amesbury, MA 01913	GA. Non-smoking. 12 Step Meeting	Wednesday
2:00 PM	Saint Monica Church. St. Vincent de Paul Building behind school	212 Lawrence Street	Methuen, MA 01844	BA. Regular. Non-smoking	Saturday
7:30 PM	United Methodist Church	87 Church Street. Route 62	Wilmington, MA 01887	GA. Non-smoking. Open meeting 3rd meeting of month	Thursday
3:00 PM	St. John's the Baptist Church (Rectory Basement)	17 Chestnut Street (Behind City Hall)	Peabody, MA 01960	GA. Non-Smoking	Saturday
7:30 PM	Avon Baptist Church	119 North Main Street (Rt. 28)	Avon, MA 02322	GA. Non-Smoking. Combined meeting. Open meeting last Wednesday of the month	Wednesday
7:30 PM	Avon Baptist Church. Chapel room.	119 North Main Street (Rt. 28)	Avon, MA 02322	Gam-Anon	Wednesday
7:30 - 9 PM	Plainville United Methodist Church	16 E Bacon St. (Intersection of Rt. 106 and Rt. 1A)	Plainville, MA 02762	GA. Open Meeting. Non-smoking.	Thursday

Gamblers Anonymous: 855-222-5542
Bettors Anonymous: 978-988-1777 or 781-662-5199
Gam-Anon: 888-644-8482

REGION B

Know when to play, and when to step away.

Perhaps you've been gambling longer than you planned. Or you've often gambled until your last dollar was gone. Or you've used your savings or paycheck to gamble while bills go unpaid.

The first step to gain control of your gambling is to decide if you need or want to change. If so, the **Voluntary Self-Exclusion Program** can be a valuable resource for you.

What is the Voluntary Self-Exclusion Program?

The program enables you to voluntarily exclude yourself from all Massachusetts gaming venues for a pre-determined length of time.

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For more information and to enroll, contact:

- GameSense Info Center
  Located at Plainridge Park Casino
- Massachusetts Gaming Commission
  617-979-8400
- Massachusetts Council on Compulsive Gambling
  800-426-1234

Learn more at
GameSenseMA.com

If you or someone you know needs immediate help with a potential gambling problem, call the Massachusetts Council on Compulsive Gambling Helpline - 24 hours:

800-426-1234

GameSense

Voluntary Self-Exclusion

Know when to step away.

GameSense

How do I sign up to be voluntarily self-excluded?

To access the program, visit one of the following locations:

- The GameSense Info Center located at Plainridge Park Casino. If a GameSense Advisor isn't available you can also ask any casino staff for help. Sign up is available 24 hours a day.
- The Massachusetts Council on Compulsive Gambling. Call 800-426-1234 for an appointment.
- The Massachusetts Gaming Commission located in Boston. Call 617-979-8400 for an appointment.

What happens while I'm signing up?

No matter where you choose to sign up, you will meet with a professional who has been trained to handle requests for self-exclusion. They understand the difficult decision you're making and will offer support to help you make a knowledgeable choice.

You will need to show your government-issued identification, one that includes your signature and a photograph – e.g., a driver's license, passport, or other identification. You will also sign the Voluntary Self-Exclusion Agreement and have your photograph taken.

While additional help isn't required, the professional you meet with will discuss options and refer you to additional resources. Again, the choice is yours.

How long will I be self-excluded?

The length of the exclusion period is up to you. Your choices include: six months; one year; three years, five years or lifetime. You can renew or extend the period at any time but you can't reduce amount of time you select.

What happens when the term of my Voluntary Self-Exclusion ends?

If you choose to remain in the program: You can re-enroll at the Massachusetts Gaming Commission, Massachusetts Council on Compulsive Gambling or other authorized agent. It's not recommended that you go to the GameSense Info Center at Plainridge Park Casino.

What happens once I'm voluntarily self-excluded?

During the period of your exclusion you will not be allowed to enter the gaming floor of any Massachusetts casino. To reduce the temptation to return to the casino, all reward points will be forfeited and marketing materials to you suspended. Persons who break the agreement and are found on the casino floor will be escorted from the gaming floor and forfeit any winnings.

Once you've signed up, the information you provide will be given to all security offices in gaming venues throughout the Commonwealth. It is intended as a service to help you honor your commitment.

Is there additional help available?

Yes! In fact, research has shown that Voluntary Self-Exclusion, when combined with other support, can be an effective means to stop gambling or successfully regain control of your gambling behavior. In addition to voluntary exclusion you can access help by visiting the GameSense Info Center or by calling the Massachusetts Council on Compulsive Gambling. Additional help is available in the following ways:

- **Individual Counseling:** In addition to voluntary self-exclusion you may wish to consider seeking the help of a qualified clinical professional. Depending on your situation, these services may be available to you at a free or reduced rate. You will receive help and support from trained professionals who will understand what you're experiencing, not judge you, , and who can help you address and reduce problems associated with gambling. If interested, just ask.
- **Self-help Options:** If you aren't interested in counseling but still want to examine the role of gambling in your life, you may wish to consider the many self-help options.
- **Your First Step to Change,** a booklet that allows you to decide if you want to change your gambling and if you do, it guides you through that process (available in print and e-formats).
- **Gamblers Anonymous** or other 12-step programs may interest you.
- **Referrals** to allied health professionals, credit counseling, or an attorney.

How do I un-enroll from the program?

You'll need to participate in a brief information session. A trained professional will discuss with you safe gaming tips, risks of gambling and help available should you want it. It is required that you attend this session.

A-2

Can I exclude a spouse or family member?

It's understandable that you want to help a loved one who is experiencing a problem with gambling. However, only individuals seeking exclusion can sign up. No one can do it for them. Information about how to help loved ones with a gambling problem can be found at the GameSense Info Center or by contacting the Massachusetts Council on Compulsive Gambling.

Voluntary Self-Exclusion isn't for me. Are there other options?

Yes! Voluntary self-exclusion may not be what you're looking for but the good news is there are other steps you can take.

- Voluntary credit suspension allows you to restrict access to credit in Massachusetts gaming facilities.
- Voluntary marketing suspension allows you to stop all marketing and promotional materials from being mailed to you by specific casinos.

GameSense Advisors can help you sign up for these programs and other resources that you may find helpful.

Know when to play.
Know when to step away.

9. Did you often gamble until your last dollar was gone?
10. Did you ever borrow to finance your gambling?
11. Have you ever sold anything to finance gambling?
12. Were you reluctant to use "gambling money" for normal expenditures?
13. Did gambling make you careless of the welfare of yourself and your family?
14. Did you ever gamble longer than you had planned?
15. Have you ever gambled to escape worry or trouble?
16. Have you ever committed, or considered committing, an illegal act to finance gambling?
17. Did gambling cause you to have difficulty in sleeping?
18. Do arguments, disappointments or frustrations create within you an urge to gamble?
19. Did you ever have an urge to celebrate any good fortune by a few hours of gambling?
20. Have you ever considered self destruction as a result of your gambling?*

Most compulsive gamblers will answer yes to at least seven of these questions.

How can you find out more about GA?

Many cities have a phone number listed for Gamblers Anonymous. Look in your local directory. Or you may write to Gamblers Anonymous, National Service Office, P.O. Box 17173, Los Angeles, CA 90017, or call (213) 386-8789.

If you think you are a compulsive gambler, try a GA meeting. You will find a lot of support to arrest the illness. The sooner you start an effective program of treatment, the sooner you will begin to recover!

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* Twenty Questions are reprinted with permission from Gamblers Anonymous, Inc.

Hazelden®

800-328-9000
hazelden.org

Order No. 1393 ISBN: 978-0-89486-266-3

What is GA?

Gamblers Anonymous (GA) is a fellowship in which people share their experience, support, and hope in order to stop gambling and build better lives.

GA was started in 1957 by two compulsive gamblers who were able to quit after they began regular meetings to talk about their gambling. Since then, GA has grown steadily and has groups throughout the United States and abroad.

GA considers compulsive gambling, like alcoholism, a progressive illness – one that cannot be cured but can be arrested by not gambling and by following a set of spiritual principles. The GA program for recovery is like that of Alcoholics Anonymous (AA), based on the Twelve Steps. The first of those Steps involves admitting to oneself that gambling has become an uncontrollable compulsion. Recognizing the problem and a sincere desire to stop gambling are all a person needs to do to recover through GA.

What happens at GA?

At GA meetings, members share their gambling and abstinence experiences. They discuss how the Twelve Steps can be used as tools to solve their compulsive gambling.

Anonymity and confidentiality are important aspects of GA. They help create an atmosphere in which members feel free to share personal experiences. Those who have successfully quit gambling offer inspiration and motivation to newcomers and encourage each other to continue to refrain from gambling.

The only requirement for membership is a desire to stop gambling. There are no dues or membership fees; GA is self-supporting through members' contributions. Each group is autonomous. The national service office in Los Angeles provides information to problem gamblers everywhere.

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Is GA a religious organization?

No, GA is not religious. Essential to the program for recovery, however, is bringing about character changes within oneself by adhering to spiritual principles. Most members feel a belief in a "Higher Power" is necessary to sustain the desire to stop gambling. But each person is responsible for defining his or her meaning of a Higher Power. For example, some consider the fellowship of their GA group as a Higher Power. GA is open to people of any religion, agnostics, and atheists, so long as they have a sincere desire to stop gambling.

What does abstinence from gambling mean?

Gambling, for the compulsive gambler, is defined as follows: any betting or wagering for oneself or others, whether for money or not, no matter how slight or insignificant, where the outcome is uncertain or depends on "skill" or chance. That means no penny-ante poker or World Series pool at the office.

Alcoholics Anonymous advises members to avoid the first drink. For compulsive gamblers, that first bet is the one to avoid, even if it's only matching for a cup of coffee.

What are the Twelve Steps?

Gamblers Anonymous uses an adapted version of the Twelve Steps of Alcoholics Anonymous as the foundation for a simple program of recovery free from compulsive gambling. By following these Steps to the best of their abilities, thousands of men and women have succeeded in making new lives for themselves, free from gambling.

Here are the Steps that are a program of recovery:

1. We admitted we were powerless over gambling – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to a normal way of thinking and living.
3. Made a decision to turn our will and our lives over to the care of this Power of our own understanding.
4. Made a searching and fearless moral and financial inventory of ourselves.
5. Admitted to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have these defects of character removed.
7. Humbly asked God (of our understanding) to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having made an effort to practice these principles in all our affairs, we tried to carry this message to other compulsive gamblers.*

* The GA Twelve Steps for recovering are reprinted with permission of GA National Board of Trustees.

Are you a compulsive gambler?

Only you can decide. In short, compulsive gamblers are those whose gambling has caused continuing problems in any facet of their lives. The following questions may be of help to you.

1. Did you ever lose time from work due to gambling?
2. Has gambling ever made your home life unhappy?
3. Did gambling affect your reputation?
4. Have you ever felt remorse after gambling?
5. Did you ever gamble to get money with which to pay debts or otherwise solve financial difficulties?
6. Did gambling cause a decrease in your ambition or efficiency?
7. After losing did you feel you must return as soon as possible and win back your losses?
8. After a win did you have a strong urge to return and win more?

GAMBLERS ANONYMOUS®
INTERNATIONAL SERVICE OFFICE
P.O. BOX 17173
LOS ANGELES, CALIFORNIA 90017
PHONE: (626) 960-3500
FAX: (626) 960-3501
WEBSITE: www.gamblersanonymous.org
E-MAIL: isomain@gamblersanonymous.org

FOR MEETING INFORMATION
IN YOUR AREA CALL
(855) 2-CALL-GA
(855) 222-5542

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REVISED 9/99
PRINTED 8/14

GAMBLERS ANONYMOUS

YOUR FIRST MEETING

Welcome to your first Gamblers Anonymous meeting. Take heart – we have all been where you are right now. After this meeting you should feel a sense of relief. We not only understand your gambling problem, but we will offer direction and support in helping you get out of the mess you are in. So try to relax, sit back and listen to what the members have to say.

If you feel threatened in your relationship with others because of loss of their respect, financial failure, and low self esteem, remember that we all felt the same way before our first meeting.

To come to Gamblers Anonymous is to admit that you have a problem you have not been able to solve. Compulsive gambling is an illness. You will find you will be able to live a normal, happy life without gambling with the help of the Gamblers Anonymous program.

You may have negative feelings about yourself – self-pity, self-hate, worthlessness, remorse or even thoughts of suicide. Others at the meeting will offer new perspectives, ideas and solutions. Their "therapy" will offer hope that your present situation need not be permanent. You will be welcome at the meeting. You will meet others who have a gambling problem, yet are learning how to abstain from gambling. We will show you how to relieve the pressures, including the financial difficulties, that you are now experiencing.

Up to now, you knew something was wrong. You might have even thought of your gambling problem only as a financial one. You have probably gone to great lengths to hide your gambling and to keep your financial problems a secret. As matters grew worse, the more difficult it became to keep things hidden. The burden of an "unsharable secret" then became part of the gambling problem. Because you have kept your problems to yourself, you may believe that you are unique. In Gamblers Anonymous, you will find great relief in hearing the stories of others who have had similar experiences. The members relate these experiences not only in the sense that they have had the same problems, felt the same emotions, or did the same things, but that they find it extremely helpful to share with others. Moreover, this revealing of faults takes place in an atmosphere of acceptance. You have been devoting a great deal of energy into keeping your image intact and this pursuit has become an overwhelming burden. In Gamblers Anonymous you can put down that burden. You do not have to "con" us; you do not have to pretend that you are a success. In short, you do not have to go through all the face-saving techniques which have become a preoccupation in your everyday life.

You will soon realize that your problems are not unique. By hearing the experiences shared at meetings, you will no longer think you are the "worst person on earth" and beyond all help. There will be stories worse than yours and some not quite as bad. You will realize that gambling has caused many problems in your life and Gamblers Anonymous is the solution to those problems. In Gamblers Anonymous you will find people who truly understand you and what you have been going through – people who have faced the same obstacles and are learning how to overcome them.

While gambling, your perception of others was narrow, distorted and unrealistic. By listening to other members, you will learn ways of thinking and living you had not thought possible. In the program, you will be able to set attainable goals and develop acceptable values using the examples and guidance of other Gamblers Anonymous members who have turned their lives around.

We all welcome you to your first Gamblers Anonymous meeting.

- **Think the bet all the way through** and weigh the consequences. Most of us don't consider the possibility that if we gamble, we might lose. Consider the possibility that you will lose. Think of all the other times you have lost. **All forms of gambling are losing propositions.** You will probably lose again. Will losing this money – in addition to money already lost and problems you already have – really make you feel better? And if you were to win, what would happen to the money? What has happened to all the money from past winnings? Where is it? What is the cause of your current financial situation? **Isn't it gambling that has put you in this predicament?** Can't you see yourself betting away any winnings – PLUS MORE? Isn't it true that with a win you might pay off a few bills, yet set aside some cash for MORE GAMBLING? Isn't it true that any winnings would be used as ammunition to keep waging the war of gambling?
- **Write about the pros and cons of gambling in your life.** Take a sheet of paper and divide it into two columns. On the left side, list all the good things that gambling has given you. On the right side, list all the bad things that have happened to you as a result of your gambling. Be thorough and honest. (Note: You may want to rate each item from 1 - 10 in terms of importance, with 10 being the most important and 1 being the least. When you're through, total up each column and compare the score.) Once the list is complete, use this tool as a reminder of the effects of gambling on your life.
- Make a decision about **how you will spend your free time** instead of gambling.
- Make a decision that you won't gamble **JUST FOR TODAY!**

Again, these are all merely suggestions. Why not figure out the ones that will work best for you?

GAMBLERS ANONYMOUS
INTERNATIONAL SERVICE OFFICE
P.O. BOX 17173
LOS ANGELES, CALIFORNIA 90017
PHONE: (213) 386-8789
FAX: (213) 386-0030
WEBSITE: www.gamblersanonymous.org
E-MAIL: isomain@gamblersanonymous.org

FOR MEETING INFORMATION
IN YOUR AREA CALL
(888) GA-HELPS
(888) 424-3577

A37
REVISED 9/00
PRINTED 3/09

GAMBLERS ANONYMOUS

Suggestions for Coping with Urges to Gamble

Many compulsive gamblers, especially those in early stages of recovery, experience urges to gamble. Repetition of the gambling behavior over a relatively long period of time, combined with thoughts of gambling and associated pleasurable feelings, causes the compulsive gambler to experience cravings. Sometimes these urges to bet are so intense and overpowering that they cause the gambler to relapse.

Following are some suggestions to cope with urges to gamble.

SUGGESTIONS TO PREVENT URGES FROM OCCURRING

- **Attend Gamblers Anonymous meetings as often as needed**, but at least once a week.
- Become more involved in the Gamblers Anonymous Program. **Take a Trusted Servant position.**
- **Telephone other GA members on a regular basis.**
- **Read and re-read the Gamblers Anonymous Combo Book.** Many GA members have said "Everything I need to stay away from a bet is right here in this little yellow book."
- **Ask another Gamblers Anonymous member to be your sponsor.**
- **Read and LIVE the Gamblers Anonymous Steps of Recovery.** At first, it is OK to have a healthy skepticism about working the Steps. However, thousands of GA members have reported that the more they become involved in the Steps of Recovery, the less likely they are to gamble. It is suggested that you ask another GA member – preferably your sponsor – to help guide you through the Steps.
- **Don't go in or near establishments where gambling is available**, including web sites on the Internet. Shop in stores or supermarkets that are gambling-free or where gambling is out of sight
- **Don't look at anything that will remind you of gambling** – for example, the sports or stock market sections of the newspaper, lottery tickets, racing programs, or advertisements for casinos or other forms of gambling.
- **Don't associate with people who gamble.** (This may mean curtailing relationships with friends or relatives.)
- **Avoid getting caught up in conversations about gambling.**
- **Carry only the bare minimum amount of money that you need for the day.** If possible, have your **paycheck direct-deposited** or put someone you trust in charge of your finances. **Destroy your credit, debit, and ATM cards** – anything that will put a barrier between you and excess cash.
- **Establish an anniversary date** – that is, your first Gamblers Anonymous meeting after your last bet. Many GA members gain a healthy inner confidence from knowing that they have acquired the habit of not wagering over time.
- **Change your attitude.** There is a world of difference in the statements "I have to stop gambling" and "I want to stop gambling." Think about it. If you *have* to do anything, then you probably won't *want* to.
- **Change your behavior.** This is one of the most difficult tasks in all of human endeavors, let alone in the Gamblers Anonymous Program. However, it states in the yellow combo book that it is necessary for a compulsive gambler to bring about a character change in order to prevent a relapse. GA members have reported that character defects such as anger, impatience, laziness, self-pity, etc., have led them back to gambling. Replacing negative habits with healthy ones is vital for maintaining abstinence.

- **Consider getting your body into better physical condition.** It has been said, "Bring the body and the mind will follow." If compulsive gambling is a sickness of the mind, then it makes sense for a compulsive gambler to be in relatively good physical condition. Remember the saying: "Healthy body, healthy mind."

SUGGESTIONS FOR WHEN YOU HAVE AN URGE TO GAMBLE

- First acknowledge the urge. Become acutely aware of it – how you feel and what is going on in your mind. Then say to yourself, "Oh, OK. I am now having an urge to gamble. Right now I want to gamble. **TOO BAD I DON'T GAMBLE ANYMORE."**
- OK. So your urge to gamble is very strong. Again, acknowledge the urge and become aware of what is happening and say to yourself, "OK, maybe I'll gamble in 10 minutes." **Wait 10 minutes.** If the urge is still there, say to yourself, "OK, maybe I'll gamble in another 10 minutes." Then find something else to do for 10 minutes. If the urge persists, **keep putting off gambling for 10-minute stretches.** Keep doing this. The urge to gamble will pass.
- **Make believe your mind is a slide projector** and the thoughts that enter your brain are slides. Go to a quiet place, close your eyes and **CHANGE THE SLIDE!** Refuse to entertain thoughts about gambling. Think about a family member, a loved one, your job, a pleasant activity – anything but gambling. You can do it if you quiet your mind and concentrate.
- **Accept the fact that you cannot gamble safely.** This may seem painfully obvious, but many GA members have reported relapsing after having debated mentally with themselves on this point. Among some of the common inner arguments: "It'll be different this time," "I'm not that bad yet," "I'll quit once I get even," and "I'm due." **Acceptance is one of the key components of the GA program.**
- **Say the Serenity Prayer:** "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference." Repeat the prayer until the urge dissipates. A quieting of the mind will quiet the urge to gamble.
- **Work Recovery Steps Two and Three.** Envision yourself giving the urge to gamble to a Higher Power. Many GA members live by the saying, "Let go and let God."
- **Go to a Gamblers Anonymous meeting regardless of the way you feel.**
- Go to a quiet place and **meditate.** One simple method might be to close your eyes and stare out into space, visualizing the urge as a concrete object (it doesn't matter what it is). Concentrate on it for several minutes. As you hold the object in your mind, visualize it breaking up into tiny pieces. Your urge to gamble will disintegrate with it.
- **Telephone someone you trust.** Tell him or her about your urge to gamble.
- Leaving cash, checks, and credit cards behind, go and **meet with someone.**
- Stop dwelling on the urge. Get outside of yourself. **Go and help someone else.**

101 Federal Street Boston, MA 02110
800-426-1234

WELCOME

We congratulate and respect your decision to enroll in the MA Voluntary Self Exclusion (VSE) Program. VSE is intended to offer you one means of addressing problem gambling behavior, as well as an opportunity to make a positive change in your life.

Enrolling in the Voluntary Self-Exclusion Program was no doubt a difficult decision. Please know that we are here to support you by providing information, as well as referrals to resources and treatment providers.

Enclosed in this package are materials that will:

- Aid your understanding of problem gambling
- Help you understand the VSE process
- Answer commonly-held questions about VSE

If you still have questions after reading the enclosed materials, do not hesitate to call a VSE coordinator or designated agent at:

(VSE Enrollment & Information Line: 617-533-9737)

(Mass. Council Helpline: 800-426-1234)

101 Federal Street Boston, MA 02110
800-426-1234

Frequently Asked Questions about VSE Enrollment

What am I excluded from?

During the period of your exclusion, you will not be allowed to enter the gaming floor of any Massachusetts casino. The information you have provided will be given to security personnel, MGC Agents, as well as our GameSense Advisors. If you enter a gaming area and are identified, you may be asked to leave or be escorted from the building by security personnel.

What happens if I am in a gaming area and win while in the Self-Exclusion Program?

If you are in the casino gambling and win while on the Self-Exclusion list, you will not be eligible to collect your winnings. If you attempt to claim a prize, it will not be paid.

Can I keep my rewards points?

To reduce the temptation to return to the casino, your reward points will be forfeited and marketing materials directed to you will be suspended as well.

When does my Self-Exclusion expire?

The Self-Exclusion period begins the moment you meet with a designated agent, complete and submit the enrollment form. Depending on the term of exclusion you selected, your period of Self-Exclusion would expire 6 months, 1 year, 2 years, 3 years, or 5 years from the day you completed the form.

Do I need to re-enroll after the date of expiration?

If you wish to remain in the program: You can, but it is not necessary to re-enroll. Your name will remain within the Voluntary Self-Exclusion database the Massachusetts Gaming Commission shares with its Gaming Licensees until you submit a petition for removal.

If you wish to un-enroll from the Voluntary Self-Exclusion Program: You will need to participate in an exit session with a designated agent from the Massachusetts Council on Compulsive Gambling, or another authorized agent. The exit session will include discuss: Risks and Responsibility Factors; Responsible Gaming Tips; and Access to Resources should you feel you need them at any time in the future.

I've changed my mind. Can I opt out of the Voluntary Self-Exclusion Program before my term expires?

Unfortunately, you cannot opt out of the term of Self-Exclusion that you selected before it is set to expire. This is intended as a service to help you honor the commitment you made to the VSE program.

Region B DPH Outpatient Counseling Services

Berkshire, Franklin, Hampden, and Hampshire Counties

The Gandara Center
2155 Main Street **Springfield**, MA 01104
Referral Contact: Jaime Maldonado
(413) 732-2120 ext. 210 or *Renee Pinero x203*
Clinicians available who are fluent in Spanish

OTHER TREATMENT SERVICES

Holyoke Medical Center
The Center for Behavioral Health
Partial Hospitalization and Intensive Outpatient Program (PHP/IOP)
575 Beech Street
Holyoke, MA 01040
Central Intake: 413-534-2627
Referral Contact: Sara Taylor 413-540-5013

Counseling available to anyone concerned about gambling; those who gamble, their families and/or significant others.
Treatment available regardless of insurance coverage.
Translation services should be available upon request. For assistance, contact Omar Cabre a at 617-624-5089 (DPH).

Region B Private Practice List

Berkshire, Franklin, Hampden, and Hampshire Counties

Geoffrey W. Locke, PhD. LICSW, CADAC, CAS
48 N. Pleasant St., #205
Amherst, MA 01007
413-253-8900

Natalie Lavallee, LMHC, MA PGS
Therapeutic Connection
264 N. Main St. Suite 13
E. Longmeadow, MA 01028
(P) 413-525-1711 x5
(F) 413-525-1770

Eunice Aviles, PsyD, LMHC, MA PGS
3 locations:
1. Brightwood Health Center, 380 Plainfield St., **Springfield**, MA
2. 26 South Prospect St., Suite 19, **Amherst**, MA 01002
3. 57 Mulberry St., **Springfield**, MA 01105
(P) 413-657-6104 – same for all locations
(F) 413-737-3655 – same for all locations

Financial Resource Referrals

General information
http://www.massresources.org/credit-counseling.html

Self-Management of Finances

Mint.com
https://www.mint.com/

Moneywise
http://www.moneywise.com/

Credit Counseling Agencies
American Credit Counseling Service, Inc. **
Community Service Since 1988
4 Taunton Street, Suite 5 Plainville, MA 02762 Toll Free (800) 729-0551 -- Fax: (508) 695-0148
http://www.accs.org/

American Consumer Credit Counseling http://www.consumercredit.com
130 Rumford Ave #202
Auburndale, MA
(617) 559-5700

Cambridge Credit Counseling http://www.cambridge-credit.org/
67 Hunt St #305
Agawam, MA
(800) 527-7595

Money Management International http://www.moneymanagement.org/About-Us/Locations.aspx
Main number (866) 226-0278

Massachusetts Branches -Boston
31 Milk St.
Boston, MA 02109
(508)993-1002

Bankruptcy Lawyer referral

Timothy Mauser

11 Beacon St. suite 605

Boston, MA 02108

617.338.9080

GA Pressure Relief

Go to a GA meeting and ask about how to schedule a Pressure Relief meeting.

Casino Self-Exclusion Guidelines

Twin River Casinos
100 Twin River Road
Lincoln, RI 02865
(401) 475-8400

- A person must be physically present at the casinos to request self-exclusion
- Self-Exclusion is managed by the facility security
- A picture and form must be completed.
- A person can choose length of time for self-exclusion
- Self-exclusion is a non-reversible agreement.

Foxwoods Resort and Casinos
350 Trolley Line Boulevard
Mashantucket, CT 06338
(860) 312-3000

- A person ***does not*** have to be physically present at the casinos to request self-exclusion
- Self-Exclusion is managed by the Casino's Inspection Division which is part of their Gaming Commission
- A notarized form must be completed and submitted.
- A person can choose 5-years or lifetime exclusion.
- A letter from the casino will be sent in order to make the exclusion official
- Self-exclusion is a non-reversible agreement.

Mohegan Sun Resort and Casinos
1 Mohegan Sun Boulevard
Montville, CT 06382
(888) 226-7711

- A person ***does not*** have to be physically present at the casinos to request self-exclusion
- Self-Exclusion is managed by the facility security
- A notarized form must be completed and submitted.
- Only ***lifetime exclusion*** available.
- A letter from the casino will be sent in order to make the exclusion official
- Self-exclusion is a non-reversible agreement.

Massachusetts Council on
Compulsive Gambling

We understand the problem. We can help.

RESOURCES

Revised 3/5/2014

Resource	Telephone	Web Address
TWELVE STEP PROGRAMS		
Gamblers Anonymous Hotline	855-222-5542*	
National	626-960-3500	gamblersanonymous.org
Connecticut	855-222-5542*	
Massachusetts	888-830-2271	
Western Massachusetts Hotline	855-222-5542*	
New York State	877-846-7369	
New York City (Long Island)	877-442-4248	
New Hampshire	855-222-5542*	
Rhode Island	855-222-5542*	
Gam-anon		
National	718-352-1671	gam-anon.org
Massachusetts	888-644-8482	
Bettors Anonymous	978-988-1777	bettorsanonymous.org
Melrose	781-662-5199	
Debtors Anonymous	800-421-2383	debtorsanonymous.org
Needham	781-453-2743	
ADOLESCENTS		
Wannabet Magazine	212-722-1503	wannabet.org
Youth Gambling International (Canada)	514-398-1391	youthgambling.com
RESEARCH		
National Opinion Research (Boston Office)	617-316-3700	norc.org
Institute for Research on Gambling Disorders	978-338-6610	gamblingdisorders.org

*** If you are calling from out of state or using a phone with an out of state area code, you will be forwarded to that specific area code/state's gambling helpline even though you might not currently be in that state.**

National Council on Problem Gambling	202.547.9204	
STATE COUNCILS	Helpline #	
Alabama Council on Compulsive Gambling Inc.	800-522-4700*	alccg.org
Arizona Council on Compulsive Gambling	800-572-1142	azccg.org
Spanish	888-665-8346	
California Council on Compulsive Gambling	800-GAMBLER	calproblemgambling.org
Problem Gambling of Colorado	800-522-4700*	problemgamblingcolorado.org
Connecticut Council on Problem Gambling	800-346-6238	ccpg.org
Delaware Council on Gambling Problems	888-850-8888	dcgp.org
Florida Council on Compulsive Gambling	888-ADMIT-IT	gamblinghelp.org
Illinois Council on Problem Gambling	800-522-4700*	icpg.info
Indiana Council on Problem Gambling	800-994-8448	indianaproblemgambling.org
Kansas Coalition on Problem Gambling	800-522-4700*	ksgamblinghelp.com
Kentucky Council on Problem Gambling	800-426-2537	kycpg.org
Louisiana Association on Compulsive Gambling	800-770-7867	helpforgambling.org
Problem Gambling Council of Maryland	800-522-4700*	ncpgambling.org
Massachusetts Council on Compulsive Gambling	800-426-1234	masscompulsivegambling.org
Michigan Association on Problem Gambling	800-270-7117	michapg.com
Minnesota-North star Alliance on Problem Gambling	800-333-4673	northstarproblemgambling.org
Mississippi Council on Problem & Compulsive Gambling	888-777-9696	msgambler.org
Missouri Council on Problem Concerns	888-238-7633	888betsoff.com
Montana Council on Problem Gambling	800-900-9979	mtcpgambling.com
Nebraska Council on Compulsive Gambling	800-560-2126	nebraskacouncil.com
Nevada Council on Problem Gambling	800-522-4700*	nevadacouncil.org
Council on Compulsive Gambling of New Jersey	800-426-2537	800gambler.org
New Mexico Council on Problem Gambling	800-572-1142	nmcpg.org
New York Council on Problem Gambling	518-867-4084	nyproblemgambling.org
North Carolina Council on Problem Gambling	800-522-4700*	Nccouncilpg.org
Ohio Council on Problem Gambling	800-522-4700*	ohiocpg.org
Oklahoma Council on Problem & Compulsive Gambling	800-522-4700*	oapcg.org
Oregon Council on Problem Gambling	800-233-8479	oregoncpg.com
Council on Compulsive Gambling of Pennsylvania	800-848-1880	pacouncil.com
Rhode Island Council on Problem Gambling	877-942-6253	ricpg.net
Texas Council on Problem & Compulsive Gambling	800-522-4700*	
Utah-Idaho Council on Problem Gambling	800-522-4700	
Vermont Council on Problem Gambling	800-522-4700*	vcpg.org
Virginia Council on Problem Gambling (802-463-9557)	800-522-4700*	vacpg.org

WashingtonState Evergreen Council on ProblemGambling	800-547-6133	evergreencpg.org
Wisconsin Council on Problem Gambling	800-426-2535	Wi-problemgamblers.org

*** If you are calling from out of state or using a phone with an out of state area code, you will be forwarded to that specific area code/state's gambling helpline even though you might not currently be in that state.**

AGENCY NUMBERS		
Alcoholics Anonymous Boston	617-426-9444	aa.org (national)
Al-Anon	757-563-1600	al-anon.org (national)
Al-Anon – Massachusetts	508-366-0556	
Alcohol and Drug Hotline	800-327-5050	
Battered Women's' Hotline (Cambridge) Safelink	617-661-7230	
Child at Risk Hotline (DHHS MA)	800-792-5200	
Elder Abuse Hotline	800-922-2275	
MA Coalition for the Homeless Safelink	781-595-7570	
MA Substance Abuse Information and Education Helpline	800-327-5050	
TTY	888-448-8321	
National Domestic Violence Hotline	800-799-7233	
TTY	800-787-3224	
National Sexual Assault Hotline	800-656-4673	
Overeaters Anonymous	505-891-2664	
Rape Crisis: Cambridge	617-492-8306 800-841-8371	
Samaritans	877-870-4673	
GENERAL RESOURCES		
Attorney General, MA	617-727-2200	
TTY	617-727-4765	
Bar Association Lawyer Referral (MA)	866-627-7577	
Boston	617-654-0400	
TTY	617-338-0585	
Department of Revenue (Richard Claytor)	774-299-6570	mass.gov/dor/
Dep't of Revenue – Child Support Enforcement Division	617-626-4158	
Cambridge Health Alliance Division on Addictions	781-306-8600	
Consumer Credit Counseling	866-889-9347	creditcounseling.org
Consumer Hotline (MA Attorney General)	617-727-8400	
National Foundation for Credit Counseling English	800-388-2227	
Spanish	800-682-9832	
National Endowment for Financial Education	303-741-6333	nefe.org
NCAA Agent, Gambling and Amateurism Activities	317-917-6222	
GAMBLING RESOURCE NUMBERS		

Massachusetts Lottery	781-849-3141	
CONNECTICUT CASINO SELF-EXCLUSION		
Foxwoods-Mashantucket Gaming Commission	860-312-3091	
Mohegan Sun Security	860-862-7698	

Massachusetts Council on Compulsive Gambling
190 High Street, Suite 5
Boston, MA 02110
617.426.4554 (office)
800.426.1234 (helpline)
masscompulsivegambling.org

REGION C

Congratulations

We deeply respect your decision to enroll in the MA Voluntary Self-Exclusion (VSE) Program. VSE is intended to offer you one means of addressing problem gambling behavior, as well as an opportunity to make a positive change in your life.

Enrolling in the Voluntary Self-Exclusion Program was no doubt a difficult decision. Please know that we are here to support you by providing information, as well as referrals to resources and treatment providers.

Enclosed in this package are:

- Materials to aid in your understanding
- Resources to help manage your gambling
- Answers to commonly-held questions about VSE

If you still have questions after reading the enclosed materials, do not hesitate to call a VSE coordinator or designated agent at:

VSE Enrollment & Information Line: (617) 533-9737

The Problem Gambling Helpline: (800) 426-1234

MASSGAMING

Massachusetts Council on COMPULSIVE GAMBLING
We understand the problem. We can help.

GameSense

Frequently Asked Questions about VSE Enrollment

"Where exactly am I excluded from?"

During the period of your exclusion, you will not be allowed to enter the gaming floor of any Massachusetts casino. The information you have provided will be given to casino personnel, MGC Agents, as well as our GameSense Advisors. If you enter a gaming area and are identified, you may be asked to leave or be escorted from the building by security personnel.

"What happens if I am in a gaming area and win while enrolled in a Self-Exclusion Program?"

If you are in the casino gambling and win while on the Self-Exclusion list, you will not be eligible to collect your winnings. If you attempt to claim a prize, it will not be paid.

"Can I keep my rewards points?"

To reduce the temptation to return to the casino, your reward points will be forfeited and marketing materials directed to you will be suspended as well.

"When does my Self-Exclusion expire?"

The Self-Exclusion period begins the moment you meet with a designated agent, complete and submit the enrollment form. Depending on the term of exclusion you selected, your period of Self-Exclusion would expire 6 months, 1 year, 3 years, or 5 years from the day you completed the form.

"Do I need to re-enroll after the date of expiration?"

If you wish to remain in the program: You can, but it is not necessary to re-enroll. Your name will remain within the Voluntary Self-Exclusion database the Massachusetts Gaming Commission shares with its Gaming Licensees until you submit a petition for removal.

If you wish to un-enroll from the Voluntary Self-Exclusion Program: You will need to participate in an exit session with a designated agent from the Massachusetts Council on Compulsive Gambling, or another authorized agent. The exit session will include discuss: Risks and Responsibility Factors; Responsible Gaming Tips; and Access to Resources should you feel you need them at any time in the future.

"I've changed my mind. Can I opt out of the Voluntary Self-Exclusion Program before my term expires?"

Unfortunately, you cannot opt out of the term of Self-Exclusion that you selected before it is set to expire. This is intended as a service to help you honor the commitment you made to the VSE program.

"Where can I find more information about getting help?"

Please call the Problem Gambling Helpline at 800-426-1234.

"Who can I talk to about my Self-Exclusion application?"

You may call the VCS Coordinator at 617-533-9737.

MASSGAMING

Massachusetts Council on COMPULSIVE GAMBLING
We understand the problem. We can help.

GameSense

Region C
Barnstable, Bristol, Dukes, Plymouth and Nantucket Counties

Department of Public Health Counseling Services

Counseling is available to anyone concerned about gambling; those who gamble, their families and/or significant others. Treatment is made available regardless of insurance coverage. Many outpatient counseling centers are able to offer other services through programs offered in the center. Translation services should be available upon request. For translation requests please first contact the center or you may contact Omar Cabrera at the Department of Public Health at 617-624-5089.

Southern New England Behavioral Health & Trauma Center
140 Park St. Attleboro, MA 02703
Referral Contact: Tony Levesque
(508) 226-1660 Ext. 213

Stanley Street Treatment & Resources, Inc.
386 Stanley Street, Fall River, MA 02720
Referral Contact: Robin Quinterno
(508) 235-7020

Steppingstone, Inc. Outpatient Treatment Services
279 N. Main Street, Fall River, MA 02720
Referral Contact: Lisa Rogers
(508) 679-0033

Clinicians in Private Practice

Private practice clinicians operate independently of any counseling organization. Services are rendered in a private office setting and focus primarily on the individual but may also incorporate family into treatment. Each clinician offers different payment methods. Contact the private practitioner to discuss what insurances they accept or if they provide services on a sliding scale of payment. All private practice clinicians have been trained in gambling disorder and other addictions.

Linda Garvey-Dickey, LMHC, CADC1, MAPGS
51 Mill Street, Suite 8
Hanover, MA 02339
781-243-6305

Thomas Wright, D.Min., MSW, LICSW, LADC I (MA), MAPGS
765 Commonwealth Ave.
Warwick, RI 02886
508-380-2840

Financial Resource Referrals:

General Information
http://www.massresources.org/credit-counseling.html

Self-Management of Finances:

Mint.com
https://www.mint.com/

Moneywise
http://www.moneywise.com/

Credit Counseling Agencies:

American Credit Counseling Service, Inc. **
Community Service Since 1988
4 Taunton Street, Suite 5 Plainville, MA 02762 Toll Free (800) 729-0551 -- Fax: (508) 695-0148
http://www.accs.org/

Money Management International
Main number (866) 226-0278
Massachusetts Branches -Boston
31 Milk St.
Boston, MA 02109
http://www.moneymanagement.org/About-Us/Locations.aspx

Legal Resources:

Boston Bar Association Lawyer Referrals
(617) 742-0625 or Toll Free: (800) 552-7046
http://www.bostonbarlawyer.org/
Monday through Thursday, 8:30 am to 5:30 pm
Friday from 8:30 am to 5:00 pm

South Coastal Counties Legal Services
Toll-free: 1-800-244-8393

New Center for Legal Advocacy
Toll-free: 1-800-244-9023

Consumer Hotline (MA Attorney General)
617-727-8400

Trial Court Law Libraries
Librarians will assist pro-se litigants with legal research.
(617) 878-0339
(800) 445-8989

Peer Recovery Centers:

Hyannis Recovery Support Center (Opening late July 2015)
209 Main Street, Hyannis, MA 02601

Region C
Barnstable, Bristol, Dukes, Plymouth and Nantucket Counties
List of Gamblers Anonymous Meetings

Time	Location	Address	City	Notes	Day
7:30 PM	Dennis Senior Center Basement	1045 Route 134 (Rte. 6, Exit 9B · Mid Cape Hwy)	East Dennis, MA 02641	GA. Non·smoking	Wednesday
11:00 am - 12:30 pm	Christ the King Church	3 Jobs Fishing Road. (Route 151 & Jobs Fishing Road near Mashpee Commons), Parking in rear	Mashpee, MA 02649	GA. Non·smoking	Thursday
10:30 am - 12 pm	Brockton V.A. Hospital. Bldg 22	940 Belmont St, (Rte 24, exit 17)	Brockton, MA 02301	GA. Step and Topics. Regular. H	Saturday
7:45 - 9:15 PM	Caritas Good Samaritan Hospital Moakley Conference Room	235 North Pearl Street	Brockton, MA 02301	Step meeting. H. Non·smoking	Friday
7:30 PM	Mirimar Retreat House · Father Ford Ctr. First Bldg on Left. First Floor	121 Parks Street	Duxbury, MA 02332	GA. Regular. H. Non·Smoking	Monday
7:30 PM	Mirimar Retreat House · Father Ford Ctr. First Bldg on Left. First Floor	121 Parks Street	Duxbury, MA 02332	Combined meeting Non·smoking	Monday
7:30 - 9:00 PM	St. Joseph's School Rear School Building	1355 North Main . Corner of N. Main and Weetamoe Street	Fall River, MA 02720	Open. 12 Step Meeting	Tuesday
7:00 - 8:30 PM	St. Joseph the Worker Church	1 Maguan Street (Int. Rt. 14 & 58)	Hanson, MA 02341	GA. Open Meeting. H	Thursday
6:45 PM	Seven Hills Behavioral Health	26 Gifford Street	New Bedford, MA 02740	GA. Regular. H	Monday
7:00 PM	United Memorial Methodist Church	176 Somerset Avenue	Taunton, MA 02780	GA. Regular. H. Non·smoking	Thursday
12:15 PM - 1:30 PM	Cochesett United Methodist Church	517 West Center Street (Intersection of Route 106 & 24)	West Bridgewater, MA 02379	GA. Non·smoking. Open	Wednesday

Massachusetts Council on COMPULSIVE GAMBLING
We understand the problem. We can help.

GameSense

APPENDIX B: INFORMED CONSENT AND TELEPHONE SCRIPTS

INFORMED CONSENT AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH	
We try to make this form easy to understand. However, it might have words or ideas that are not clear to you. Please ask study staff to explain anything you do not understand.	
Study Title: Massachusetts Voluntary Self-Exclusion Study	
Name of Investigators: Sarah E. Nelson, PhD; Debi A. LaPlante, PhD; Heather M. Gray, PhD; Matthew Tom, PhD	
Consent form version date or number: 3	
Name and telephone number of study contact to call with questions: Sarah Nelson, 617-575-5616	
CHA IRB Number: **IRB Approval Date:** **IRB Expiration Date:**	**Study Sponsor(s):** Massachusetts Gaming Commission

You are invited to take part in a research study by Dr. Nelson and her colleagues from the Cambridge Health Alliance, the Massachusetts Gaming Commission, and the Massachusetts Council on Compulsive Gambling. The purpose of the study is to learn about how our research team can improve the voluntary self-exclusion program. We also want to learn more about the people who sign up for voluntary self-exclusion. We want the program to meet enrollees' needs. We are inviting everyone who signs up for voluntary self-exclusion to participate in this research study.

Taking part in this study is voluntary. You have the choice to take part or not. If you take part in the study, you can leave the study at any time for any reason. If you do not want to take part, you can still enroll in the voluntary self-exclusion program. If you decide to stop being in this study, you can still be in the voluntary self-exclusion program.

If you choose to participate in the study, we will give you a short questionnaire to fill out about your experiences and reasons for signing up for self-exclusion. We will give this questionnaire to you once you have signed up for self-exclusion. It will take about 15-20 minutes to complete.

In about six months, if you give us consent to, we will contact you by telephone or email with another questionnaire or interview. We want to learn about your experiences since you self-excluded. That questionnaire/interview will take about 30 minutes. We will also mail you a reminder prior to that contact so that you can update your email address or telephone number if it has changed. If you consent to follow-up, we might also contact you more than six months from now to see if you want to continue to participate in the study.

If you complete the baseline questionnaire today, we will give you a $15 gift card. If you complete the 6-month questionnaire/interview, we will mail you a $25 gift card at that time.

Please check yes in the box below if you consent to be contacted in six months to see if you want to participate in a follow-up interview. If you do not check the 'yes' box, we will not contact you in six months. You can still participate in the study if you do not check 'yes'.

☐ **yes** ☐ **no** I consent to have the study team contact me in six months to see if I want to participate in a follow-up interview.

If you give us consent to, we will also look at some of your records for this study. We will look at you self-exclusion application. If you have a player card you have used at Plainridge Park Casino, we will use the records from your card in this study. If you have used Play Management at Plainridge Park Casino, we also will look at those records. We will look at these records from when you started gambling at Plainridge until the end of the study period. We will do this so we can learn more about how people gamble before they sign up for self-exclusion.

Please check yes in the boxes below if you consent to have the study team look at your self-exclusion application and player card records. If you do not check the 'yes' boxes, we will not access these records. You can still participate in the study if you do not check 'yes'.

☐ **yes** ☐ **no** I consent to have the study team access my self-exclusion application.

☐ **yes** ☐ **no** I consent to have the study team access my player card records.

This research is not designed to benefit you directly. However, what we learn might help others in the future. We want to improve the self-exclusion process. Your participation in this study will help us do that.

A potential risk of participating in this study is that the questions might upset you. Below, we tell you how to contact someone if you feel emotional discomfort or embarrassment. We appreciate that some of the questions we ask might be sensitive and the information you share with us is confidential. We will make every effort to keep all of your information private and confidential. We will not include any information that could identify you in any publication. The study database will not have your identifiable information (name, address, telephone number, *etc*.) in it. We will use a unique ID# to identify you within the data files. We will keep your identifiable information separate from your data. We only will use your identifiable information to contact you for your 6-month follow-up and to get your records, if you consent to those procedures. People on the research team looking at your data in the study database will not be able to see that it belongs to you. A separate file will link your contact information to your study ID#. The research team will only look at that file when trying to contact you.

If you decide to take part in this study, you need to sign this form. We will give you a copy of the signed form. Please keep your copy for your records. If you choose to take part and then decide to stop, call the study investigator at the number on the front of this form. We will use any information collected from you <u>before</u> the date you leave the study.

If you have questions about this study please ask study staff. You can also speak to study staff if you feel uncomfortable with any of the questions or would like more information about resources to help address gambling-related problems. You also can call the study investigator, Dr. Sarah Nelson, at 617-575-5616 for answers to any

study-related questions. That number will be checked on nights and weekends, as well as during normal business hours. The study investigator can also refer you to Dr. Howard Shaffer, a licensed clinician on the study team, if you have further concerns. If you have questions about your rights as a study participant please contact the IRB office. This office is open Monday to Friday (not holidays) from 8:30am until 5:00pm:

IRB Chair: **Dr. Lior Givon** 617-806-8702

Confirmation from Person Obtaining and Documenting Consent

I, the study participant, have read this form or it has been read to me. I understand my part in this study and have had my questions answered to my satisfaction. I agree to take part in this research study.

_____ _____

Participant's Signature Date

I have informed the study participant, _____ of the procedures, purpose, and risks related to participation in the above-described study, how his/her information may be used, shared, and reported, and his/her privacy rights. The study participant has been provided with a signed copy of this form.

_____ _____

Signature of Researcher Obtaining Consent Date

_____

Printed Name of Researcher Obtaining Consent

This form is valid only if it has the IRB stamp of approval.

Massachusetts Voluntary Self-Exclusion Program (MA-VSEP) Study

Telephone Script and Oral Consent Procedure

Interviewer: Good (morning, afternoon, evening), may I please speak with (insert intended recipient)

[Recipient is available]

Interviewer: Good (morning, afternoon, evening). My name is (insert name), and I am calling on behalf of the Cambridge Health Alliance, Division on Addiction. We are doing a research study on the Massachusetts Voluntary Self Exclusion Program. When you enrolled in Voluntary Self Exclusion, you gave the Massachusetts Gaming Commission permission to share your contact information with us to contact you about possibly participating in the study.

The purpose of this study is to hopefully learn how to improve your experience with the voluntary self-exclusion program and the experience of those in a similar situation who might decide to enroll in the program. I was wondering if you had a couple minutes to talk further about the purpose of the study and what is involved?

(If potential participant is unsure) I just want to let you know that your participation is completely voluntary and I understand if you have some concerns. If you had 2 minutes, would you mind if I read off a more detailed description of the study, that way you can make an informed decision? If you're still not interested, I totally understand and we will take you off of our list.

[Interviewer proceeds with oral informed consent, below]

So I understand that was a lot of information. Do you have any questions?

[Recipient is not available; Leave following message]

Interviewer: I would like to inform him/her that Cambridge Health Alliance called about participating in a brief interview. S/he can call back at 617-575-XXXX or we will call back within one week. Thank you for your time.

Oral Informed Consent

Principal Investigator: Sarah Nelson, PhD - snelson@hms.harvard.edu 617-575-5616
Division on Addiction, Cambridge Health Alliance
101 Station Landing Suite 2100 Medford, MA 02155

We would like to invite you to take part in a research study being conducted by the Division on Addiction at Cambridge Health Alliance in collaboration with the Massachusetts Gaming Commission, and the Massachusetts Council on Compulsive Gambling. The purpose of the study is to learn about how our research team can improve the voluntary self-exclusion program. We also want to learn more about the people who sign up for voluntary self-exclusion. We want the program to meet enrollees' needs. We are inviting everyone who signs up for voluntary self-exclusion to participate in this research study.

Taking part in this study is voluntary. You have the choice to take part or not. If you take part in the study, you can leave the study at any time for any reason. If you choose to participate in the study, we will give you a short questionnaire to fill out about your experiences during and reasons for signing up for self-exclusion. It will take about 10-20 minutes to complete. You can do it on the phone now or we can set up a different time [*if nec:* or you can do it online]. If you complete the baseline questionnaire, we will mail you a $15 Dunkin' Donuts gift card.

If you agree, in about six months from when you signed up for self exclusion, we will contact you by telephone or email with another survey. That survey will take about 30 minutes. We might also mail you a reminder prior to that contact so that you can update your email address or telephone number if it has changed. We might also contact you more than six months from now to see if you want to continue to participate in the study. If you complete the 6-month questionnaire/interview, we will mail you a $25 gift card at that time.

Finally, if you agree, we will look at some of your records for this study. We will look at your self-exclusion application. If you have a player card you have used at Plainridge Park Casino, we will use the records from your card in this study. [*Once operational:* If you have used Play Management at Plainridge Park Casino, we also will look at those records.] We will look at these records from when you started gambling at Plainridge until the end of the study period. We will do this so we can learn more about how people gamble before they sign up for self-exclusion. Your name will not be attached to the records.

This research is not designed to benefit you directly. However, what we learn might help others in the future. We want to improve the self-exclusion process. Your participation in this study will help us do that.

We appreciate that some of the questions we ask might be sensitive and the information you share with us is private. We will make every effort to keep all of your information private and confidential. We will not include any information that could identify you in any publication. The study database will not have your identifiable information (name, address, telephone number, *etc*.) in it. We will use a unique ID# to identify you within the data files. We will keep your identifiable information separate from your data. We only will use your identifiable information to contact you for your 6-month follow-up and to get your records. People on the research team looking at your data in the study database will not be able to see that it belongs to you. A separate file will link your contact information to your study ID#. The research team will only look at that file when trying to contact you.

Are you willing to do the questionnaire part of the study?

Yes ☐ No ☐

Are you willing to have us contact you in the future about the study?

Yes ☐ No ☐

Are you willing to let us access your self-exclusion and Plainridge records?

Yes ☐ No ☐

_____
Participant's Name

_____
Signature of Researcher Obtaining Consent

_____
Date

Do you have any other questions about the study?

Can you do the interview now?

[Recipient says "yes". Complete the MA SE Remote Baseline Survey]

Thank you. Now I would like to get a little bit of contact information from you so we can get in touch for the follow-up interview at a later time.

[Complete the VSEP Study Contact Information Sheet]

Thank you for your time. We can either email or mail your gift card to you. We will also include a sheet with study information so you can get in touch with us later if you need to.

[Recipient says "no". Schedule an alternate time to complete MA SE Remote Baseline Survey. Complete the VSEP Study Contact Information Sheet.]
[Complete the MA SE Remote Baseline Survey at next scheduled appointment]

OR

[Recipient says "no". If they don't have time to ever do it over the phone, offer to email them the link or mail the survey. Complete the VSEP Study Contact Information Sheet.]

[Send following email or letter with link to or paper copy of MA SE Remote Baseline Survey:]

Email or Letter
Thank you for agreeing to participate in our survey. [You will find attached a link to the survey. You will find the survey attached.]. It will take 10-20 minutes to complete. Your Study ID # is [XXX]. Please complete the survey at your earliest convenience. [We have provided a self-addressed stamped envelope so you can easily mail it back to us.] When we receive the completed survey, we will [mail you/email you] a $5 Dunkin' Donuts gift card. Thank you for your time!

APPENDIX C: BASELINE SURVEY AND FOLLOW-UP INTERVIEW

MA-VSEP Study Baseline Assessment **ID#_____**

Voluntary Self Exclusion

1. How did you hear about the Voluntary Self-exclusion program? (click all that apply)
   - ○ A GameSense Advisor (GSA) told me about it
   - ○ A Plainridge Park Casino employee (not a GSA) told me about it
   - ○ A friend/family member told me about it
   - ○ I read about it in the newspaper
   - ○ I saw an ad on TV
   - ○ I saw an ad online
   - ○ I heard an ad on the radio
   - ○ I saw a billboard
   - ○ Another professional told me about it
   - ○ I don't know/don't remember
   - ○ Other (specify) [ ]

2. How satisfied are you with your interaction with the GameSense Advisor?
   - ○ Not at all satisfied
   - ○ Slightly satisfied
   - ○ Moderately satisfied
   - ○ Very satisfied
   - ○ Extremely satisfied

3. If you visited the GameSense Information Center (GSIC)…

   a. Did you feel that the space was private?
      - ○ Yes
      - ○ No
      - ○ N/A: I did not visit the GSIC

   b. Did you feel that the space was comfortable?
      - ○ Yes
      - ○ No
      - ○ N/A: I did not visit the GSIC

4. To what extent do you agree or disagree with each of these statements? [Check one per row.]

   My GameSense Advisor (was…)

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
a. Caring					
b. Helpful					
c. Knowledgeable					
d. Listened to me					

Gambling

5. Think about all the times you ever placed a bet for money in your lifetime—from betting on sports in an office pool, to playing cards for money with friends, buying lottery tickets, playing bingo, buying high risk stocks, playing pool or golf for money, playing slot machines, betting on horse races, and any other kind of betting or gambling. Taking all these things together, what is your best estimate of how many times you ever made a bet of any kind for money in your entire life?

   ○ Never
   ○ 1-10 times
   ○ 11-50 times
   ○ 51-100 times
   ○ 101-500 times
   ○ 501-1,000 times
   ○ More than 1,000 times

6. To the best of your knowledge, about how old were you when you placed your first bet for money?

   ☐ years old

7. Approximately how often in the past 12 months have you bet or spent money on each of the following activities?

	Never	A couple of times	Less than once a month	About once a month	A couple times a month	Weekly	A couple times a week	Daily or more
Casino / Slot Parlor Gambling								
a. Playing roulette, dice, keno, or table games (other than poker) at a casino?	○	○	○	○	○	○	○	○
b. Playing poker at a casino?	○	○	○	○	○	○	○	○
c. Betting on sports at a casino?	○	○	○	○	○	○	○	○
d. Playing slot machines, video poker machines, video keno, or other gambling machines at a casino / slots parlor?	○	○	○	○	○	○	○	○
e. Playing other types of games at a casino? (specify)	○	○	○	○	○	○	○	○
Non-Casino Gambling (non-charitable)								
f. Playing the lottery, keno, instant Lotto games, or instant scratch-off tickets (not at a casino or slots parlor)?	○	○	○	○	○	○	○	○
g. Betting on sports with friends or in an office pool?	○	○	○	○	○	○	○	○
h. Betting on sports with a bookie or with parlay cards?	○	○	○	○	○	○	○	○
i. Betting on horse or dog races?	○	○	○	○	○	○	○	○
i. Betting on dog or cock fights?	○	○	○	○	○	○	○	○
k. Playing games of physical skill for money, such as pool, golf, or bowling?	○	○	○	○	○	○	○	○
l. Day trading (e.g., stocks, commodities, etc.)	○	○	○	○	○	○	○	○
m. Playing poker, chess, or other game of mental skill for money (not at a casino)?	○	○	○	○	○	○	○	○
n. Playing slot machines, video poker machines, or other gambling machines (not at a casino or slots parlor)?	○	○	○	○	○	○	○	○
o. Playing fantasy sports (for money)?	○	○	○	○	○	○	○	○
p. Gambling on the Internet (for money - other than fantasy sports)?	○	○	○	○	○	○	○	○
q. Other type of non-charitable non-casino gambling? (specify)	○	○	○	○	○	○	○	○
Charitable Gambling (not for profit)								
r. Gambling at a non-profit gathering/event (e.g., church bingo game, fundraiser, raffle, etc.)	○	○	○	○	○	○	○	○
s. Gambling at a recurring charitable tournament or charitable poker room (e.g., Rockingham Park)	○	○	○	○	○	○	○	○

8. How often do you drink alcohol or use other drugs while gambling?

   ○ Never/seldom
   ○ Sometimes
   ○ Often
   ○ Always

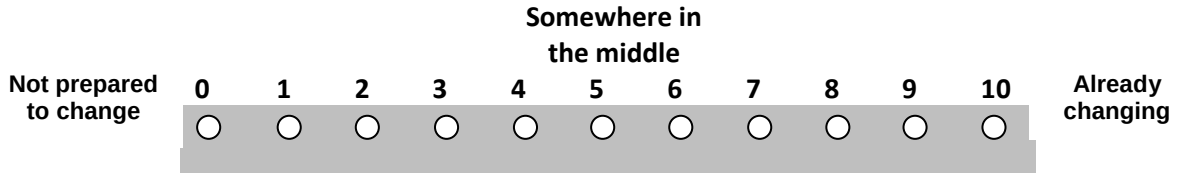
9. In the past 12 months, have you had any of the following experiences associated with your gambling? Please answer 'yes" or "no" for each one:

	Yes	No
a. In the past 12 months, did you ever gamble to get out of a bad mood – like feeling nervous, sad, or down?	○	○
b. In the past 12 months, did you ever gamble to forget your problems?	○	○
c. In the past 12 months, did you try to quit or cut down on your gambling, but found you couldn't do it?	○	○
d. In the past 12 months, did you ever find that you had to increase the amount of money you would gamble to keep it exciting?	○	○
e. In the past 12 months, did you ever spend a lot of time thinking about gambling, planning your bets, or studying the odds?	○	○
f. In the past 12 months, did you ever spend a lot of time thinking about ways to get money together so you could gamble?	○	○
g. In the past 12 months, did you ever spend a lot of time thinking about the times when you won or lost?	○	○
h. In the past 12 months, did you ever have job or school trouble because of your gambling – like missing too much work, being demoted at work, losing your job, or dropping out of school?	○	○
i. In the past 12 months, did you ever break up or come close to breaking up with anyone who was important to you because of your gambling?	○	○
j. In the past 12 months, did you ever try to keep you family or friends from knowing how much you gambled?	○	○
k. In the past 12 months, did you ever have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?	○	○
l. In the past 12 months, did you ever find that you became restless, irritable, or anxious when trying to quit or cut down on your gambling?	○	○
m. In the past 12 months, did you ever raise gambling money by writing a bad check, signing someone else's name to a check, stealing, cashing someone else's check, or in some other illegal way?	○	○
n. In the past 12 months, did you ever find you had to gamble again as soon as possible after losing in order to win back your losses?	○	○
o. In the past 12 months, did you ever find you had to gamble again as soon as possible after winning in order to win more?	○	○
p. In the past 12 months, after losing money gambling, did you ever return another day soon after to try to win back your losses?	○	○

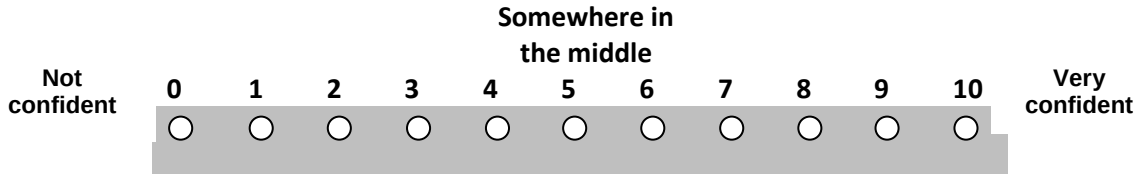
10. About how old were you the first time you began having some of these experiences associated with your gambling?

    ☐ years old

11. Using the 0 to 10 scale below, where 0 means no prepared to change and 10 means already changing, how *ready* are you to change your gambling behavior?



12. Using the 0 to 10 scale below, where 0 means no prepared to change and 10 means already changing, how confident are you in your *ability* to change your gambling behavior?



13. Please tell me the degree to which you agree or disagree with the following statements:

	Disagree strongly	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree strongly
a. A gambling machine can be lucky	○	○	○	○	○
b. Gambling is an acceptable form of entertainment	○	○	○	○	○
c. If someone keeps betting, their luck will turn around	○	○	○	○	○
d. I would support having a resort casino in my community	○	○	○	○	○
e. Gambling is dangerous	○	○	○	○	○
f. After a few losses, people are due to win	○	○	○	○	○
g. Casinos lead to increased job opportunities in an area	○	○	○	○	○
h. A gambling machine or certain numbers can be “hot” or “cold”	○	○	○	○	○
i. If a number or symbol hasn’t shown up for a while, it is due to show up	○	○	○	○	○
j. Gambling is a fun activity	○	○	○	○	○
k. Overall, the costs of having casinos in Massachusetts outweigh the benefits	○	○	○	○	○
l. People can do things that will make them luckier	○	○	○	○	○
m. I would support having a slots parlor in my community	○	○	○	○	○
n. A lucky charm can help someone win	○	○	○	○	○
o. Casinos lead to increased crime in an area	○	○	○	○	○

Health

	Poor	Fair	Good	Very Good	Excellent
14. How would you rate your overall physical health – poor, fair, good, very good, or excellent?	○	○	○	○	○
15. How would you rate your overall mental health – poor, fair, good, very good, or excellent?	○	○	○	○	○

16. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Having little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Feeling much more anxious or worried than most people	○	○	○	○
d. Feeling so nervous that nothing could calm you down	○	○	○	○

Experiences

	Yes	No
17. During the past 12 months, have you experienced the death of a family member, friend, significant other or loved one?	○	○
18. During the past 12 months, have you had to cope with the illness or injury of a family member, friend, significant other, or loved one?	○	○
19. During the past 12 months, have you had a difficult conflict with a family member, friend, significant other, or loved one?	○	○
20. During the past 12 months, have you experienced any major difficult changes to your living situation (e.g., divorce, foreclosure, homelessness)?	○	○
21. During the past 12 months, have you experienced the addition of a child or other family member to the household?	○	○
22. During the past 12 months, have you felt socially isolated or lonely?	○	○
23. During the past 12 months, have you been laid off or fired or had to resign unexpect-edly from a job?	○	○
24. During the past 12 months, have you had any major difficulties with your finances?	○	○
25. During the past 12 months, have you had difficulties accessing healthcare or medical services?	○	○
26. During the past 12 months, have you lost any community services or support people on whom you used to rely?	○	○

Support

	Poor	Fair	Good	Very Good	Excellent
27. (If applicable) How would you rate your overall relationship with your spouse or partner?	○	○	○	○	○
28. How would you rate your overall relationships with your immediate family?	○	○	○	○	○
29. How would you rate your overall relationships with your friends?	○	○	○	○	○

30. Please tell me the degree to which you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
a. You have people close to you who respect you and your efforts to improve your life.	○	○	○	○	○
b. You have people close to you who understand your situation and problems.	○	○	○	○	○
c. You have people close to you who can always be trusted.	○	○	○	○	○
d. You have people close to you who motivate and encourage you in your endeavors/ recovery/etc.	○	○	○	○	○
e. You have people close to you who expect you to make positive changes in your life.	○	○	○	○	○
f. You have close family members who help you stay away from gambling.	○	○	○	○	○
g. You have people close to you who help you develop confidence in yourself.	○	○	○	○	○
h. You have good friends who do not gamble.	○	○	○	○	○
i. You work in situations where gambling is common.	○	○	○	○	○

31. In your life, have you ever talked to a medical doctor or other professional about your problems with gambling? By "other professional" we mean psychologists, counselors, spiritual advisors, and other healing professionals.

○ Yes
○ No

32. In your life, did you ever call a gambling helpline for help with your gambling problems?

○ Yes
○ No

33. How many times did you call a gambling helpline in the past 12 months?

[ ] times

34. Have you ever received treatment for a mental health or substance use problem other than gambling-related problems?

- ○ Yes
- ○ No, no prior mental health or substance use problems
- ○ No, but I think I might have a mental health or substance use problem

35. Have you received any of the following kinds of treatment?

	Yes	No	If Yes: Within the past 12 months?
a. Gambling treatment program	○	○	☐
b. Inpatient alcohol/drug treatment program	○	○	☐
c. Outpatient alcohol/drug treatment program	○	○	☐
d. Inpatient mental health treatment	○	○	☐
e. Outpatient mental health treatment	○	○	☐
f. Financial counseling	○	○	☐
g. Vocational counseling	○	○	☐
h. Marital counseling	○	○	☐
i. Other service/counseling (please specify)	○	○	☐

36. Have you participated in any of the following groups?

		Most recent participation	Frequency of participation when last participated
a. Gamblers' Anonymous	○ Yes ○ No	○ 12+ months ago ○ 3-11 months ago ○ 1-2 months ago ○ Past 30 days ○ Within last week	○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
b. Other 12-step or support group (e.g., Alcoholics Anonymous, Narcotics Anonymous)	○ Yes ○ No	○ 12+ months ago ○ 3-11 months ago ○ 1-2 months ago ○ Past 30 days ○ Within last week	○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily

Demographics

37. How old are you?

☐ years old

38. How do you identify?

- ○ Man
- ○ Woman

MA-VSEP Study Follow-up Survey for MA-VSEP Enrollees

[Introduction for participants who complete survey online or via mail: They will already have participated in oral informed consent at time of baseline]

When you enrolled in the Massachusetts Voluntary Self Exclusion Program (MA-VSEP), you agreed to participate in a research study about the program. At the time that you signed up, or shortly after, you completed a short survey about your experiences.

This survey will help us understand your experiences since you signed up for the voluntary self-exclusion program. It also will help us learn how the MA-VSEP might be improved in the future.

We will not share your personal responses with Plainridge Park Casino or the Massachusetts Gaming Commission. No one but the research team will know how you responded. Your responses will not affect your self-exclusion status.

The survey will take about 30 minutes to complete, and you will receive a $25 gift card once you complete the survey.

If you have any questions or concerns about this research study, or would like more information, please contact the study investigator, Sarah Nelson, at 617-575-5616 or snelson@hms.harvard.edu.

1_1. Are you willing to participate and ready to begin the survey?

- ○ Yes, I am ready to begin the survey *[Proceed to Q1]*
- ○ No *[Proceed to Q1_2]*

1_2. Can we contact you at a later time about this survey?

- ○ Yes *[Exit]*
- ○ No *[Exit]*

ID#_____

Voluntary Self Exclusion and Gambling

1. How satisfied have you been with the Massachusetts Voluntary Self Exclusion Program (MA-VSEP)?
   - ○ Not at all satisfied
   - ○ Slightly satisfied
   - ○ Moderately satisfied
   - ○ Very satisfied
   - ○ Extremely satisfied

2. Have you gone to Plainridge Park Casino since signing up for the MA-VSEP?
   - ○ Yes
   - ○ No

[If Q2 = Yes]

3. How many times have you gone to Plainridge Park Casino since signing up for the MA-VSEP?
   - ☐ times

[If Q2 = Yes]

4. Have you tried to enter the gaming area at Plainridge Park Casino since signing up for the MA-VSEP?
   - ○ Yes
   - ○ No

[If Q4 = Yes]

5. How many times have you tried to enter the gaming area at Plainridge Park Casino since signing up for the MA-VSEP?
   - ☐ times

[If Q4 = Yes]

6. Have you been caught trying to enter the gaming area at Plainridge Park Casino since signing up for the MA-VSEP?
   - ○ Yes
   - ○ No

[If Q6 = Yes]

7. How many times have you been caught trying to enter the gaming area at Plainridge Park Casino since signing up for the MA-VSEP?
   - ☐ times

[If Q6 = Yes]

8. Briefly, what happened each time you were caught?

9. How recently did you place your last bet?

   ○ Within the last week
   ○ Within the past month
   ○ 1-2 months ago
   ○ 3-11 months ago
   ○ More than a year ago

[If Q9 ≠ More than a year ago]

10. Have you gambled at all (for example, betting on sports in an office pool, playing cards for money with friends, buying lottery tickets, playing bingo, buying high risk stocks, playing pool or golf for money, playing slot machines, betting on horse races, or any other kind of betting or gambling) since signing up for the MA-VSEP?

    ○ Yes
    ○ No

[If Q10 = Yes]

11. Approximately how often have you bet or spent money on each of the following activities ***since signing up for the MA-VSEP***?

	Never	A couple of times	Less than once a month	About once a month	A couple times a month	Weekly	A couple times a week	Daily or more
Casino / Slot Parlor Gambling								
a. Playing roulette, dice, keno, or table games (other than poker) at a casino?	○	○	○	○	○	○	○	○
b. Playing poker at a casino?	○	○	○	○	○	○	○	○
c. Betting on sports at a casino?	○	○	○	○	○	○	○	○
d. Playing slot machines, video poker machines, video keno, or other gambling machines at a casino / slots parlor?	○	○	○	○	○	○	○	○
e. Playing other types of games at a casino? (specify) ☐	○	○	○	○	○	○	○	○
Non-Casino Gambling (non-charitable)								
f. Playing the lottery, keno, instant Lotto games, or instant scratch-off tickets (not at a casino or slots parlor)?	○	○	○	○	○	○	○	○
g. Betting on sports with friends or in an office pool?	○	○	○	○	○	○	○	○
h. Betting on sports with a bookie or with parlay cards?	○	○	○	○	○	○	○	○
i. Betting on horse or dog races?	○	○	○	○	○	○	○	○
i. Betting on dog or cock fights?	○	○	○	○	○	○	○	○
k. Playing games of physical skill for money, such as pool, golf, or bowling?	○	○	○	○	○	○	○	○
l. Day trading (e.g., stocks, commodities, etc.)	○	○	○	○	○	○	○	○
m. Playing poker, chess, or other game of mental skill for money (not at a casino)?	○	○	○	○	○	○	○	○
n. Playing slot machines, video poker machines, or other gambling machines (not at a casino or slots parlor)?	○	○	○	○	○	○	○	○
o. Playing fantasy sports (for money)?	○	○	○	○	○	○	○	○
p. Gambling on the Internet (for money - other than fantasy sports)?	○	○	○	○	○	○	○	○
q. Other type of non-charitable non-casino gambling? (specify) ☐	○	○	○	○	○	○	○	○
Charitable Gambling (not for profit)								
r. Gambling at a non-profit gathering/event (e.g., church bingo game, fundraiser, raffle, etc.)	○	○	○	○	○	○	○	○
s. Gambling at a recurring charitable tournament or charitable poker room (e.g., Rockingham Park)	○	○	○	○	○	○	○	○

[If Q10 = Yes]

12. ***Since signing up for MA-VSEP***, on what type of game have you lost the most money?

- ○ Casino slot, keno, or video poker machines
- ○ Casino table games (other than poker)
- ○ Other casino games (specify) _____
- ○ Betting on sports with friends / Office pools
- ○ Betting on horse or dog races
- ○ Playing games of physical skill for money, such as pool, golf, or bowling
- ○ Playing poker, chess, or other games of mental skill for money (not at a casino)
- ○ Playing slot machines (not at a casino)
- ○ Playing the lottery, keno, instant Lotto games, or instant scratch tickets (not at a casino/slots parlor)
- ○ Playing fantasy sports (for money)
- ○ Gambling on the Internet (for money – other than fantasy sports)
- ○ Other non-charity, non-casino gambling (specify) _____
- ○ Gambling at a non-profit gathering/event (e.g., church bingo game, fundraiser, etc.

[If Q10 = Yes]

13. ***Since signing up for MA-VSEP,*** approximately how often have you *gambled at* the following locations?

	Never	A couple of times	Less than once a month	About once a month	A couple times a month	Weekly	A couple times a week	Daily or more
a. Slots parlor / casino in Massachusetts (e.g., Plainridge Park Casino)	○	○	○	○	○	○	○	○
b. Slots parlor / casino in a state neighboring Massachusetts (i.e., NH, VT, NY, CT, RI)	○	○	○	○	○	○	○	○
c. Other slots parlor / casino	○	○	○	○	○	○	○	○

[If Q10 = Yes]

14. ***Since signing up for MA-VSEP***, have you had any of the following experiences associated with your gambling? Please answer 'yes" or "no" for each one:

	Yes	**No**
a. Since signing up for MA-VSEP, have you gambled to get out of a bad mood – like feeling nervous, sad, or down?	○	○
b. Since signing up for MA-VSEP, have you gambled to forget your problems?	○	○
c. Since signing up for MA-VSEP, have you tried to quit or cut down on your gambling, but found you couldn't do it?	○	○
d. Since signing up for MA-VSEP, have you found that you had to increase the amount of money you gamble to keep it exciting?	○	○
e. Since signing up for MA-VSEP, have you spent a lot of time thinking about gambling, planning your bets, or studying the odds?	○	○
f. Since signing up for MA-VSEP, have you spent a lot of time thinking about ways to get money together so you could gamble?	○	○
g. Since signing up for MA-VSEP, have you spent a lot of time thinking about the times when you won or lost?	○	○
h. Since signing up for MA-VSEP, have you had job or school trouble because of your gambling – like missing too much work, being demoted at work, losing your job, or dropping out of school?	○	○
i. Since signing up for MA-VSEP, have you broken up or come close to breaking up with anyone who was important to you because of your gambling?	○	○
j. Since signing up for MA-VSEP, have you tried to keep your family or friends from knowing how much you gamble?	○	○
k. Since signing up for MA-VSEP, have you had such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?	○	○
l. Since signing up for MA-VSEP, have you found that you became restless, irritable, or anxious when trying to quit or cut down on your gambling?	○	○
m. Since signing up for MA-VSEP, have you raised gambling money by writing a bad check, signing someone else's name to a check, stealing, cashing someone else's check, or in some other illegal way?	○	○
n. Since signing up for MA-VSEP, have you found you had to gamble again as soon as possible after losing in order to win back your losses?	○	○
o. Since signing up for MA-VSEP, have you found you had to gamble again as soon as possible after winning in order to win more?	○	○
p. Since signing up for MA-VSEP, after losing money gambling, have you returned another day soon after to try to win back your losses?	○	○

[If Q10 = Yes]

15. ***Since signing up for MA-VSEP***, taking all of your wins and losses together, how much money, if any, have you lost due to gambling?

    $ ☐

[If Q10 = Yes]

16. ***Since signing up for MA-VSEP***, on any *one* day what is the largest amount of money you have lost gambling?

    $ ☐

[If Q10 = Yes]

17. ***Since signing up for MA-VSEP***, have you ever needed to get more money in the middle of a gambling outing? (For example, after beginning gambling, have you used an ATM or gotten a cash advance on a credit card while at a casino?)

    ○ Yes
    ○ No

[If Q10 = Yes]

18. ***Since signing up for MA-VSEP***, how often do you drink alcohol or use other drugs while gambling?

    ○ Never/seldom
    ○ Sometimes
    ○ Often
    ○ Always

19. Which of the following statements comes closest to describing your gambling behavior ***since signing up for the MA-VSEP***?

    ○ I am not gambling now and I *was* gambling before signing up for MA-VSEP
    ○ I am gambling less than I used to gamble
    ○ I am gambling more than I used to gamble
    ○ I am gambling about the same as I used to gamble
    ○ I am not gambling now and I was not gambling before signing up for MA-VSEP

[If Q10 = Yes]

20. What are the primary reasons that you currently gamble? (Check all that apply)

☐ I gamble for the feeling of excitement I get
☐ I gamble to get money I need
☐ I gamble because others around me are gambling
☐ I gamble because I have a good time
☐ I gamble because I feel lonely
☐ I gamble because it is challenging
☐ I gamble because it is an important part of my social life
☐ I gamble because I feel sad or depressed
☐ I gamble for other reasons (specify) _____

21. Using the 0 to 10 scale below, where 0 means not prepared to change and 10 means already changing, how *ready* are you to change your gambling behavior?

Not prepared to change	0	1	2	3	4	5	6	7	8	9	10	Already changing
	○	○	○	○	○	○	○	○	○	○	○	

Somewhere in the middle

22. Using the 0 to 10 scale below, where 0 means not confident and 10 means very confident, how confident are you in your *ability* to change your gambling behavior?

Not confi-dent	0	1	2	3	4	5	6	7	8	9	10	Very confi-dent
	○	○	○	○	○	○	○	○	○	○	○	

Somewhere in the middle

Health

	Poor	Fair	Good	Very Good	Excellent
23. How would you rate your overall physical health – poor, fair, good, very good, or excellent?	○	○	○	○	○
24. How would you rate your overall mental health – poor, fair, good, very good, or excellent?	○	○	○	○	○

25. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Having little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Feeling much more anxious or worried than most people	○	○	○	○
d. Feeling so nervous that nothing could calm you down	○	○	○	○

Please answer the following questions about substance use

	Have you used since signing up for MA-VSEP?	When did you last use?	How frequently have you used since signing up for MA-VSEP?	How frequently did you use in the six months before signing up for MA-VSEP?
26. Alcohol	○ No ○ Yes	○ Never ○ Before MA-VSEP sign up ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Used in last week	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
27. Tobacco	○ No ○ Yes	○ Never ○ Before MA-VSEP sign up ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Used in last week	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
28. Marijuana/ Hashish (used without medi-cal status)	○ No ○ Yes	○ Never ○ Before MA-VSEP sign up ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Used in last week	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
29. Other Illicit Drugs	○ No ○ Yes	○ Never ○ Before MA-VSEP sign up ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Used in last week	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
30. Prescription Drugs (Answer only for mis-use, abuse, or use without prescription)	○ No ○ Yes	○ Never ○ Before MA-VSEP sign up ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Used in last week	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily	○ Not at all ○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily

Experiences

	Yes	No
31. ***Since signing up for MA-VSEP***, have you experienced the death of a family member, friend, significant other or loved one?	○	○
32. ***Since signing up for MA-VSEP***, have you had to cope with the illness or injury of a family member, friend, significant other, or loved one?	○	○
33. ***Since signing up for MA-VSEP***, have you had a difficult conflict with a family member, friend, significant other, or loved one?	○	○
34. ***Since signing up for MA-VSEP***, have you experienced any major difficult changes to your living situation (e.g., divorce, foreclosure, homelessness)?	○	○
35. ***Since signing up for MA-VSEP***, have you experienced the addition of a child or other family member to the household?	○	○
36. ***Since signing up for MA-VSEP***, have you felt socially isolated or lonely?	○	○
37. ***Since signing up for MA-VSEP***, have you gotten laid off or fired or had to resign unexpectedly from a job?	○	○
38. ***Since signing up for MA-VSEP***, have you had any major difficulties with your finances?	○	○
39. ***Since signing up for MA-VSEP***, have you had difficulties accessing healthcare or medical services?	○	○
40. ***Since signing up for MA-VSEP***, have you lost any community services or support people on whom you used to rely?	○	○

Support

	Poor	Fair	Good	Very Good	Excellent	N/A
41. How would you rate your overall relationship with your spouse or partner?	○	○	○	○	○	○
42. How would you rate your overall relationships with your immediate family?	○	○	○	○	○	○
43. How would you rate your overall relationships with your friends?	○	○	○	○	○	○

44. Please indicate the degree to which you agree or disagree with the following statements:

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
j. You have people close to you who respect you and your efforts to improve your life.	○	○	○	○	○
k. You have people close to you who understand your situation and problems.	○	○	○	○	○
l. You have people close to you who can always be trusted.	○	○	○	○	○
m. You have people close to you who motivate and encourage you in your endeavors/ recovery/etc.	○	○	○	○	○
n. You have people close to you who expect you to make positive changes in your life.	○	○	○	○	○
o. You have close family members who help you stay away from gambling.	○	○	○	○	○
p. You have people close to you who help you develop confidence in yourself.	○	○	○	○	○
q. You have good friends who do not gamble.	○	○	○	○	○
r. You work in situations where gambling is common.	○	○	○	○	○

45. ***Since signing up for MA-VSEP***, have you talked to a medical doctor or other professional about your problems with gambling? By "other professional" we mean psychologists, counselors, spiritual advisors, and other healing professionals.

- ○ Yes
- ○ No

46. ***Since signing up for MA-VSEP***, have you called a gambling helpline for help with your gambling problems?

- ○ Yes
- ○ No

47. ***Since signing up for MA-VSEP***, have you used any online or print-based self-help materials for gambling problems?

- ○ Yes
- ○ No

48. ***Since signing up for MA-VSEP***, have you received treatment for a mental health or substance use problem other than gambling-related problems?

- ○ Yes
- ○ No, no prior mental health or substance use problems
- ○ No, but I think I might have a mental health or substance use problem

49. ***Since signing up for MA-VSEP***, have you received any of the following kinds of treatment?

	Yes	**No**
j. Gambling treatment program	○	○
k. Inpatient alcohol/drug treatment program	○	○
l. Outpatient alcohol/drug treatment program	○	○
m. Inpatient mental health treatment	○	○
n. Outpatient mental health treatment	○	○
o. Financial counseling	○	○
p. Vocational counseling	○	○
q. Marital counseling	○	○
r. Other service/counseling (please specify)	○	○

50. Have you ever, in your lifetime, participated in any of the following groups?

		When did you most recently participate in this program?	When you last participated in this program, how frequently did you do so? If you're participating in this program now, describe your current situation.
c. Gamblers' Anonymous	○ Yes ○ No	○ Prior to signing up for MA-VSEP ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Within last week	○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily
d. Other 12-step or support group (e.g., Alcoholics Anonymous, Narcotics Anonymous)	○ Yes ○ No	○ Prior to signing up for MA-VSEP ○ 3-6 months ago ○ 1-2 months ago ○ Past 30 days ○ Within last week	○ Less than once a month ○ 1-3 times a month ○ 1-2 times a week ○ 3-6 times a week ○ Daily

51. Were you given a packet of resources when you signed up for MA-VSEP?,

    ○ Yes
    ○ No

[If Q46 = Yes]

52. Did someone (a Game Sense Advisor or other staff) review those resources with you when you signed up for MA-VSEP?

    ○ Yes
    ○ No

[If Q46 = Yes]

53. Did you end up using any of those resources?

    ○ Yes
    ○ No

54. Did someone (a Game Sense Advisor or other staff) call you to check in after you signed up for MA-VSEP?

    ○ Yes
    ○ No

55. Did signing up for MA-VSEP influence you to seek any kind of treatment or self-help for gambling or other problems?

    ○ Yes
    ○ No

[If Q50 = Yes]

56. Briefly, how did it influence you?

57. Have you ever signed up for voluntary self exclusion in another state or with another casino?

- ○ Yes
- ○ No

[If Q52=yes]

58. How does your experience with MA-VSEP compare to your experiences with other self exclusion programs?

- ○ Better
- ○ About the same
- ○ Worse

[If Q52=yes]

59. Please explain how your experience with MA-VSEP compares to your experience with other self exclusion programs. If it has been different, how has it been different?

60. Briefly, how might the MA-VSEP be improved?

61. Has the MA-VSEP helped you? If so, how? If not, why not?

Demographics

62. What is your annual household income from all sources, before taxes?

- ○ Less than $20,000
- ○ $20,000 but less than $30,000
- ○ $30,000 but less than $40,000
- ○ $40,000 but less than $50,000
- ○ $50,000 but less than $60,000
- ○ $60,000 but less than $75,000
- ○ $75,000 but less than $100,000
- ○ $100,000 but less than $125,000
- ○ $125,000 but less than $150,000
- ○ $150,000 or more

63. What is your current employment status? (Choose all that apply)

- ☐ Employed full-time (non-temporary)
- ☐ Employed part-time (non-temporary)
- ☐ Employed temporarily
- ☐ Self-employed
- ☐ Other (specify) _____
- ☐ Retired
- ☐ Looking for work; Unemployed
- ☐ Homemaker
- ☐ Temporarily laid off
- ☐ Student
- ☐ Maternity Leave
- ☐ Illness / Sick Leave
- ☐ Disabled

64. Are you currently married, separated, divorced, widowed, or never married?

- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Never married

[If Q59 = Never married]

65. Are you currently living with someone in a marriage-like relationship?

- ○ Yes
- ○ No

66. Pending future research funding, can we contact you in the future to continue the study?

- ○ Yes
- ○ No

APPENDIX D: MA-VSEP APPLICATIONS

1. Version 1: June 2015 – December 2015

2. Version 2: December 2015 – March 2016

3. Version 3: March 2016 – November 2017

MA Voluntary Self-Exclusion Form

Type or print (in ink) all information requested on this form. You may bring this completed form to any designated agent for review or complete the form with a designated agent. For a list of designated agents and locations, please visit our website at massgaming.com/vse

(*) **Denotes a Required Field**

SECTION 1: PERSONAL INFORMATION

Applicant ID

***Term of Exclusion** Six Months One Year Three Years Five Years Lifetime

***Term Expires**

***Photograph**

***First Name**

Middle Name

***Last Name**

Aliases

***Home Street Address**

***City/Town**

***State**

***Postal Code**

***Country**

***Primary Number**

***Email Address**

Player Card Number

SECTION 2: PHYSICAL DESCRIPTION AND OTHER IDENTIFYING INFORMATION

***Gender** Female Male **Height** Ft In

***Date of Birth** ***Social Security Number**

***Race** White Asian (e.g., Chinese, Filipino, Indian)

Black or African American Native Hawaiian or other Pacific Islander

American Indian or Alaskan Native Other (Specify)

***ID Type** Green Card License Passport Other

***Issuing Entity**

***ID Number**

MA Voluntary Self-Exclusion Form

SECTION 3: MA-VSEP ENROLLMENT PACKET

[PLEASE NOTE: Answers to the following questions are OPTIONAL and are NOT REQUIRED.]

1. Briefly, why are you signing up for the Voluntary Self-Exclusion Program? (Choose all that apply)

Because I can't control my gambling

Because I don't want to lose any more money gambling

Because I need a barrier to keep me from entering casinos

Because I am worried that I will be tempted to enter the casino

Because I have a gambling problem

Because I am depressed or distressed about my gambling

Because I feel pressured to gamble when my friends and/or family gamble

Because I want to improve my relationship with my family and/or friends

Because my family or friends asked me to sign up

Because my family or friends are making me sign up

Because I want to support my family / friends who are also signing up

2. What prompted you to sign up for the Voluntary Self-Exclusion Program today, in particular?

3. In the past 12 months, on what type of game have you lost the most money?

Casino slot, keno, or video poker machines

Casino table games (other than poker)

Other casino games (specify)

Betting on sports with friends / Office pools

Betting on horse or dog races

Playing games of physical skill for money, such as pool, golf, or bowling

Playing poker, chess, or other games of mental skill for money (not at a casino)

Playing slot machines (not at a casino)

Playing the lottery, keno, instant Lotto games, or instant scratch tickets

Playing fantasy sports (for money)

Gambling on the Internet (for money – other than fantasy sports)

Other non-charity, non-casino gambling (specify)

Gambling at a non-profit gathering/event (e.g., church bingo game, fundraiser)

4. Approximately how often in the past 12 months have you *gambled at* the following locations? (Choose ONE response per row)

	Never	A couple of times	Less than once a month	About once a month	A couple times a month	Weekly	A couple times a week	Daily or more
a. Slots parlor / casino in Massachusetts (e.g., Plainridge Park Casino)								
b. Slots parlor / casino in a state neighboring Massachusetts (i.e., NH, VT, NY, CT, RI)								
c. Other slots parlor / casino								

5. What is your annual household income from all sources, before taxes?

Less than $20,000
$20,000 but less than $30,000
$30,000 but less than $40,000
$40,000 but less than $50,000
$50,000 but less than $60,000
$60,000 but less than $75,000
$75,000 but less than $100,000
$100,000 but less than $125,000
$125,000 but less than $150,000
$150,000 or more

6. What is your current employment status? (Choose all that apply)

Employed full-time (non-temporary)
Employed part-time (non-temporary)
Employed temporarily
Self-employed
Retired
Looking for work; Unemployed
Homemaker
Temporarily laid off
Student
Maternity Leave
Illness/Sick Leave
Disabled
Other (Specify) _____

7. Are you currently married, separated, divorced, widowed, or never married?

Married
Separated
Divorced
Widowed
Never Married

8. (If not married) Are you currently living with someone in a marriage-like relationship?

Yes
No

9. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?

Yes
No

Massachusetts Gaming Commission
101 Federal Street, 23rd Floor
Boston, MA 02110

SECTION 4: TERMS AND CONDITIONS

_____ (initial here) I understand that by placing my name on the Voluntary Self-Exclusion list, I am prohibited from entering the gaming area of a gaming establishment ("Casino") or any area in which pari-mutuel or simulcasting wagers are placed for the duration of the exclusion period.

_____ (initial here) I understand that this Self-Exclusion Agreement applies to all gaming establishments licensed by the Commission in Massachusetts, any affiliates of the gaming licensee, whether within Massachusetts or another jurisdiction, and that the Commission may share the list with other domestic or international gaming jurisdictions resulting in placement on those lists.

_____ (initial here) I am submitting this application voluntarily of my own free will, free from outside influences, and I am doing so understanding the effects of my decision.

_____ (initial here) I am not presently under the influence of drugs, an alcoholic beverage, or suffering from a mental health condition that impairs my ability make an informed decision.

_____ (initial here) I acknowledge one or more of the following apply: (a) I identify as a problem gambler as an individual who believes their gambling behavior is currently, or may in the future without intervention, cause problems in their life or on the lives of the their family, friends, and/or co-workers; (b) I feel that my gambling behavior is currently causing problems in my life or may, without intervention, cause problems in my life; or (c) there is some other reason why I wish to add my name to the list.

_____ (initial here) I acknowledge this Self-Exclusion request is irrevocable during the_____ time period selected in Section 1. (An individual may only select the lifetime duration if their name has previously appeared on the Voluntary Self-Exclusion list for at least six months.)

_____ (initial here) I understand I may be refused entry and/or ejected from the gaming area of a gaming establishment ("Casino") by the gaming licensee, an agent of the Commission, or law enforcement personnel.

_____ (initial here) I understand that I may not collect any winnings or recover any losses resulting from any gaming activity at a gaming establishment for the duration of the exclusion period.

_____ (initial here) I understand that any and all rewards and points earned through my player reward program to date shall be forfeited.

_____ (initial here) I agree that should I violate the agreement to refrain from entering a gaming area of a gaming establishment or any area in which pari-mutuel or simulcasting wagers are placed during the exclusion period ("The Excluded Area"), I will notify the Commission of such violation within 24 hours of my presence within The Excluded Area; and agree to release the Commonwealth of Massachusetts, the MGC, the Licensee, and all affiliated employees from any claims associated with my breach of this agreement.

_____ (initial here) I understand that upon expiration of the selected duration of exclusion, I have the opportunity to request the removal of my name from the list or petition for exclusion for a new duration. My name shall remain on the list after the expiration of the selected duration of exclusion until such time when I submit a petition for removal in accordance with 205 CMR 133.04(4) and it is approved by the Commission or its designee.

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Boston, MA 02110

SECTION 4: TERMS AND CONDITIONS (continued)

_____ (initial here)

I agree to participate in an exit session with a designated agent. The exit session shall include a review of the risks and responsibilities of gambling, budget setting and a review of problem gambling resources should I wish to seek them.

_____ (initial here)

I am aware that my signature below authorizes the Massachusetts Gaming Commission to direct all Massachusetts gaming Licensees to suspend my credit privileges for a minimum period of six months from the date of this request and indefinitely thereafter, until such time as I submit a written request to the Commission for the reinstatement of any such credit privileges.

_____ (initial here)

I understand that by placing my name on the list, I will be denied access to complimentary services or items, check cashing privileges, player reward programs, and other similar benefits to persons on the list and I will not be extended credit to the extent that I have existing credit at a gaming establishment my privileges will be suspended.

SECTION 5: CONSENT FOR RELEASE OF INFORMATION

_____ (initial here)

I hereby authorize the MGC and its agents to release my information and/or records to a gaming licensee for the purpose of initial entry to and subsequent maintenance of the Voluntary Self-Exclusion list and/or Voluntary Self-Exclusion database. I understand that the Voluntary Self-Exclusion list is exempt from disclosure under M.G.L. c. 66, and shall not be publicly disclosed by a gaming licensee.

_____ (initial here)

I understand, however, that a gaming licensee may share the Voluntary Self-Exclusion list with other gaming licensees in Massachusetts or its affiliates in other jurisdictions for the purpose of assisting in the proper administration or responsible gaming programs operated by affiliated gaming establishments.

_____ (initial here)

I hereby acknowledge and consent that the MGC may de-identify or anonymize information contained in the Self-Exclusion list and may further disclose this information to one or more research entities appointed by the Commission for the purpose of evaluating the effectiveness and ensuring the proper administration of the Voluntary Self-Exclusion process.

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101 Federal Street, 23rd Floor
Boston, MA 02110

SECTION 6: ACKNOWLEDGEMENT

To the best of my knowledge and understanding, I attest that the following information which I have provided above is true and accurate.

Signature_____

Print Name_____

Date_____

Signature of Designated Agent_____

Print Name_____

Date_____

MA Voluntary Self-Exclusion Form

Type or print (in ink) all information requested on this form. You may bring this completed form to any designated agent for review or complete the form with a designated agent. For a list of designated agents and locations, please visit our website at massgaming.com/vse

(*) **Denotes a Required Field**

SECTION 1: PERSONAL INFORMATION

Applicant ID

***Term of Exclusion** Six Months One Year Three Years Five Years Lifetime

***Term Expires**

***Photograph**

***First Name**

Middle Name

***Last Name**

Aliases

***Home Street Address**

***City/Town**

***State**

***Postal Code**

***Country**

***Primary Number**

***Email Address**

Player Card Number

SECTION 2: PHYSICAL DESCRIPTION AND OTHER IDENTIFYING INFORMATION

***Gender** Female Male **Height** Ft In

***Date of Birth** ***Social Security Number**

***Race** White Asian (e.g., Chinese, Filipino, Indian)

Black or African American Native Hawaiian or other Pacific Islander

American Indian or Alaskan Native Other (Specify)

***ID Type** Green Card License Passport Other

***Issuing Entity**

***ID Number**

Massachusetts Gaming Commission
101 Federal Street, 23rd Floor
Boston, MA 02110

SECTION 3: TERMS AND CONDITIONS

_____ (initial here) I understand that by placing my name on the Voluntary Self-Exclusion list, I am prohibited from entering the gaming area of a gaming establishment ("Casino") or any area in which pari-mutuel or simulcasting wagers are placed for the duration of the exclusion period.

_____ (initial here) I understand that this Self-Exclusion Agreement applies to all gaming establishments licensed by the Commission in Massachusetts, any affiliates of the gaming licensee, whether within Massachusetts or another jurisdiction, and that the Commission may share the list with other domestic or international gaming jurisdictions resulting in placement on those lists.

_____ (initial here) I am submitting this application voluntarily of my own free will, free from outside influences, and I am doing so understanding the effects of my decision.

_____ (initial here) I am not presently under the influence of drugs, an alcoholic beverage, or suffering from a mental health condition that impairs my ability make an informed decision.

_____ (initial here) I acknowledge one or more of the following apply: (a) I identify as a problem gambler as an individual who believes their gambling behavior is currently, or may in the future without intervention, cause problems in their life or on the lives of the their family, friends, and/or co-workers; (b) I feel that my gambling behavior is currently causing problems in my life or may, without intervention, cause problems in my life; or (c) there is some other reason why I wish to add my name to the list.

_____ (initial here) I acknowledge this Self-Exclusion request is irrevocable during the_____ time period selected in Section 1. (An individual may only select the lifetime duration if their name has previously appeared on the Voluntary Self-Exclusion list for at least six months.)

_____ (initial here) I understand I may be refused entry and/or ejected from the gaming area of a gaming establishment ("Casino") by the gaming licensee, an agent of the Commission, or law enforcement personnel.

_____ (initial here) I understand that I may not collect any winnings or recover any losses resulting from any gaming activity at a gaming establishment for the duration of the exclusion period.

_____ (initial here) I understand that any and all rewards and points earned through my player reward program to date shall be forfeited.

_____ (initial here) I agree that should I violate the agreement to refrain from entering a gaming area of a gaming establishment or any area in which pari-mutuel or simulcasting wagers are placed during the exclusion period ("The Excluded Area"), I will notify the Commission of such violation within 24 hours of my presence within The Excluded Area; and agree to release the Commonwealth of Massachusetts, the MGC, the Licensee, and all affiliated employees from any claims associated with my breach of this agreement.

_____ (initial here) I understand that upon expiration of the selected duration of exclusion, I have the opportunity to request the removal of my name from the list or petition for exclusion for a new duration. My name shall remain on the list after the expiration of the selected duration of exclusion until such time when I submit a petition for removal in accordance with 205 CMR 133.04(4) and it is approved by the Commission or its designee.

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Boston, MA 02110

SECTION 3: TERMS AND CONDITIONS (continued)

_____ (initial here)

I agree to participate in an exit session with a designated agent. The exit session shall include a review of the risks and responsibilities of gambling, budget setting and a review of problem gambling resources should I wish to seek them.

_____ (initial here)

I am aware that my signature below authorizes the Massachusetts Gaming Commission to direct all Massachusetts gaming Licensees to suspend my credit privileges for a minimum period of six months from the date of this request and indefinitely thereafter, until such time as I submit a written request to the Commission for the reinstatement of any such credit privileges.

_____ (initial here)

I understand that by placing my name on the list, I will be denied access to complimentary services or items, check cashing privileges, player reward programs, and other similar benefits to persons on the list and I will not be extended credit to the extent that I have existing credit at a gaming establishment my privileges will be suspended.

SECTION 4: CONSENT FOR RELEASE OF INFORMATION

_____ (initial here)

I hereby authorize the MGC and its agents to release my information and/or records to a gaming licensee for the purpose of initial entry to and subsequent maintenance of the Voluntary Self-Exclusion list and/or Voluntary Self-Exclusion database. I understand that the Voluntary Self-Exclusion list is exempt from disclosure under M.G.L. c. 66, and shall not be publicly disclosed by a gaming licensee.

_____ (initial here)

I understand, however, that a gaming licensee may share the Voluntary Self-Exclusion list with other gaming licensees in Massachusetts or its affiliates in other jurisdictions for the purpose of assisting in the proper administration or responsible gaming programs operated by affiliated gaming establishments.

_____ (initial here)

I hereby acknowledge and consent that the MGC may de-identify or anonymize information contained in the Self-Exclusion list and may further disclose this information to one or more research entities appointed by the Commission for the purpose of evaluating the effectiveness and ensuring the proper administration of the Voluntary Self-Exclusion process.

Massachusetts Gaming Commission
101 Federal Street, 23rd Floor
Boston, MA 02110

SECTION 5: ACKNOWLEDGEMENT

To the best of my knowledge and understanding, I attest that the following information which I have provided above is true and accurate.

Signature_____

Print Name_____

Date_____

Signature of Designated Agent_____

Print Name_____

Date_____

MA Voluntary Self-Exclusion Form

Type or print (in ink) all information requested on this form. You may bring this completed form to any designated agent for review or complete the form with a designated agent. For a list of designated agents and locations, please visit our website at massgaming.com/vse

(*) **Denotes a Required Field**

Applicant ID _____

(Internal use only)

SECTION 1: PERSONAL INFORMATION

***Term of Exclusion** Not Answered *(Only eligible for lifetime once another term has been completed)*

***Term Expires** _____

(***Please Note**: Enrollees must participate in an exit interview upon term expiration in order to be removed from VSE)*

***First Name** _____ **Middle Name** _____

***Last Name** _____

Aliases _____

***Home Street Address** _____

***City/Town** _____

***State** _____

***Postal Code** _____

***Country** _____

***Primary Number** _____

***Email Address** _____

Player Card Number _____

***Photograph**

SECTION 2: PHYSICAL DESCRIPTION AND OTHER IDENTIFYING INFORMATION

***Gender** Not Answered **Height** **Ft** _____ **In** _____ ***Date of Birth** _____

***Social Security Number** _____

OR

***ID Type** Not Answered Other _____

***Issuing State/Country** _____

***ID Number** _____

***Race** Not Answered Specify Other _____

Hispanic Origin? Not Answered

MA Voluntary Self-Exclusion Form

SECTION 3: MA-VSEP APPLICATION QUESTIONS

Answers to the following questions help us evaluate and improve the Voluntary Self-Exclusion Program to better serve enrollees.

1. Briefly, why are you signing up for the Voluntary Exclusion Program? (Choose all that apply)

- ☐ Because I can't control my gambling
- ☐ Because I don't want to lose any more money gambling
- ☐ Because I need a barrier to keep me from entering casinos
- ☐ Because I'm worried that I will be tempted to enter the casino
- ☐ Because I have a gambling problem
- ☐ Because I am depressed or distressed about my gambling
- ☐ Because I feel pressured to gamble when my friends and/or family gamble
- ☐ Because I want to improve my relationship with my family and/or friends
- ☐ Because my family or friends asked me to sign up
- ☐ Because my family or friends are making me sign up
- ☐ Because I want to support my family / friends who are also signing up
- ☐ Other reasons (specify)

2. What prompted you to sign up for the Voluntary Exclusion Program ***today***, in particular?

3. In the past 12 months, on what type of game have you lost the most money?

Not Answered

Specify Other

4. Approximately how often in the past 12 months have you *gambled at* the following locations?

a. Slots parlor / casino in Massachusetts (e.g., Plainridge Park Casino)	Not Answered
b. Slots parlor / casino in a state neighboring Massachusetts (i.e., NH, VT, NY, CT, RI)	Not Answered
c. Other slots parlor / casino	Not Answered

5. How recently did you place your last bet?

Not Answered

6. What are the primary reasons that you gamble? (Choose all that apply)

- ☐ I gamble for the feeling of excitement I get
- ☐ I gamble to get money I need
- ☐ I gamble because others around me are gambling
- ☐ I gamble because I have a good time
- ☐ I gamble because I feel lonely
- ☐ I gamble because it's challenging
- ☐ I gamble because it's an important part of my social life
- ☐ I gamble because I feel sad or depressed
- ☐ I gamble for other reasons (specify)

7. Taking all of your wins and losses over the past 12 months together, how much money, if any, have you lost in the past 12 months due to gambling?

$

8. In the past 12 months, what is the largest amount of money you have lost gambling on any *one* day?

$

9. In the past 12 months, have you ever needed to get more money in the middle of a gambling outing? (For example, after beginning gambling, have you used an ATM or gotten a cash advance on a credit card while at a casino?)

Not Answered

10. During the past 12 months, have you become restless, irritable, or anxious when trying to stop/cut down on gambling?

Not Answered

11. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?

Not Answered

MA Voluntary Self-Exclusion Form

12. During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?

Not Answered

13. Are you planning to quit gambling now that you are entering the Voluntary Exclusion Program?

Not Answered

14. What is your annual household income from all sources, before taxes?

Not Answered

15. What is your current employment status? (Choose all that apply)

- ☐ Employed full-time (non-temporary)
- ☐ Employed part-time (non-temporary)
- ☐ Employed temporarily
- ☐ Self-employed
- ☐ Other (specify)
- ☐ Retired
- ☐ Looking for work; Unemployed
- ☐ Homemaker
- ☐ Temporarily laid off
- ☐ Student
- ☐ Maternity Leave
- ☐ Illness / Sick Leave
- ☐ Disabled

16. Are you of Hispanic Ethnicity? (i.e., Spanish, Latino, Mexican, Chicano, Puerto Rican, Cuban or other Hispanic origin)

Not Answered

17. What is your race? (Choose all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian (e.g., Chinese, Filipino, Indian)
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other (Specify) _____

18. Are you currently married, separated, divorced, widowed, or never married?

Not Answered

19. (If not married) Are you currently living with someone in a marriage-like relationship?

Not Answered

20. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?

Not Answered

21. Have you or any member of your immediate family ever worked in the gambling industry?

Not Answered

Massachusetts Gaming Commission
101 Federal Street, 12th Floor
Boston, MA 02110

SECTION 4: TERMS AND CONDITIONS

_____ (initial here) I understand that by placing my name on the Voluntary Self-Exclusion list, I am prohibited from entering the gaming area of a gaming establishment ("Casino") or any area in which pari-mutuel or simulcasting wagers are placed for the duration of the exclusion period.

_____ (initial here) I understand that this Self-Exclusion Agreement applies to all gaming establishments licensed by the Commission in Massachusetts, any affiliates of the gaming licensee, whether within Massachusetts or another jurisdiction, and that the Commission may share the list with other domestic or international gaming jurisdictions resulting in placement on those lists.

_____ (initial here) I am submitting this application voluntarily of my own free will, free from outside influences, and I am doing so understanding the effects of my decision.

_____ (initial here) I am not presently under the influence of drugs, an alcoholic beverage, or suffering from a mental health condition that impairs my ability make an informed decision.

_____ (initial here) I acknowledge one or more of the following apply: (a) I identify as a problem gambler as an individual who believes their gambling behavior is currently, or may in the future without intervention, cause problems in their life or on the lives of the their family, friends, and/or co-workers; (b) I feel that my gambling behavior is currently causing problems in my life or may, without intervention, cause problems in my life; or (c) there is some other reason why I wish to add my name to the list.

_____ (initial here) I acknowledge this Self-Exclusion request is irrevocable during the_____ time period selected in Section 1. (An individual may only select the lifetime duration if their name has previously appeared on the Voluntary Self-Exclusion list for at least six months.)

_____ (initial here) I understand I may be refused entry and/or ejected from the gaming area of a gaming establishment ("Casino") by the gaming licensee, an agent of the Commission, or law enforcement personnel.

_____ (initial here) I understand that I may not collect any winnings or recover any losses resulting from any gaming activity at a gaming establishment for the duration of the exclusion period.

_____ (initial here) I understand that any and all rewards and points earned through my player reward program to date shall be forfeited.

_____ (initial here) I agree that should I violate the agreement to refrain from entering a gaming area of a gaming establishment or any area in which pari-mutuel or simulcasting wagers are placed during the exclusion period ("The Excluded Area"), I will notify the Commission of such violation within 24 hours of my presence within The Excluded Area; and agree to release the Commonwealth of Massachusetts, the MGC, the Licensee, and all affiliated employees from any claims associated with my breach of this agreement.

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Boston, MA 02110

SECTION 4: TERMS AND CONDITIONS (continued)

_____ (initial here)

I understand that upon expiration of the selected duration of exclusion, I may request removal from the list by participating in an exit session with a designated agent. My name shall remain on the list after the expiration of the selected duration of exclusion until such time when I submit a petition for removal in accordance with 205 CMR 133.04(4) and it is approved by the Commission or its designee.

_____ (initial here)

I agree to schedule and participate in an exit interview with a designated agent in order to remove myself from the list. The exit session shall include a review of the risks and responsibilities of gambling, budget setting and a review of problem gambling resources should I wish to seek them. The exit session may be scheduled by contacting the Massachusetts Council on Compulsive Gambling at 617-426-4554

_____ (initial here)

I am aware that my signature below authorizes the Massachusetts Gaming Commission to direct all Massachusetts gaming Licensees to suspend my credit privileges for a minimum period of six months from the date of this request and indefinitely thereafter, until such time as I submit a written request to the Commission for the reinstatement of any such credit privileges.

_____ (initial here)

I understand that by placing my name on the list, I will be denied access to complimentary services or items, check cashing privileges, player reward programs, and other similar benefits to persons on the list and I will not be extended credit to the extent that I have existing credit at a gaming establishment my privileges will be suspended.

SECTION 5: RELEASE OF INFORMATION

_____ (initial here)

I understand that the MGC and its agents will release my information contained in this form to a gaming licensee for maintenance of the Voluntary Self-Exclusion list and/or Voluntary Self-Exclusion database. I understand that the Voluntary Self-Exclusion list is exempt from disclosure under M.G.L. c. 66, and shall not be publicly disclosed by a gaming licensee.

_____ (initial here)

I understand that a gaming licensee may share the Voluntary Self-Exclusion list with its affiliates in other jurisdictions for the purpose of assisting in the proper administration or responsible gaming programs operated by affiliated gaming establishments.

_____ (initial here)

I understand that the MGC may de-identify or anonymize information contained in the Self-Exclusion list and may further disclose this information to one or more research entities appointed by the Commission for the purpose of evaluating the effectiveness and ensuring the proper administration of the Voluntary Self-Exclusion process.

Massachusetts Gaming Commission
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Boston, MA 02110

SECTION 6: CONSENT FOR RELEASE OF CONTACT INFORMATION

Not Answered	The MGC is collaborating with the Cambridge Health Alliance to evaluate and improve the Voluntary Self-Exclusion Program. MGC would like to provide your contact information to the Division so they may offer you the opportunity to participate in the study. Consenting does not mean you agree to participate in the study, just that you are willing to be contacted about the study. Do you consent to the MGC providing your contact information to the Cambridge Health Alliance?
Not Answered	The Massachusetts Council on Compulsive Gaming (MCCG) would like to follow up with you within one week to see how you are doing and assure you've been able to connect with addition resources if you choose. Do you consent to allow the MGC to provide your contact information to MCCG?

SECTION 7: ACKNOWLEDGEMENT

I attest that the following information which I have provided in this form is true and accurate.

Enrollee Signature _____

Enrollee Print Name _____

Date _____

Signature and Title of Designated Agent _____

Print Name _____

Date _____

_____ (initial here) I certify that I have been offered a copy of the "MA Voluntary Self Exclusion Form" by the processing agent.

APPENDIX E: MA-VSEP ONE WEEK CHECK-IN FORM

MA VSEP:
Follow Up Information Sheet

Name_____

Enrollment Date_____ Enrollment Time_____

Date One Week Check-In Due _____

Preferred Phone # for One Week Contact _____ cell home work
[circle one]

Alternate Phone # for One Week Contact _____ cell home work
[circle one]

Email Address for One Week Contact _____

May we leave a message on your voice mail? ☐ Yes ☐ No **_____** *(initial)*

May we text you on your cell phone? ☐ Yes ☐ No **_____** *(initial)*

Good times and best ways to reach enrollee

AT MA-VSEP Enrollment

Did you review resources with enrollee?

Yes ☐ No ☐

Did you provide individualized information about resources in the enrollee's area?

Yes ☐ No ☐

[If yes]
Please briefly describe what resources were discussed

Did the enrollee accept offer to connect him or her directly with resources?

Yes ☐ No ☐

Were you able to connect the enrollee directly with a treatment resource or the helpline?

Yes ☐ No ☐ Enrollee not interested ☐

[If no]
Please briefly why not and any additional plans that were made

[If yes]
Please briefly describe the connection you were able to make and next steps

FOLLOW-UP CONTACT ATTEMPTS

Attempt #	Date & Time	Notes
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

FOLLOW-UP CONTACT

Were you able to reach the enrollee?

Yes ☐ No ☐

Has the enrollee accessed any resources since enrollment (e.g., helpline, GA, treatment)?

Yes ☐ No ☐

[If yes]
Please briefly describe what actions the enrollee has taken

Did you offer to connect the enrollee directly with resources?

Yes ☐ No ☐ Already connected ☐

Did the enrollee accept offer to connect him or her directly with resources?

Yes ☐ No ☐ Already connected ☐

Were you able to connect the enrollee directly with a treatment resource or the helpline?

Yes ☐ No ☐

[If no]
Please briefly why not and any additional plans that were made

[If yes]
Please briefly describe the connection you were able to make and next steps

Additional Notes

APPENDIX F: ANALYSIS OF MISSING DATA BY INSTRUMENT AND ITEM

MA-VSEP Application (Maximum n=263 MA-VSEP enrollees)

MA-VSEP Application Question	# (%) of MA-VSEP Enrollees Who Did Not Answer Question	Notes
Length of exclusion term	0 (0%)	
Gender	0 (0%)	
Year of birth	0 (0%)	
Race	0 (0%)	In version 2 of the application, Hispanic was included as a race. We recoded this instance to indicate Hispanic ethnicity and unknown race.
Ethnicity	66 (25.1%)	Not included in version 1 of the application.
Reason for MA-VSEP enrollment	85 (32.3%)	Not included in version 2 of the application. 5 of these 85 *did* answer the question as part of the baseline survey.
Reason for MA-VSEP enrollment on this day in particular	118 (44.9%)	Not included in version 2 of the application. 12 of these 118 *did* answer the question as part of the baseline survey.
PY: Game on which you lost the most money	104 (39.5%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 8 of these 104 *did* answer the question as part of the baseline survey.
PY: Gambling locations	Gambling at PPC: 104 (39.5%) Gambling at neighboring casinos: 128 (48.7%) Gambling at non-neighboring casinos: 147 (55.9%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 8 of the 104, 13 of the 128, and 16 of the 147 *did* answer these questions as part of the baseline survey.
Household income	121 (46.0%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 11 of the 121 *did* answer this question as part of the baseline survey.
Current employment status	92 (35.0%)	Not included in version 2 of the application. 6 of the 92 *did* answer this question as part of the baseline survey.
Marital status	110 (41.8%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 10 of the 110 *did* answer this question as part of the baseline survey.
Living with someone in marriage-like relationship	113 (43.0%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 113 does not include the 56 who were not asked this question because they were married. 6 of the 113 *did* answer this question as part of the baseline survey.
Ever served in Armed Forces	112 (42.6%)	Not included in version 2 of the application. Affected by data anomalies described in Methods section. 9 of the 112 *did* answer this question as part of the baseline survey.
Recency of last bet	158 (60.1%)	Not included in versions 1 or 2 of the application. Affected by data anomalies described in Methods section. 24 of the 158 *did* answer this question as part of the baseline survey.

[continued]

MA-VSEP Application Question	# (%) of MA-VSEP Enrollees Who Did Not Answer Question	Notes
Reasons for gambling	145 (55.1%)	Not included in versions 1 or 2 of the application. 23 of the 145 *did* answer this question as part of the baseline survey.
PY: Total amount lost	165 (62.7%)	Not included in versions 1 or 2 of the application. 24 of the 165 *did* answer this question as part of the baseline survey.
PY: Largest amount lost in one day	158 (60.1%)	Not included in versions 1 or 2 of the application. 24 of the 158 *did* answer this question as part of the baseline survey.
PY: Needed to get more money in the middle of a gambling outing	161 (61.2%)	Not included in versions 1 or 2 of the application. Affected by data anomalies described in Methods section. 25 of the 161 *did* answer this question as part of the baseline survey.
PY BBGS Screener	158 (60.1%)	Not included in versions 1 or 2 of the application. Affected by data anomalies described in Methods section. 34 of the 158 *did* answer these questions as part of the baseline survey.
Intentions to quit gambling	159 (32.3%)	Not included in versions 1 or 2 of the application. Affected by data anomalies described in Methods section. 25 of the 159 *did* answer these questions as part of the baseline survey.
Self or family worked in gambling industry	162 (61.6%)	Not included in versions 1 or 2 of the application. Affected by data anomalies described in Methods section. 25 of the 162 *did* answer these questions as part of the baseline survey.

Note. Version 1 of the MA-VSEP application was in use from June 2015 through November 2015. Version 2 of the MA-VSEP application was in use from December 2015 through February 2016. Version 3 of the MA-VSEP application was in use from March 2016 through the end of the baseline component of the study in November 2017.

MA-VSEP One Week Check-In (Maximum n=67 MA-VSEP enrollees who agreed to receive a check-in call)

One Week Check-In Form Question (filled out by GSAs or MCCG staff)	# (%) of MA-VSEP Enrollees Who Agreed to Receive a Check-In Call for Whom GSAs o MCCG Staff Did Not Answer Question	Notes
At enrollment: Reviewed resources with enrollee	8 (11.9%)	
At enrollment: Provided individualized information about resources in the enrollee's area	11 (16.4%)	
At enrollment: Describe what resources were discussed	27 (40.3%)	27 does not include the 12 who were not asked this question because they did not discuss resources.
At enrollment: Whether enrollee accepted offer to connect directly with resources	10 (14.9%)	10 does not include the 10 who were not asked this question because they did not discuss individualized resources.
At enrollment: Able to connect enrollee directly with resources	17 (25.4%)	17 does not include the 2 for whom this question was not asked because the enrollee did not accept offer to connect directly with resources or the 3 for whom this question was not asked because resources were not discussed.
At enrollment: If no direct connection, why not and what else was done	31 (46.2%)	31 does not include the 24 for whom this question was not asked because the answer to the previous question was "yes" or "not interested" or the 3 for whom this question was not asked because resources were not discussed.
At enrollment: If connection, describe connection and next steps	23 (34.3%)	31 does not include the 41 for whom this question was not asked because the answer to the previous question was "no" or "not interested" or the 3 for whom this question was not asked because resources were not discussed.
At check-in: Whether reached enrollee	0 (0.0%)	
At check-in: Whether enrollee has accessed any resources since enrollment	15 (22.4%)	15 does not include the 24 for whom this question was not asked because no check-in contact was established.
At check-in: What actions the enrollee has taken	17 (25.4%)	17 does not include the 13 for whom this question was not asked because enrollee had not accessed resources or the 24 for whom this question was not asked because no check-in contact was established.
At check-in: Offer to connect the enrollee directly with resources	11 (16.4%)	11 does not include the 24 for whom this question was not asked because no check-in contact was established.
At check-in: Whether enrollee accepted offer to connect directly with resources	18 (26.9%)	18 does not include the 24 for whom this question was not asked because no check-in contact was established.
At check-in: Able to connect enrollee directly with resources	15 (22.4%)	15 does not include the 24 for whom this question was not asked because no check-in contact was established. However, this question was answered whether the answer to the previous questions about connecting enrollees with services were yes or no, despite skip logic instructing respondent to only answer this question if the enrollee accepted the offer to connect with services.

[continued]

One Week Check-In Form Question (filled out by GSAs or MCCG staff)	# (%) of MA-VSEP Enrollees Who Agreed to Receive a Check-In Call for Whom GSAs o MCCG Staff Did Not Answer Question	Notes
At check-in: If no direct connection, why not and what else was done	17 (25.4%)	17 does not include the 7 for whom this question was not asked because direct connection was established or the 24 for whom this question was not asked because no check-in contact was established.
At check-in: If connection, describe connection and next steps.	9 (13.4%)	9 does not include the 19 for whom this question was not asked because direct connection was not established or the 24 for whom this question was not asked because no check-in contact was established.
Additional notes	7 (10.4%)	

Note. The first half of these forms were supposed to be completed for all MA-VSEP enrollees; however, GSAs only filled out the forms when they forwarded enrollees' information to MCCG for the check-in call and consequently only filled them out for the 67 enrollees who agreed to receive a check-in call.

MA-VSEP Baseline Survey (Maximum n=63 MA-VSEP enrollees who agreed to complete the baseline survey)

Baseline Survey Question	# (%) of MA-VSEP Enrollees Who Agreed to Complete the Baseline Survey Who Did Not Answer Question	Notes
Reason for MA-VSEP enrollment	17 (27.0%)	Question also asked on MA-VSEP application.
Reason for MA-VSEP enrollment on this day in particular	20 (31.7%)	Question also asked on MA-VSEP application.
How enrollee heard about MA-VSEP	2 (3.2%)	
Satisfaction w/ interaction w/ GSA	3 (4.8%)	
GameSense Info Center	Private: 1 (1.6%) Comfortable: 2 (3.2%)	
Questions about GSA	1 (1.6%)	
PY: Game on which you lost the most money	19 (30.2%)	Question also asked on MA-VSEP application.
PY: Gambling locations	Gambling at PPC: 18 (28.6%) Gambling at neighboring casinos: 19 (30.2%) Gambling at non-neighboring casinos: 20 (31.7%)	Question also asked on MA-VSEP application.
# of bets in lifetime	0 (0.0%)	
Age at 1st bet	0 (0.0%)	
Recency of last bet	20 (31.7%)	Question also asked on MA-VSEP application.
Reasons for gambling	19 (30.2%)	Question also asked on MA-VSEP application.
PY: Total amount lost	19 (30.2%)	Question also asked on MA-VSEP application.
PY: Largest amount lost in one day	19 (30.2%)	Question also asked on MA-VSEP application.
PY: Needed to get more money in the middle of a gambling outing	19 (30.2%)	Question also asked on MA-VSEP application.
PY: Frequency of play on different game types	0-4 (0.0%-6.3%)	
Frequency of drinking/drugging while gambling	0 (0.0%)	
PY: Gambling problems	0-1 (0.0%-1.6%)	
Age first experienced problems	5 (7.9%)	
Intentions to quit gambling	20 (31.7%)	Question also asked on MA-VSEP application.
Readiness and confidence to change gambling behavior	0 (0.0%)	
Attitudes about gambling	0-2 (0.0%-3.2%)	
Overall physical and mental health	0 (0.0%)	
Past two weeks depression and anxiety symptoms	0 (0.0%)	
PY life events	0 (0.0%)	
Relationships	w/ spouse or partner: 25 (39.7%) w/ immediate family: 2 (3.2%) w/ friends: 4 (6.3%)	
Social support	0-4 (0.0%-6.3%)	
Spoke w/ professional about gambling problems	0 (0.0%)	

[continued]

Baseline Survey Question	# (%) of MA-VSEP Enrollees Who Agreed to Complete the Baseline Survey Who Did Not Answer Question	Notes
Called helpline about gambling problems	0 (0.0%)	
PY: # of times called helpline	0 (0.0%)	0 does not include the 33 who were not asked this question because they had never called a gambling helpline.
Received treatment for mental health or substance use problem	0 (0.0%)	
Types of treatment received	0 (0.0%)	
PY: Types of treatment received	2-9 (3.2%-14.3%)	2-9 does not include 32-60 respondents who were not asked these questions because they answered no to lifetime receipt of treatment type.
Lifetime Gamblers Anonymous participation	0 (0.0%)	
Lifetime other 12-step participation	0 (0.0%)	
Most recent Gamblers Anonymous participation	0 (0.0%)	0 does not include the 31 who were not asked this question because they had never been to Gamblers Anonymous
Most recent other 12-step participation	0 (0.0%)	0 does not include the 50 who were not asked this question because they had never been to another 12-step group
Frequency of Gamblers Anonymous participation	1 (1.6%)	1 does not include the 31 who were not asked this question because they had never been to Gamblers Anonymous
Frequency of other 12-step participation	1 (1.6%)	1 does not include the 50 who were not asked this question because they had never been to another 12-step group
Household income	18 (28.6%)	Question also asked on MA-VSEP application.
Employment	18 (28.6%)	Question also asked on MA-VSEP application.
Ethnicity	18 (28.6%)	
Race	18 (28.6%)	Question also asked on MA-VSEP application.
Marital status	18 (28.6%)	Question also asked on MA-VSEP application.
Living with someone in marriage-like relationship	18 (28.6%)	18 does not include 12 who were not asked this question because they were married. Question also asked on MA-VSEP application.
Ever served in Armed Forces	18 (28.6%)	Question also asked on MA-VSEP application.
Self or family worked in gambling industry	18 (28.6%)	Question also asked on MA-VSEP application.

Note. Other than "relationships, the questions for which more than 9 respondents are missing data are questions that were not asked on the baseline survey when versions of the MA-VSEP application were active that included these questions.

MA-VSEP Follow-Up Interview (Maximum n=46 MA-VSEP enrollees who agreed to complete the follow-up interview)

Follow-Up Survey Question	# (%) of MA-VSEP Enrollees Who Agreed to Complete the Follow-Up Survey Who Did Not Answer Question	Notes
Satisfaction w/ MA-VSEP	0 (0.0%)	
Since MA-VSEP: Gone to PPC	0 (0.0%)	
Since MA-VSEP: # of times gone to PPC	0 (0.0%)	0 does not include the 36 who were not asked this question because they had not returned to PPC.
Since MA-VSEP: Tried to enter gaming area at PPC	0 (0.0%)	0 does not include the 36 who were not asked this question because they had not returned to PPC.
Since MA-VSEP: # of times tried to enter gaming area at PPC	0 (0.0%)	0 does not include the 39 who were not asked this question because they had not tried to enter the gaming area at PPC.
Since MA-VSEP: Caught trying to enter gaming area at PPC	1 (2.2%)	1 does not include the 39 who were not asked this question because they had not tried to enter the gaming area at PPC.
Since MA-VSEP: # of times caught trying to enter gaming area at PPC	1 (2.2%)	1 does not include the 43 who were not asked this question because they had not been caught trying to enter the gaming area at PPC.
What happened when caught	1 (2.2%)	1 does not include the 43 who were not asked this question because they had not been caught trying to enter the gaming area at PPC.
Recency of last bet	1 (2.2%)	
Since MA-VSEP: Any gambling	0 (0.0%)	
Since MA-VSEP: Frequency of play on different game types	0 (0.0%)	
Since MA-VSEP: Game on which you lost the most money	1 (2.2%)	1 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Since MA-VSEP: Gambling locations	0 (0.0%)	
Since MA-VSEP: Gambling problems	0 (0.0%)	
Since MA-VSEP: Total amount lost	0 (0.0%)	0 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Since MA-VSEP: Largest amount lost in one day	0 (0.0%)	0 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Since MA-VSEP: Needed to get more money in the middle of a gambling outing	1 (2.2%)	1 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Since MA-VSEP: Frequency of drinking/drugging while gambling	0 (0.0%)	0 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Reasons for gambling	0 (0.0%)	0 does not include the 13 who were not asked this question because they had not gambled on any game since MA-VSEP enrollment.
Since MA-VSEP: Perception of gambling behavior	0 (0.0%)	
Readiness and confidence to change gambling behavior	Readiness: 0 (0.0%) Confidence: 4 (8.7%)	
Overall physical and mental health	0 (0.0%)	
Past two weeks depression and anxiety symptoms	0 (0.0%)	

[continued]

Follow-Up Survey Question	# (%) of MA-VSEP Enrollees Who Agreed to Complete the Follow-Up Survey Who Did Not Answer Question	Notes
Since MA-VSEP: Substance use	0 (0.0%)	
Since MA-VSEP: Substance use recency	0 (0.0%)	0 does not include 17-45 respondents who were not asked these questions because they answered no to use of specific substance.
Since MA-VSEP: Substance use frequency	0 (0.0%)	0 does not include 17-45 respondents who were not asked these questions because they answered no to use of specific substance.
6 months prior to MA-VSEP: Substance use frequency	0 (0.0%)	0 does not include 17-45 respondents who were not asked these questions because they answered no to use of specific substance.
Since MA-VSEP: Life events	0 (0.0%)	
Relationships	w/ spouse or partner: 20 (43.5%) w/ immediate family: 0 (0.0%) w/ friends: 2 (4.3%)	
Social support	0-1 (0.0%-2.2%)	
Since MA-VSEP: Spoke w/ professional about gambling problems	0 (0.0%)	
Since MA-VSEP: Called helpline about gambling problems	0 (0.0%)	
Since MA-VSEP: Used online or print-based self-help materials for gambling problems	0 (0.0%)	
Since MA-VSEP: Received treatment for mental health or substance use problem	0 (0.0%)	
Since MA-VSEP: Types of treatment received	0-1 (0.0%-2.2%)	
Gamblers Anonymous participation	0 (0.0%)	
Other 12-step participation	0 (0.0%)	
Most recent Gamblers Anonymous participation	0 (0.0%)	0 does not include the 22 who were not asked this question because they had never been to Gamblers Anonymous
Most recent other 12-step participation	0 (0.0%)	0 does not include the 33 who were not asked this question because they had never been to another 12-step group
Frequency of Gamblers Anonymous participation	1 (2.2%)	1 does not include the 22 who were not asked this question because they had never been to Gamblers Anonymous
Frequency of other 12-step participation	1 (2.2%)	1 does not include the 33 who were not asked this question because they had never been to another 12-step group
Received resource packet at MA-VSEP enrollment	0 (0.0%)	
Reviewed resource packet w/ staff at MA-VSEP enrollment	1 (2.2%)	1 does not include the 2 who were not asked this question because they reported that they had not received resource packets at MA-VSEP enrollment.
Used resources from MA-VSEP packet	0.0%	0 does not include the 2 who were not asked this question because they reported that they had not received resource packets at MA-VSEP enrollment.

[continued]

Follow-Up Survey Question	# (%) of MA-VSEP Enrollees Who Agreed to Complete the Follow-Up Survey Who Did Not Answer Question	Notes
Received check-in call after MA-VSEP enrollment	4 (8.7%)	
MA-VSEP enrollment influenced treatment-seeking or self-help	0 (0.0%)	
How MA-VSEP enrollment influenced treatment-seeking or self-help	0 (0.0%)	0 does not include 27 who were not asked this question because they indicated that MA-VSEP enrollment had not influenced treatment-seeking or self-help.
Signed up for VSE in another state or w/ another casino	0 (0.0%)	
Comparison between MA-VSEP and other program	1 (2.2%)	1 does not include 11 who were not asked this question because they indicated that they had not signed up for VSE elsewhere.
How MA-VSEP can be improved	0 (0.0%)	
How MA-VSEP has been helpful	0 (0.0%)	
Household income	0 (0.0%)	
Employment	0 (0.0%)	
Marital status	0 (0.0%)	Question also asked on MA-VSEP application.
Living with someone in marriage-like relationship	13 (28.3%)	13 does not include 16 who were not asked this question because they were married. Question also asked on MA-VSEP application.

APPENDIX G: MA-VSEP ENROLLEES' SPECIFIC REASONS FOR ENROLLING IN MA-VSEP ON THAT DAY

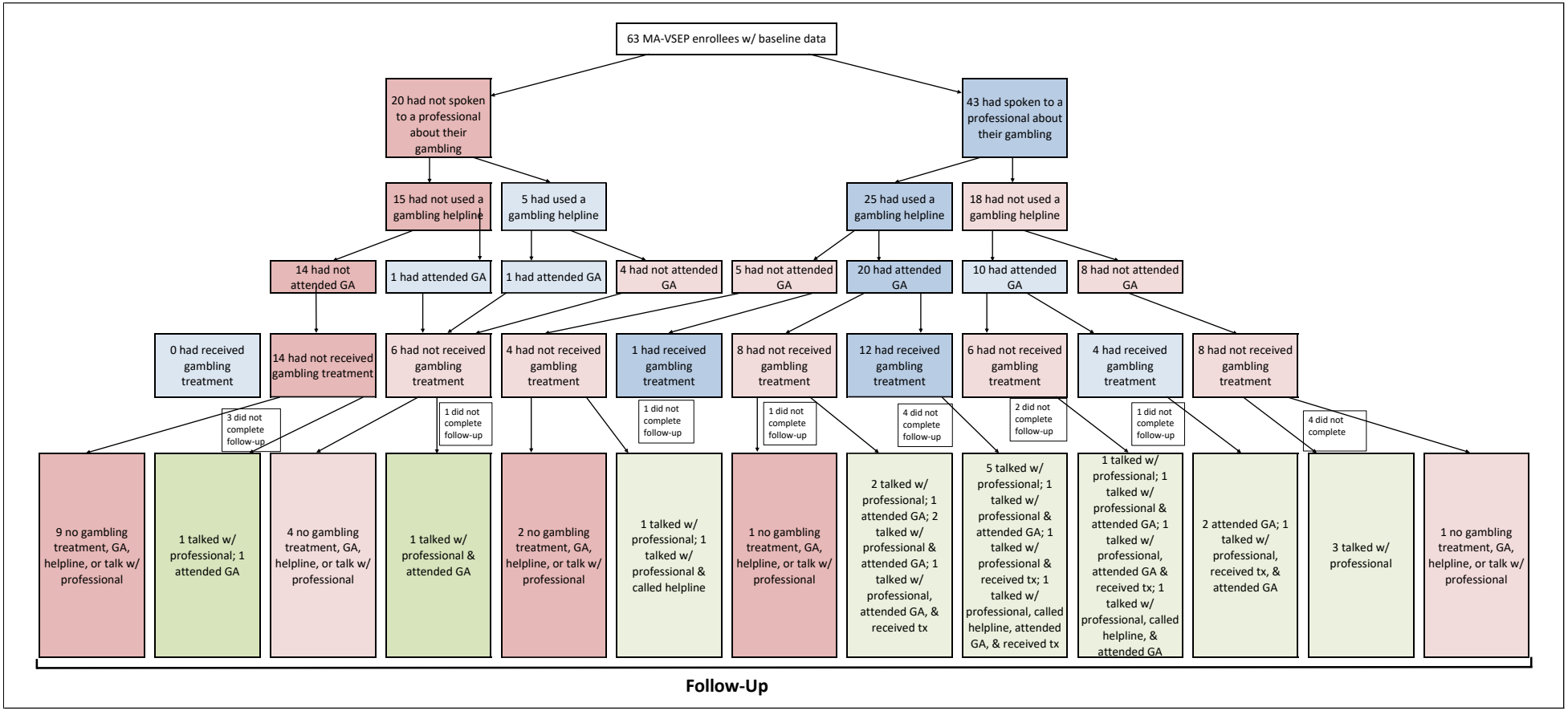
Open Response Reasons for Enrolling in MA-VSEP *Today* (N=158)
You feel it is the best decision for you do it tonight
Work around here
Want to recover. Had it in mind for a while, after being away from gambling for 2 months I felt ready
Wants a different life
Wanted to ensure to be signed out of each casino. Had done other casinos, need to do this one as well to stop the temptation.
Want to build a better life. Blew $300, and was walking out of the casino, saw GameSense and decided to try 6 months.
Trying to win my money back, and I know I have a gambling problem.
Trying to stop. Was thinking about it and the stress associated with gambling and decided it was time to stop. Knew that id spend the money I won.
tried of losing money
Tried (sp?) of losing money.
totally done
Today is the day. Lost more money than usual
tired of losing money
tired of hurting my family
This cusion [sic] doest [sic] pay out.
The overall mass gaming so-unfair rules. Plus, I don't want to lose anymore money.
The dissapointment [sic] to one man in general. The one person over the years who has tried to help me through tough times. He has had my back thru [sic] thick & thin, regardless of my poor decisions. just had enough, too much time
Started to gamble 2 yrs ago today. Lost a large amount of money.
spent too much money, behind .....
Spent more money than I had in free slot play around $500. It was becoming a frequent habit after work. I worked close by. I was already there and I had lost more than I had wanted to and decided this was it.
Spent money I don't have.
Spending too much time. Was debating it for awhile
Spending too much money and time gambling.
son is in town
slot machine play
Sister told her about the program
seeing your green shirt. Had been thinking about it, was playing at the casino that day and wasn't winning, had heard about it be-fore
Received an email from PPC and decided he had enough
Reached my bottom
putting it off for a while, decided today is the day
planned on it for a long time but did not know it was possible here
Planned action. Gave himself permission to check it out, spent whatever money he brought, then signed up. Went on a day he knew he would be able to sign up (had the day off of work).
on my own
Nothing particular. I finished school, my friend who know about my problem said to me let's go through this self-exclusion journey together. I had self-excluded from foxwood and mohegan sun. We did all of them from Maine to Delaware. We did this all in 2 days.
Nothing
no reason
New year
Needed to stop
Needed to get it done.
I was just done. Tired of losing. I had made up my mind that I was going to play and before I left I was going to sign up.
myself. Was drinking too much and spending money
My lack of self control. Knowledge of the option to do so.

Open Response Reasons for Enrolling in MA-VSEP *Today* (N=158) [cont.]
my friends and family asked to sign up
My 6 yr anniversary for stopping gambling
Moral Son
Money spent too quickly no entertainment provided.
Me
Lost to much need stop my child step. the day her son could go with her. he didn't want it to go any longer
Lost money more than what I could afford
lost money after being up
Lost lots of money, worst day of life! Every time I make money, whatever sometimes I dont pay rent and I go over there and lose my money. Went to the casino that day with 2,000 and lost it all in one hour. I did't know what I was doing. I had stress, this made it worse. I can't control myself.
lost all my money, had enough. I lost money I didn't have, said it was enough. Talked to the guy at GameSense (Gerry). Said I had enough, and I signed up.
Lost all money for trip to Ireland
Lost a lot today
Lost a lot of money.
Lost a lot of money and wanted .....
Lost a lot of money
lost 37000 in 3 days
Lost $1000
Live left the time in Maine and now here. Putting a stop to it today.
Last place to sign out
knew it was an option. need to cool off
Knew I was going to sign out when I entered the casino. It was planned
just want to stop gambling, I have a gambling problem
just ready
Just lost some money that was meant….
Just had enough. Sick in tired of being tired.
Just had enough. realized that I was spending too much and out of control. Did it at Twin River, was an easy time to go, had a break during job
just had enough
just decided today was the day. Thinking of quitting and saw GSA, had a conversation about losing too much money and it was fate finding the GSA.
ive been losing every time I come down, enough is enough, i had $2900 in my pocket and have .....
Its a suckers game, lost a large.....
It's been a long time since she's been in a casino entering this one makes her feel like nothing has changed. She hasn't been in a casino in one & a half years. She was excited about plain ridges open
It's a way to save money
It was planned for today
im sick of this, the machines are too strictly controlled
If I don't do nothing good today, I do this. I lost $2500 in 3 visits this week and…
I won a good deal of money and gave it back.
I want to save to buy a house.
I lost too much $ today!
I know I have a problem and it .....
I knew I needed to
I felt this was the day to do it
I do not want to lose anymore money.
hit bottom. spent too much money
havent won at Plainridge
have done it at other casino
Had made up my mind to VSE today

Open Response Reasons for Enrolling in MA-VSEP *Today* (N=158) [cont.]
Had enough.
had enough!
Had enough of losing my money.
Had a set day. Getting barred from the casino, and see how they compared to other casinos and support others.
had a set day
Had a reality check after today's
Habit is getting out of control
gambling-problem
Financially bankrupt... will file with court. Spoke with me before Christmas
Finally decided today is the day.
Figured out I can't control my gambling
Felt need to do it.
Felt it was in her best interest
felt guilty, spendi..... I had been gambling for a month and was severely depressed and needed to stop.
Fed up with gambling lose money on slot. I had lost money the day before. And I didn't want to blow $400 the next week if I had the chance to.
due to the fact that I gave PPC $80,000.00
dont want to lose his marriage due to gambling
Don't want to lose anymore money
Do not want to lose any more money. I can't deal with it anymore, didn't care that I was borrowing money from others or fighting with boyfriend.
Do not want to lose any more money
Do not want to lose any more money
do not want to lose any more money
Do not want to lose any more money.
Do not want to lose any more money
do not want to lose any more money
Do not want to hurt my wife anymore. For about 10 years I had cleaned my act up from gambling. I was better husband, father, everything. When I went back to it, I turned back into a scumbag and an addict. Borrowing money, lying about it. About 6 months ago, by accident I hit a $5k winnings. I took the money and left. One night I went there with about the same amount of money and I knew I wasnt going to leave there with any money. I was talking to myself, sitting there losing it as fast as I could. It was a cry for help. A couple weeks later you made the decision to self-exclude.
Disgusted with continual losses and getting deeper in debt.
Did not walk away when I was up$1000.00 earlier today.
did it before vacation
Decided to take this step last Friday actually (8/4) after trying not to gamble more than a specific amount and not having enough control to follow through.
Day off excluding everywhere
Control my gambling
Come here to much
change in personality, getting angry at family members who are winning. saw gambling as a rip off, knew that she would keep go-ing
Casino location is too close to home. For a while I wanted to take a cool down. When I was there I decided to do it. I wanted to take a 3 year. I'm not a compulsive gambler. I go a lot so its a way to reduce the amount of times I gamble. My goal is to gamble once or twice a year at a destination such as Las Vegas or Atlantic City.
Cannot stop gambling. because I had the time and I was with someone that would support me. I had signed out of all the other casinos and figured I would just do them all. I knew if I had signed out of 3/4, I would just go to the 4th.
Cannot control my gambling
Can't stop coming in.
can't control gambling, gambling problem
Came just to sign up
came in to the casino on multiple occasions with the intent of signing out

Open Response Reasons for Enrolling in MA-VSEP *Today* (N=158) [cont.]
Came as a group to sign out. Made arrangements to go down with two friends and all self-exclude. became familiar with gamesense and my involvement with council.
Came as a group to exclude. The sight of slot machines and supporting a friend
Big bills coming up.
better relationship with family
Began self-exclusion at ALL local casinos
been thinking about it for a while
Been here too much.
Been considering it for a while
Becoming completely broke, worried I will be homeless... I got paid on Friday an
Because my first exclusion for life
Because it's so close to home. Too tempting. I was at the casino for a 3rd or 4th time that week, lost 600-700 that day
Because I lost a lot of money
Attending college and need a break from the casino
as stated about (question 1)
already thinking about it
Tried to sign up a week or two before. Not a good experience with a GSA. went in and said let's try it again. That guy was plesant and decided to sign up for 6 months, just to give it a go
Traveling home and discovered this casino and wanted to make sure that he was banned from every casino he could go to.
Losing money, location of Plainridge was way too close to home
It was just hte right time, I'd just had enough, I was playing that day and blew a few hundred, and I just went through with it.
I was stressed out about losing money and worried it was going to get me in to trouble.
I was just done.
I had just won a runner up prize on a 10k prize, $500 slot play and I sat down and put it all back into the machine. I put everything in the machine. I put all my money and winnings into the machine. I lived there, was there every day. I lost everything.
I had heard of it. Decided I would sign up if I didn't have a good night at PPC. Had one last hurrah
i feel, since i know i have a gambling problem Plainridge is to close to home and felt it was time to exclude myself before it becomes out of control.
Budget resolve
before signing he won big, and wanted to prevent himself from losing any more money
Because I need to stop gambling and cant do it on my own

APPENDIX H: MA-VSEP ENROLLEES' GAMBLING-RELATED TREATMENT AND SELF-HELP BEFORE AND AFTER MA-VSEP ENROLLMENT



APPENDIX I: EXPLORATORY ANALYSES OF MODERATOR EFFECTS – GENDER, AGE, AND LENGTH OF ENROLLMENT

For each set of analyses conducted in the body of the report, we also conducted a series of exploratory analyses examining moderators. In these analyses, we tested whether MA-VSEP enrollee characteristics, behaviors, and changes in behavior vary by gender, age (via median split: younger than 49 or older than 48), and term of enrollment (via median split: 12 months or less or 36 months or more). We did not include race or ethnicity in these comparisons because of the uneven distribution of race and ethnicity in the sample. Because of the number of comparisons, size of the sample, and limitations of the sample, these results require replication and should be interpreted with caution.

Past Gambling Behavior Prior to MA-VSEP Enrollment

Older enrollees (i.e., age 49 and older) were more likely than younger enrollees (i.e., age 48 and younger) to report electronic gambling machines as the games on which they had lost the most money, $\chi^2(8)=15.7$, $p<.05$, but game type did not vary by gender or enrollment term.

Frequency of visiting PPC and venues in neighboring and non-neighboring states did not differ by gender, age, or term of enrollment. Recency of last bet prior to signing up for MA-VSEP also did not differ by gender, age, or term of enrollment.

MA-VSEP enrollees who responded to questions about their gambling behavior reported losing substantial amounts of money, both overall, and in any one day. These financial variables did not vary by gender or age. However, the maximum amount lost in one day varied by term of enrollment, $F(1,127)=7.6$, $p<.01$. Those who signed up for 3-year or 5-year MA-VSEP terms reported significantly greater maximum one day losses (M=$5,085.3, SD=$8,485.5) than those who signed up for 6-month or 12-month terms (M=$2,013.0, SD=$2,125.7).

MA-VSEP enrollees who completed the baseline survey (n=63) provided additional information about their gambling behavior prior to MA-VSEP enrollment. Older enrollees reported beginning gambling at a later age (M=28.8, SD=14.1) than younger enrollees (M=17.3, SD=6.7), $F(1,61)=16.3$, $p<.001$. Age of gambling initiation did not vary by gender or term of enrollment. Lifetime frequency of gambling did not vary by gender, age, or term of enrollment.

Enrollees who completed the baseline survey gambled on a variety of game types in the year prior to exclusion. Game choice varied somewhat by gender and age, but not by enrollment term. Women bet on sports with friends less frequently than men, $F(1,61)=41$, $p<.05$, and young enrollees played table games and poker at a casino and engaged in games of physical skill for money more frequently than older enrollees, $F(1,61)=11.0$, $p<.01$, $F(1,61)=5.1$, $p<.05$, and $F(1,61)=6.1$, $p<.05$, respectively. Male enrollees and younger enrollees had engaged in significantly more different types of gambling in the prior year than female and older enrollees, $F(1,61)=4.2$, $p<.05$, and $F(1,61)=8.0$, $p<.01$, respectively for gender and age.

Past Gambling Behavior at PPC Prior to MA-VSEP Enrollment – Player Card Data

For each of the 91 enrollees with player card gambling activity, we calculated the total amount they had wagered and the total amount they had lost using their card prior to their date of MA-VSEP enrollment, and the number of visits they had made to PPC during which they recorded gambling activity prior to their date of VSEP enrollment. To control for their time at-risk (i.e., some enrollees had hundreds of days during which they could have recorded card activity prior to MA-VSEP enrollment and others had only a few weeks), we calculated three additional variables: amount wagered per day (i.e., total amount wagered divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment), amount lost per day (i.e., total amount lost divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment), and frequency of play (i.e., number of visits divided by days between the enrollee's first gambling activity in the PPC system and the date of their MA-VSEP enrollment). These variables did not vary by gender, age, or enrollment term.

Past Gambling Motivations, Attitudes, and Experiences Prior to MA-VSEP Enrollment

Reasons for gambling did not vary by gender or age. However, MA-VSEP enrollees who selected enrollment terms of 36 months or more were more likely than others to report gambling because they felt sad or depressed (47.7% compared to 24.2%, $\chi^2(1)=7.6$, $p<.01$).

MA-VSEP enrollees who completed the baseline survey answered question about their beliefs about luck and probability as they relate to gambling, as well as their attitudes about the benefits and costs of gambling. Attitudes and beliefs did not vary by gender or age. However, enrollees who selected 6 month or 12 month terms had greater agreement with the statement that someone's luck would turn around if they kept gambling (M=2.4, SD=1.4) than enrollees who selected a 36 month or longer term (M=1.5, SD=1.1), $F(1,59)=12.3$, $p<.01$.

Past Gambling Problems Prior to MA-VSEP Enrollment

Both the application and the baseline survey included the Brief Bio-Social Gambling Screen, which includes three criteria of gambling disorder found to be most indicative of that disorder (BBGS: Gebauer et al., 2010). Men and women were just as likely to screen positive on the BBGS, as were older and younger enrollees; however, younger enrollees were more likely to endorse having financial trouble as a result of their gambling, $\chi^2(1)=6.0$, $p<.05$. BBGS item endorsement did not vary by enrollment term.

MA-VSEP enrollees who completed the baseline survey responded to a full assessment of gambling problems, a past 12-month adaptation of the gambling section of the Alcohol Use Disorder and Associated Disabilities Interview Schedule IV (AUDADIS-IV: Grant et al., 2003) that we have used in previous work (i.e., Nelson et al., 2013). Younger enrollees endorsed more DSM criteria (M=7.8, SD=1.8) than did older enrollees (M=6.4, SD=2.7), $F(1,61)=6.0$, $p<.05$, but criteria endorsement did not vary by gender or enrollment term.

Physical and Mental Health Prior to MA-VSEP Enrollment

Physical and mental health ratings did not vary by age, gender, or enrollment term. Depression and anxiety scores also did not differ by gender, age, or enrollment term. To examine potential triggers for mental health issues that might exacerbate gambling issues, the baseline survey asked MA-VSEP enrollees whether they had experienced any of 10 life events in the year prior to MA-VSEP enrollment. Female enrollees were more likely than male enrollees to report dealing with the illness of a friend or family member (45.8% compared to 17.9%), $\chi^2(1)=5.7$, $p<.05$, and enrollees who selected a 6 or 12 month term were more likely to report having difficulty access health care or medical services (22.2% compared to 5.6%), $\chi^2(1)=3.9$, $p<.05$, but no other gender, age, or enrollment term differences emerged. Number of stressors did not vary by gender, age, or enrollment term.

Relationships and Social Support Prior to MA-VSEP Enrollment

Enrollees who completed the baseline survey rated their relationships on a scale from 1 (poor) to 5 (excellent). There were no differences by gender, age, or enrollment term. MA-VSEP enrollees who completed the baseline survey also responded to the TCU Social Support Scale (Joe et al., 2002), a 9-item measure of social support from friends and family. Social support did not vary by gender or age. However, enrollees who selected 6 or 12 month terms reported less social support (M=33.4, SD=7.1) than enrollees who selected a term of 36 months or more (M=38.3, SD=6.7), $F(1,56)=7.2$, $p<.05$.

Past Treatment Prior to MA-VSEP Enrollment

Female enrollees were more likely than male enrollees to have talked to a doctor or professional about their gambling problems (i.e., 83.3% compared to 59.0%), $\chi^2(1)=4.1$, $p<.05$. There were no other gender, age, or enrollment term differences in past treatment, treatment types received, or self-help group attendance.

Motivations for Enrollment Prior to MA-VSEP Enrollment

Reasons for MA-VSEP enrollment did not differ by gender or age. However, enrollees who selected enrollment terms of 36 months or longer were more likely to endorse enrolling because they couldn't control their gambling (i.e., 82.7% compared to 57.6%), and because they wanted to improve relationships with their family and friends (i.e., 38.8% compared to 22.4%) than enrollees who selected shorter enrollment terms, $\chi^2(1)=13.8$, $p<.001$ and $\chi^2(1)=5.7$, $p<.05$, respectively.

Most MA-VSEP enrollees intended to quit all gambling upon MA-VSEP enrollment. This did not vary by gender or age. However, enrollees who selected a 36 month or longer enrollment term were more likely that others to intend to quit all gambling (80.0% compared to 59.3%), $\chi^2(3)=9.4$, $p<.05$.

In addition, though male and female enrollees expressed similar readiness and confidence in their ability to change their behavior, older enrollees expressed greater readiness to change their behavior (M=9.0, SD=1.4) than younger enrollees (M=7.2, SD=2.5), F(1,61)=13.0, p<.01. Neither readiness to change nor confidence in ability to change varied by length of enrollment term.

MA-VSEP Satisfaction and Experiences

MA-VSEP enrollees who participated in the baseline survey indicated how they learned about the MA-VSEP. There were no gender or enrollment term differences, but younger enrollees were more likely to report having been told about MA-VSEP by PPC staff (other than a GSA), $\chi^2(1)=4.2$, p<.05.

MA-VSEP satisfaction and impressions of the GSAs did not differ by gender, enrollment term, or age.

MA-VSEP Utilization

As Figure 28 shows, among the sample of first-time MA-VSEP enrollees (n=263), 67 (25.5%) agreed to have a one-week check-in call with staff from the MCCG. There were no statistically significant differences between those who agreed to and those who declined an MCCG one-week check-in call based on gender, age at enrollment, or term of MA-VSEP enrollment.

Among the enrollees with whom MCCG completed check-in calls, there were no differences in rates related to check-in and utilization of resources by gender, age at enrollment, or length of enrollment term.

MA-VSEP Violations

MA-VSEP violations reported by enrollees who completed the follow-up survey did not differ by gender, age at enrollment, or enrollment term.

Baseline and Follow-up Survey Respondents: Changes in Gambling Behavior after MA-VSEP Enrollment

Gambling after enrollment did not vary by age or gender, but enrollees who selected terms of 36 months or longer were more likely to report gambling after enrollment.

Across enrollees who completed the follow-up survey, frequency of gambling at PPC and other casinos decreased from baseline to follow-up. There were some differences by gender, age, and enrollment term. Enrollees who selected shorter enrollment terms (i.e., 6- or 12-months) demonstrated greater decreases in their frequency of gambling at PPC than other enrollees, F(1,39)=11.6, p<.01, younger enrollees demonstrated greater decreases in their frequency of gambling at neighboring casinos than older enrollees, F(1,37)=4.4, p<.05, and male enrollees demonstrated greater decreases in their frequency of gambling at non-neighboring casinos than female enrollees, F(1,36)=6.0, p<.05. In all three cases, the group that evidenced greater decreases also had higher baseline scores. Cell counts were low for these comparisons, so these findings should be interpreted with caution.

We also examined changes in frequency of gambling on different game types for the 10 game types engaged in by more than 10% of the baseline sample. There were no gender or enrollment term effects, but there were two age differences. Younger enrollees demonstrated greater decreases in their frequency of playing table games and poker at casinos than older enrollees, F(1,42)=4.4, p<.05 and F(1,42)=6.0, p<.05, respectively. In both cases, the younger group that evidenced greater decreases also had higher baseline scores. Cell counts were low for these comparisons, so findings should be interpreted with caution.

The number of game types MA-VSEP enrollees who completed the follow-up survey engaged in after signing up for MA-VSEP decreased. These reductions did not vary by gender or age of enrollment. However, among the 33 who continued gambling after MA-VSEP enrollment, those who had selected 6 month or 12 month terms reduced the number of game types they played more than other enrollees after enrollment, F(1,31)=6.9, p<.05.

Among the 33 who continued gambling after MA-VSEP enrollment, both total losses, and the maximum lost in one day were significantly lower than prior to baseline. These reductions did not differ by gender, enrollment term, or age at enrollment.

Enrollees' perceived changes in gambling from before MA-VSEP enrollment to after did not vary by gender or age, but enrollees who selected a longer enrollment term were more likely than others to report not gambling at all after enrollment, $\chi^2(4)=12.3$, $p<.05$.

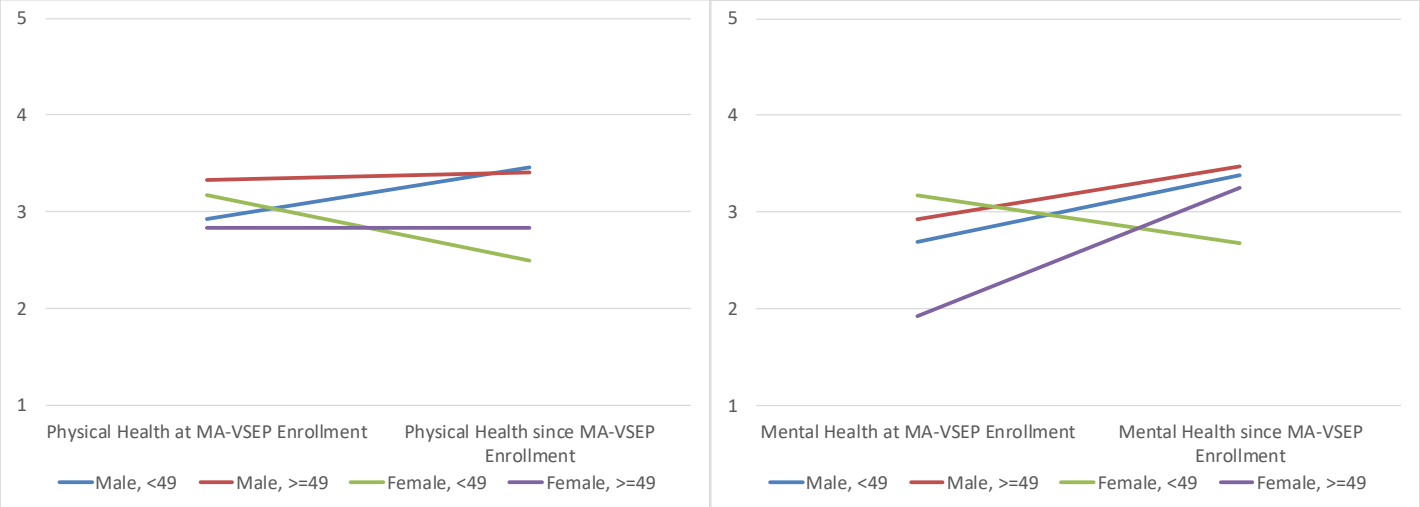
Baseline and Follow-up Survey Respondents: Changes in Gambling Problems

MA-VSEP enrollees who completed the follow-up survey were less likely to endorse each of the DSM-5 criteria for gambling disorder at follow-up than at baseline, and the average number of DSM-5 criteria endorsed by enrollees decreased. None of these findings varied by gender, enrollment term, or age.

Baseline and Follow-up Survey Respondents: Changes in Physical and Mental Health

MA-VSEP enrollees who completed the follow-up survey again responded to questions about physical and mental health, as well as the modified version of the Patient Health Questionnaire-4 assessment for anxiety and depression in the 2 weeks prior to follow-up (PHQ-4: Kroenke et al., 2009). Changes in physical health differed by gender, $F(1,42)=5.2$, $p<.05$, changes in mental health differed by age group, $F(1,42)=6.7$, $p<.05$, and both evidenced a three-way interaction between gender, age group, and time, $F(1,42)=4.1$, $p<.05$ for physical health and $F(1,42)=9.5$, $p<.01$ for mental health. As Figure I1 shows, young male enrollees experienced improvements in both their physical and mental health from MA-VSEP enrollment to follow-up, whereas young women showed declines in both across time. For older enrollees, these differences were not evident; older enrollees experienced no change in physical health, and both male and female older enrollees demonstrated improvements in mental health. There were no differences by enrollment term.

Figure I1: Age by Gender Differences in Physical and Mental Health Improvements Pre- and Post-MA-VSEP Enrollment



Baseline and Follow-up Survey Respondents: Changes in Relationships & Social Support

MA-VSEP enrollees who completed the follow-up survey again responded to questions about their relationships with family and friends, as well as the TCU Social Support Scale (Joe et al., 2002), a 9-item measure of social support from friends and family. Improvements in the quality of their relationships with their spouse or partner did not differ by gender, age, or enrollment term. Social support did not vary significantly from enrollees' baseline score, and there were no pre- post-differences by gender, age, or enrollment term.

Baseline and Follow-up Survey Respondents: Changes in Treatment Readiness

MA-VSEP enrollees' readiness to and confidence in their ability to change their gambling behavior did not change significantly from baseline to follow-up. However, there was a significant time by age group interaction for readiness to change, such that the readiness to change reported by younger MA-VSEP enrollees increased from before to after MA-VSEP enrollment (from M=7.7, SD=1.9 to M=8.4, SD=2.2), whereas the readiness of older MA-VSEP enrollees decreased slightly (from M=9.2, SD=1.3 to M=8.2, SD=2.9), $F(1,42)=4.6$, $p<.05$. Changes in readiness and confidence to change did not vary by gender or enrollment term.

APPENDIX J: EXPLORATORY ANALYSES OF PREDICTORS OF OUTCOMES AT 6- 12-MONTH FOLLOW-UP

To examine factors that predict positive change among MA-VSEP enrollees, we conducted a series of multiple linear regression and logistic regression analyses. For each regression, we entered the baseline measure, if available, of the follow-up outcome under investigation, followed by baseline measures of demographics, enrollment characteristics, gambling behavior, gambling problems, attitudes, motivations, and intentions at enrollment, physical and mental health, social support and relationships, and MA-VSEP experiences that reached at least a $p<.10$ threshold for statistical significance for the univariate analyses examining their association with the outcome variable. In the analysis section, Table J1 includes a list of those predictors and how we defined them. We conducted these regressions for the following outcomes: (1) whether enrollees reported gambling less at follow-up than prior to MA-VSEP enrollment, (2) total money lost gambling since MA-VSEP enrollment, (3) maximum daily gambling loss since MA-VSEP enrollment, (4) number of DSM-IV gambling disorder criteria endorsed at follow-up, (5) mental health at follow-up, and (6) relationship quality at follow-up.

Table J1: Baseline Predictors of Follow-Up Outcomes

Domain	Predictor
Demographics	Gender (0=male; 1=female)
	Race / Ethnicity (0=white non-Hispanic; 1=other race/ethnicity)
	Age Group (0=less than 49; 1=greater than 48)
	Household Income (0=<$50K; 1=$50K+)
	Employment (0=full-time; 1=other than full-time)
	Relationship Status (0=married or in marriage-like relationship; 1=not married)
Enrollment Characteristics	Length of Enrollment Term (0=12 months or less; 1=36 months or more)
	Removal (0=still active; 1=removed self from list)
Gambling Behavior	Frequency of Play at MA casinos (0=never; 7=daily or more)
	Frequency of Play at neighboring casinos (0=never; 7=daily or more)
	Total $ lost in past year
	Most $ lost in one day in past year
	Maximum Frequency of Play on non-casino games (0=never; 7=daily or more)
Gambling Problems	# of DSM-IV Criteria of Gambling Disorder Endorsed
Attitudes, Motivations, and Intentions	Gambling for Excitement / Good Time (0=no; 1=yes)
	Gambling to Get Money (0=no; 1=yes)
	Gambling Because Lonely/Sad (0=no; 1=yes)
	Belief in Luck (average agreement w/ 7 statements about luck: 1=disagree strongly; 5=agree strongly)
	Readiness to Change (0=not at all ready; 10=completely ready)
	Confidence in Ability to Change (0=not at all confident; 10=completely confident)
	Planning to Quit All Gambling upon Enrollment (0=no; 1=yes)
Physical and Mental Health	Physical health (1=poor; 5=excellent)
	Mental health (1=poor; 5=excellent)
	Depression or Anxiety Screen (0=did not screen positive; 1=screened positive)
	# of Stressful Life Events in Past Year
Relationships and Social Support	Relationships (average rating of relationships with partner/family/friends: 1=poor; 5=excellent)
	Social Support (summed score of agreement with 9 items: 1=disagree strongly; 5=agree strongly for each item)
MA-VSEP Experiences	MA-VSEP Interaction Satisfaction (1=not at all satisfied; 5=extremely satisfied)
	MCCG Check-In Call Willingness (0=refused; 1=agreed to)
	MCCG Check-In Call Completion (0=no; 1=yes)

Gambling

Upon univariate investigation, three variables – whether the enrollee had formally removed himself or herself from MA-VSEP list, frequency of gambling at PPC prior to MA-VSEP enrollment, and beliefs about luck – were associated with whether an enrollee reported not gambling or gambling less since MA-VSEP enrollment. Table J2 displays these predictors, and their relationship to the outcome within a logistic regression. As the table shows, the predictors contributed significantly to the likelihood of gambling less or not at all after MA-VSEP enrollment. This contribution to the model was driven by a positive relationship between beliefs in luck at baseline and gambling less or not at all since MA-VSEP enrollment, Wald $\chi^2(40)=-4.3$, $p<.05$. This analysis should be interpreted with caution due to the small n.

Table J2: Predictors of Reduced Gambling Since MA-VSEP Enrollment among MA-VSEP Enrollees (n=41)

Baseline Predictors	Outcome: Whether Enrollee Reported Not Gambling or Gambling Less Since MA-VSEP Enrollment				
	B	SE	Exp(B) [95% CI]	Step χ^2	Model χ^2
Step 1:				11.48**	11.48**
Removal (0=still active; 1=removed self from list)	-.99	1.27	.37 [.03; 4.52]		
Frequency of play at MA casinos (0=never; 7=daily+)	-.51	.34	.60 [.31; 1.18]		
Belief in luck (1=disagree strongly; 5=agree strongly)	2.11	1.02	8.22* [1.11; 60.94]		

**p<.05*

Total Amount Spent Gambling and Maximum Daily Loss Gambling

Upon univariate investigation, only one baseline variable, number of stressful life events experienced in the past year, related to total amount lost gambling since MA-VSEP enrollment ($r=.26$, $p<.10$). The baseline measure of past year total amount lost gambling did not relate to the follow-up measure ($r=-.03$, $p=.86$). Because only one variable demonstrated an association, we did not conduct a regression for this variable. However, we re-ran these analyses using only the follow-up sample who continued gambling after MA-VSEP enrollment. Among this group, two variables, relationship status and term length of MA-VSEP enrollment, were associated with total amount lost gambling since MA-VSEP enrollment, but baseline total amount lost in the past year was not. Table J3 displays these predictors, as well as the baseline measure, and their relationship to the outcome within a multiple linear regression using only data from enrollees who continued gambling after enrollment. As Table J3 shows, neither individual predictor contributed meaningfully to the model, but the addition of both contributed significantly to the model. Controlling for gambling losses in the year prior to MA-VSEP enrollment, there was a trend such that enrollees who were not married or in a marriage-like relationship had higher total losses after MA-VSEP enrollment than others ($p=.08$), and enrollees who selected longer enrollment terms had higher total losses after MA-VSEP enrollment ($p=.11$). This analysis should be interpreted with caution due to the small n.

Table J3: Predictors of Total Money Lost Gambling Since MA-VSEP Enrollment among MA-VSEP Enrollees Who Continued Gambling (n=27)

Baseline Predictors	Outcome: Total Money Lost Gambling Since MA-VSEP Enrollment among Enrollees Who Continued Gambling				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.03	.03
Total Money Lost Gambling PY	.09	.10	.18		
Step 2:				.22*	.25*
Total Money Lost Gambling PY	.09	.10	.17		
Relationship status (0=married/partner; 1=other)	10,276.04	5521.39	.34		
Length of enrollment term (0=6-12 mo; 1=36 mo+)	9,234.37	5,631.05	.30		

**p<.05*

Examining univariate results, three baseline variables – number of DSM gambling disorder criteria endorsed, readiness to change gambling behavior, and number of stressful life events experienced in the past year – related to maximum daily loss gambling since MA-VSEP enrollment. The baseline measure of maximum past year daily loss gambling did not relate

to the follow-up measure. Table J4 displays these predictors, as well as the baseline measure, and their relationship to the outcome within a multiple linear regression. As this table shows, the predictors contributed significantly to the prediction of maximum daily loss since enrollment, controlling for past year maximum daily loss prior to MA-VSEP. This contribution to the model was driven by a negative relationship between readiness to change gambling behavior at baseline and maximum daily loss since MA-VSEP enrollment, t(40)=-2.6, p<.05.

Table J4: Predictors of Maximum Daily Loss Gambling Since MA-VSEP Enrollment among MA-VSEP Enrollees (n=41; n=23)

Baseline Predictors	**Outcome: Maximum Daily Loss Gambling Since MA-VSEP Enrollment (n=41)**				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.06	.06
Maximum Daily Loss Gambling PY	.07	.05	.24		
Step 2:				.22*	.28*
Maximum Daily Loss Gambling PY	.05	.05	.17		
# of DSM-IV criteria of gambling disorder endorsed	-2.63	103.67	-.01		
Readiness to change (0=not at all ready; 10=completely ready)	-348.05	136.49	-.38*		
# of Stressful Life Events in Past Year	206.19	150.03	.23		
Baseline Predictors	**Outcome: Maximum Daily Loss Gambling Since MA-VSEP Enrollment among Enrollees Who Continued Gambling (n=23)**				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.25*	.25*
Maximum Daily Loss Gambling PY	.18	.07	.50		
Step 2:				.30	.55
Maximum Daily Loss Gambling PY	-.15	.15	-.42		
Length of enrollment term (0=6-12 mo; 1=36 mo+)	1,078.66	757.36	.29		
Total money lost gambling PY	.04	.03	.77		
# of DSM-IV criteria of gambling disorder endorsed	70.06	171.27	.08		
Gambling to get money (0=no; 1=yes)	666.24	746.65	.18		
Readiness to change (0=not at all ready; 10=completely ready)	-60.54	195.71	-.06		
MCCG Check-In Call Completion (0=no; 1=yes)	764.02	751.78	.20		

**p<.05*

We repeated these analyses using only the follow-up sample who continued gambling after MA-VSEP enrollment. Among this group, seven variables – enrollment term, gambling to get money, agreement to MCCG check-in, successful completion of MCCG check-in, total amount lost in past year, number of DSM gambling disorder criteria endorsed, and readiness to change gambling behavior – in addition to baseline past year maximum daily loss, were associated with maximum daily loss gambling since MA-VSEP enrollment. Table J4 also displays these predictors and their relationship to the outcome within a multiple linear regression using only data from enrollees who continued gambling after enrollment. As the table shows, the predictors did not contribute significantly to the model beyond the baseline measure of past year maximum daily loss. These analyses should be interpreted with caution due to the small n.

Gambling Problems

Upon univariate investigation, six variables – gambling for excitement, frequency of gambling at PPC, readiness to change gambling behavior, confidence in ability to change gambling behavior, number of past year stressful life events, and social support – in addition to baseline number of DSM-5 gambling disorder criteria endorsed, were associated with number of DSM-5 gambling disorder criteria endorsed at follow-up. Table J5 displays these predictors, as well as the baseline measure, and their relationship to the outcome within a multiple linear regression. As the table shows, as a group the predictors did not contribute significantly to the model beyond the baseline measure of number of criteria endorsed.

We also repeated these analyses using only the follow-up sample who continued gambling after MA-VSEP enrollment. Among this group, eleven variables – gender, employment, gambling for excitement, gambling to get money, quit

intentions, agreement to MCCG check-in, successful completion of MCCG check-in, total amount lost in past year, readiness to change gambling behavior, number of past year stressful life events, and social support – in addition to baseline number of DSM-5 gambling disorder criteria endorsed, were associated with number of DSM-5 gambling disorder criteria endorsed at follow-up.

Table J5 also displays these predictors and their relationship to the outcome within a multiple linear regression using only data from enrollees who continued gambling after enrollment. As the table shows, the predictors contributed significantly to the prediction of number of DSM-5 gambling disorder criteria endorsed at follow-up, controlling for number of criteria endorsed prior to MA-VSEP enrollment. Significant negative relationships between baseline past year stressful life events, baseline social support, and number of gambling disorder criteria endorsed at follow-up accounted most for this contribution, t(20)=--4.0, p<.01 and t(20)=-3.3, p<.01, respectively. These analyses should be interpreted with caution due to the small n.

Table J5: Predictors of # of DSM-5 Criteria of Gambling Disorder Endorsed among MA-VSEP Enrollees at Follow-Up (n=36; n=21)

Baseline Predictors	**Outcome: # of DSM-IV Gambling Disorder Criteria Endorsed at Follow-Up (n=36)**				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.15*	.15*
# of DSM-IV criteria of gambling disorder endorsed	.58	.24	.39*		
Step 2:				.26	.41*
# of DSM-IV criteria of gambling disorder endorsed	.45	.25	.30		
Frequency of play at MA casinos (0=never; 7=daily+)	.09	.23	.06		
Gambling for excitement/good time (0=no; 1=yes)	-1.88	3.07	-.10		
Readiness to change (0=not at all ready; 10=completely ready)	-.66	.33	-.36		
Confidence in ability to change (0=not confident; 10=confident)	.14	.25	.11		
# of Stressful Life Events in Past Year	.01	.34	.01		
Social support (0=lowest; 45=highest)	-.15	.07	-.35		
Baseline Predictors	**Outcome: # of DSM-IV Gambling Disorder Criteria Endorsed at Follow-Up among Enrollees Who Continued Gambling (n=21)**				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.34**	.40**
# of DSM-IV criteria of gambling disorder endorsed	.96	.31	.59**		
Step 2:				.55*	.89**
# of DSM-IV criteria of gambling disorder endorsed	.62	.22	.38*		
Gender (0=male; 1=female)	-.13	.86	-.02		
Employment (0=full-time; 1=other)	.47	.99	.07		
Gambling for excitement/good time (0=no; 1=yes)	-4.19	2.20	-.29		
Total money lost gambling PY	.00	.00	.33*		
Gambling to get money (0=no; 1=yes)	.52	.93	.08		
Planning to quit all gambling upon enrollment (0=no; 1=yes)	1.23	.87	.19		
Readiness to change (0=not at all ready; 10=completely ready)	.08	.27	.04		
# of Stressful Life Events in Past Year	-1.15	.29	-.69**		
Social support (0=lowest; 45=highest)	-.26	.08	-.60**		
MCCG Check-In Call Completion (0=no; 1=yes)	2.52	.94	.39*		

**p<.05; **p<.01*

Mental Health

Upon univariate investigation, ten variables – gambling for excitement, quit intentions, number of DSM gambling disorder criteria endorsed, having a positive depression or anxiety screen, readiness to change gambling behavior, physical health, number of past year stressful life events, successful completion of MCCG check-in, relationship quality, and social support – in addition to baseline mental health, were associated with mental health at follow-up. Table J6 displays these predictors, as well as the baseline measure, and their relationship to the outcome within a multiple linear regression. As the table shows, the predictors contributed significantly to the prediction of mental health at follow-up, controlling for mental health prior to MA-VSEP enrollment. The only predictor that exhibited a significant direct relationship with mental health at follow-up, controlling for mental health prior to MA-VSEP enrollment, was quit intentions. Enrollees who planned to quit all gambling when they enrolled had worse mental health than others at follow-up. This analysis should be interpreted with caution due to the small n.

Table J6: Predictors of Mental Health among MA-VSEP Enrollees at Follow-Up (n=29)

Baseline Predictors	**Outcome: Mental Health at Follow-Up**				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.29**	.29**
Mental health (1=poor; 5=excellent)	.47	.14	.53**		
Step 2:				.46*	.75**
Mental health (1=poor; 5=excellent)	.16	.18	.18		
# of DSM-IV criteria of gambling disorder endorsed	-.06	.07	-.14		
Gambling for excitement/good time (0=no; 1=yes)	.79	.87	.14		
Readiness to change (0=not at all ready; 10=completely ready)	.07	.08	.13		
Planning to quit all gambling upon enrollment (0=no; 1=yes)	-.79	.33	-.34*		
Physical health (1=poor; 5=excellent)	.02	.20	.02		
Depression/anxiety positive screen (0=no; 1=yes)	.33	.33	.15		
# of Stressful Life Events in Past Year	-.02	.12	-.03		
Relationships w/ partner/family/friends (1=poor; 5=excellent)	.23	.18	.23		
Social support (0=lowest; 45=highest)	.05	.03	.32		
MCCG Check-In Call Completion (0=no; 1=yes)	-.41	.34	-.19		

**p<.05; **p<.01*

Relationship Quality

Upon univariate investigation, ten variables – race/ethnicity, employment, number of DSM gambling disorder criteria endorsed, having a positive depression or anxiety screen, confidence in ability to change gambling behavior, physical health, mental health, number of past year stressful life events, social support, and satisfaction with the interactions with staff during the MA-VSEP enrollment process – in addition to baseline relationship quality, were associated with relationship quality at follow-up. Table J7 displays these predictors, as well as the baseline measure, and their relationship to the outcome within a multiple linear regression. As Table J7 shows, the predictors contributed significantly to the prediction of relationship quality at follow-up, controlling for relationship quality prior to MA-VSEP enrollment. The only predictor that exhibited a significant direct relationship with relationship quality at follow-up, controlling for relationship quality prior to MA-VSEP enrollment, was social support. Enrollees who reported more social support when they enrolled had better relationship quality than others at follow-up. This analysis should be interpreted with caution due to the small n.

Table J7: Predictors of Relationship Quality among MA-VSEP Enrollees at Follow-Up (n=35)

Baseline Predictors	Outcome: Relationship Quality at Follow-Up				
	B	SE	β	Step R^2 Δ	Model R^2
Step 1:				.33***	.33***
Relationships w/ partner/family/friends (1=poor; 5=excellent)	.53	.13	.58***		
Step 2:				.36*	.69**
Relationships w/ partner/family/friends (1=poor; 5=excellent)	.40	.15	.43*		
Race/eth (0=white non-hisp; 1=other race/eth)	-.68	.43	-.22		
Employment (0=full-time; 1=other)	-.35	.29	-.17		
# of DSM-IV criteria of gambling disorder endorsed	.03	.06	.08		
Depression/anxiety positive screen (0=no; 1=yes)	-.09	.27	-.05		
Confidence in ability to change (0=not confident; 10=confident)	.07	.06	.19		
Physical health (1=poor; 5=excellent)	.07	.15	.07		
Mental health (1=poor; 5=excellent)	-.24	.17	-.31		
# of Stressful Life Events in Past Year	-.03	.09	-.06		
Social support (0=lowest; 45=highest)	.05	.02	.41*		
MA-VSEP satisfaction (1=not satisfied; 5=extremely satisfied)	.24	.18	.16		

**p<.05; **p<.01; ***p<.001*

Resource Access as a Potential Mediator of Positive Change

Because of the low number of enrollees engaged in just gambling treatment before or after MA-VSEP enrollment, to examine the effect of treatment engagement on outcomes, we used the categories depicted in Figure 46. For each outcome we examined in the earlier section, we assessed the effect of treatment engagement on that outcome, controlling, where applicable, for the baseline level of the outcome. We contrast-coded the treatment engagement variables such that we had a set of three independent dichotomous variables: (1) any treatment/treatment-seeking/self-help (tx/tx-sk/sh) compared to none; (2) tx/tx-sk/sh before MA-VSEP enrollment but not after, compared to tx/tx-sk/sh after MA-VSEP enrollment (whether tx/tx-sk/sh occurred prior to enrollment or not); and (3) tx/tx-sk/sh only after MA-VSEP enrollment, compared to tx/tx-sk/sh before and after MA-VSEP enrollment. Treatment engagement did not contribute to any of the models predicting outcomes at follow-up.

Evaluation of the Massachusetts Voluntary Self Exclusion Program: June 2015 – November 2017

Sarah Nelson
Division on Addiction, Cambridge Health Alliance
Harvard Medical School

Presentation at the PHTF Executive Committee Meeting
January 23rd, 2019

1

MA-VSEP Study: Goals

- Understand enrollment trends across time and place
- Understand who signs up for MA-VSEP and why
- Evaluate MA-VSEP satisfaction and experiences of enrollees
- Examine outcomes for enrollees 6-12 months after MA-VSEP enrollment
- Examine whether MA-VSEP enrollment is a gateway to treatment

2

Voluntary Self Exclusion (VSE)

- Has been implemented by governments and casinos across the globe
- Allows individuals to ban themselves from entering specific casinos for a specified time period
- Patron agrees not to enter casino; casino agrees to remove individual from mailing lists and remove patron from the premises if caught there
- Past research suggests that VSE is associated with positive changes in gambling behaviors and problems among enrollees
  - Caveat: no control groups; causal link not established

3

MA Voluntary Self Exclusion Program (MA-VSEP)

- Can exclude at Plainridge Park Casino (PPC), MA Council for Compulsive Gambling (MCCG), or the MA Gaming Commission (MGC)
- Can exclude for 6, 12, 36, or 60 months (or lifetime if 2nd exclusion)
- Exclusion covers all MA casino properties
- Escorted from premises and forfeit money wagered, won, or lost, if caught on gaming floor
- To be removed from VSEP list, enrollees must complete an exit interview once their term has expired

4

Timeline of Study Activities

June 25th, 2015
VSEP enrollments begin

November 25th, 2015
IRB approval received and GSAs trained | Study begins

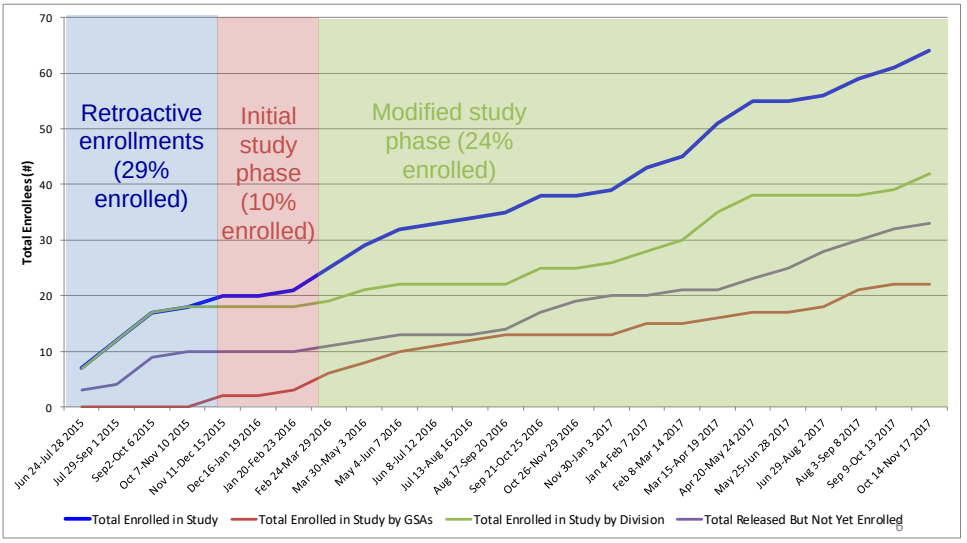
March 1st, 2016
Modified study begins – simplified, no randomization

November 24th, 2017
Baseline enrollment ends

May 24th, 2018
Follow-up interviews end

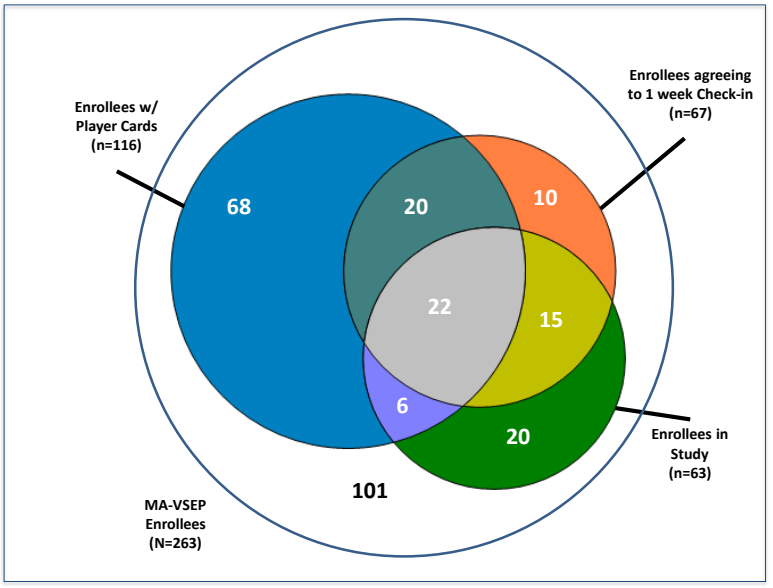
5

VSEP Study Recruitment



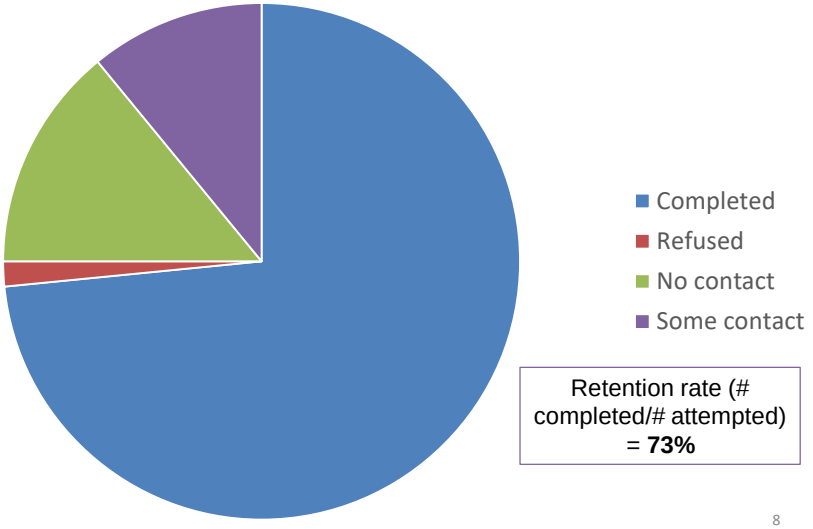
6

Samples



7

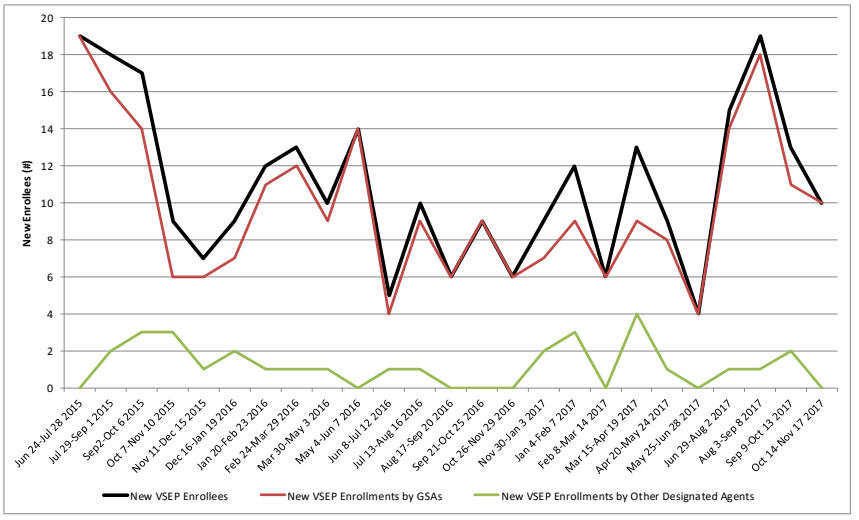
Follow-Up Interviews (n=64 in baseline sample)



Retention rate (# completed/# attempted) = **73%**

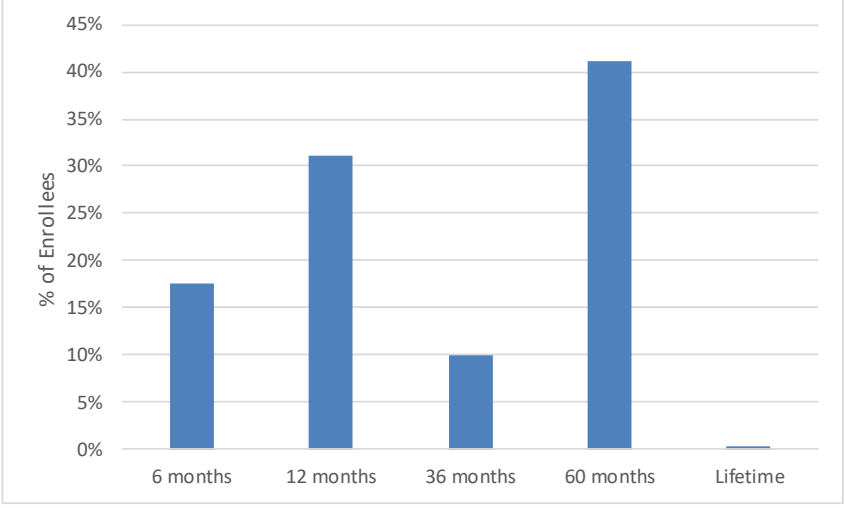
8

Goal 1: Understanding Enrollment Trends Across Time and Place



9

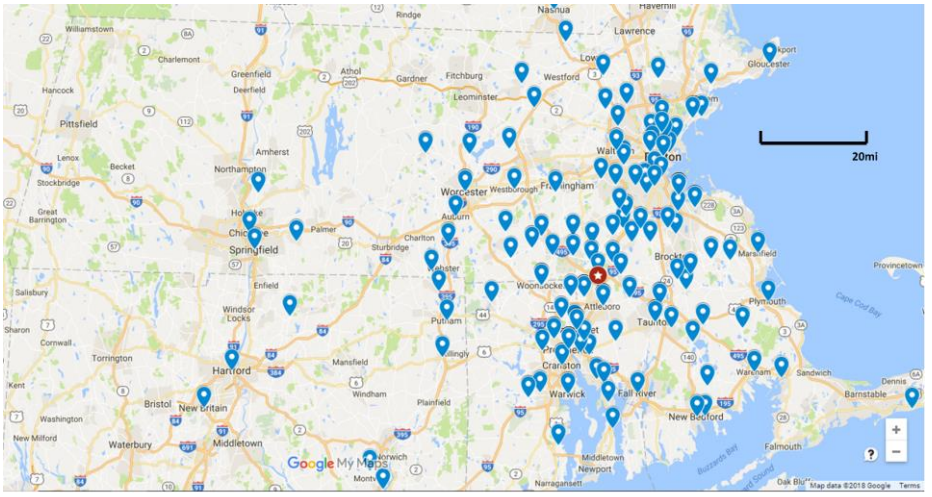
Understanding Enrollment Trends Across Time and Place: Enrollment Terms



10

Understanding Enrollment Trends Across Time and Place:

Geographic Distribution



Note. The red marker indicates the location of Plainridge Park Casino. The blue dots indicate the cities in which MA-VSEP enrollees reside.

11

Understanding Enrollment Trends Across Time and Place:

Take-Home Points

- By the end of the study, enrollment rates had not leveled off as expected but continued at a rate of 1-2 per week
- The most popular enrollment term was 5 years
- Most enrollees lived in the eastern half of MA, but more than a quarter were from RI

12

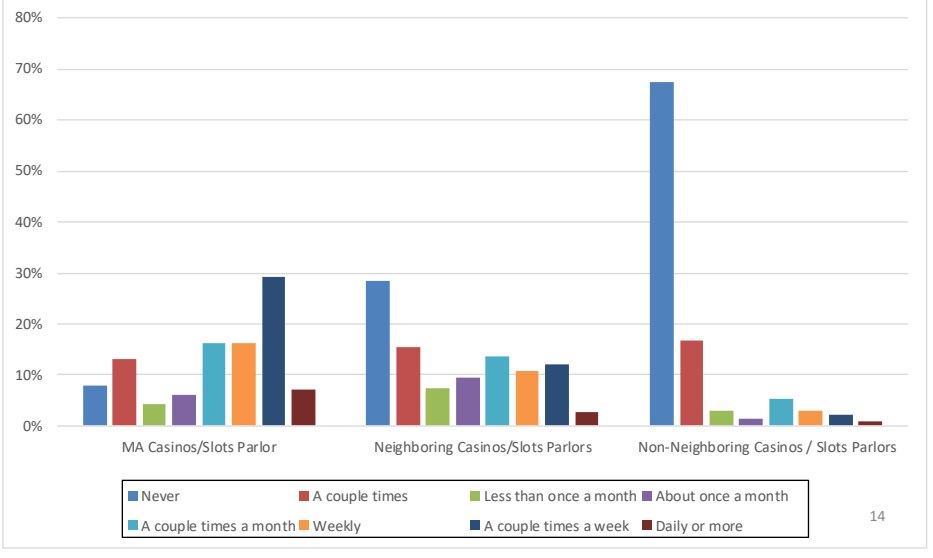
Goal 2: Who Signs Up for MA-VSEP and Why

- Demographics
  - 97% non-Hispanic
  - 79% white; 8% Black; 6% Asian
  - 58% male
  - Average age = 48 (range=22-84), though female enrollees were older (M_{age}=54) than male enrollees (M_{age}=44).
  - 57% employed full-time
  - 59% had a household income of $50,000 or greater
  - 36% married; 29% never married; 20% divorced or separated; 10% in marriage-like relationship; 6% widowed

13

Who Signs Up for MA-VSEP and Why:

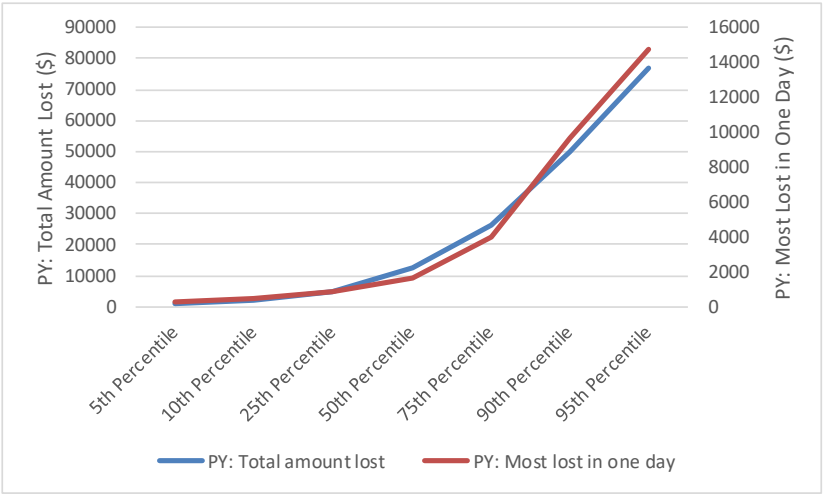
Frequency of Play at MA, Neighboring, and Non-Neighboring Casinos & Slots Parlors (n=167)



14

Who Signs Up for MA-VSEP and Why:

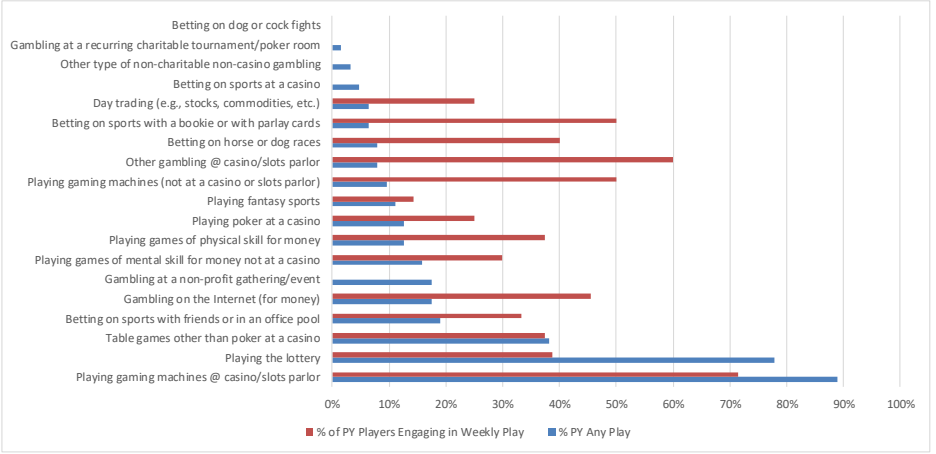
Past Year Total Lost and Most Lost in One Day - Percentiles (n=122; n=129)



15

Who Signs Up for MA-VSEP and Why:

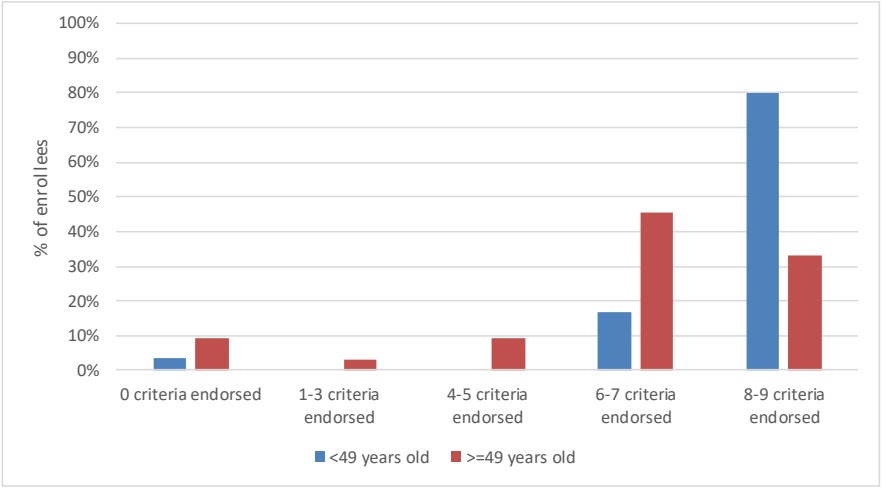
Frequency of Engagement w/ Game Types (n=63)



PY=past year

16

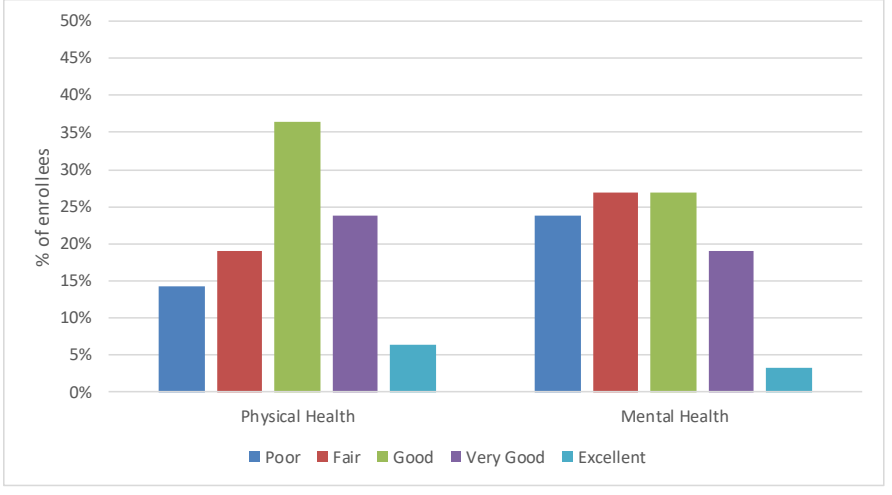
Who Signs Up for MA-VSEP and Why:
of DSM-5 Gambling Disorder Criteria Endorsed(n=63)



- 92.1% qualified for past year gambling disorder (i.e., 4+ criteria)

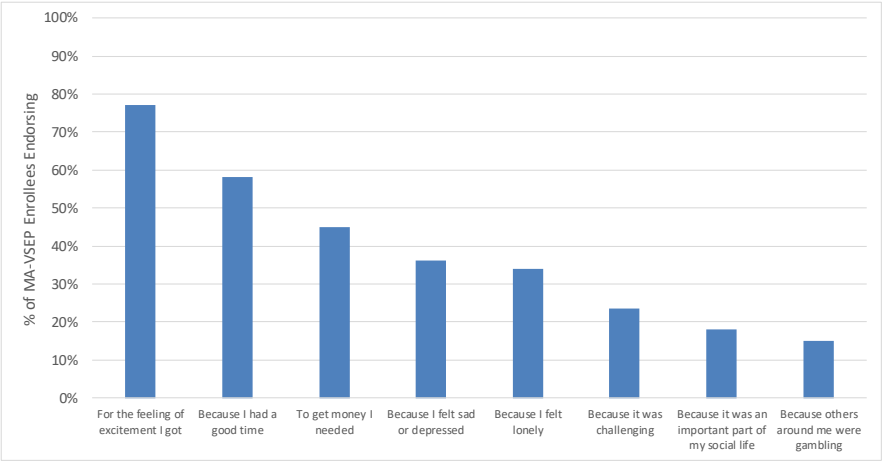
17

Who Signs Up for MA-VSEP and Why:
Physical and Mental Health (n=63)



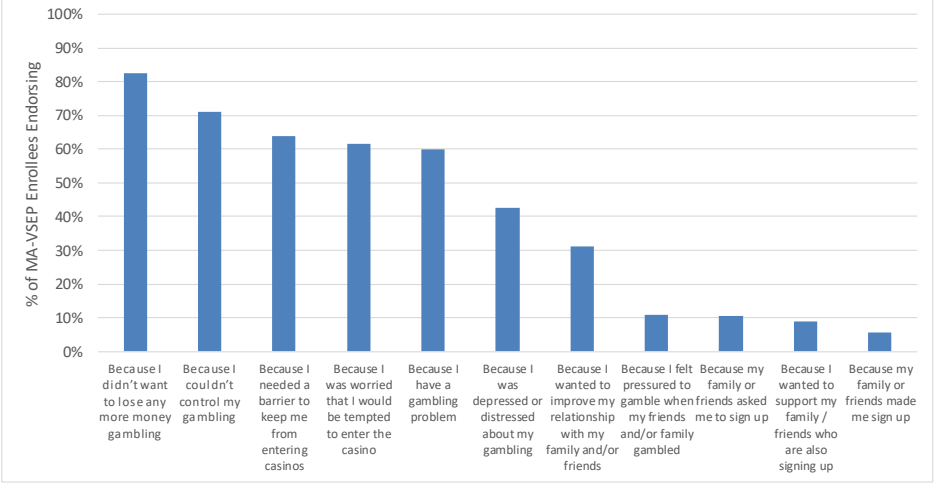
18

Who Signs Up for MA-VSEP and Why:
Reasons for Gambling (n=127)



Note. Categories are not mutually exclusive.

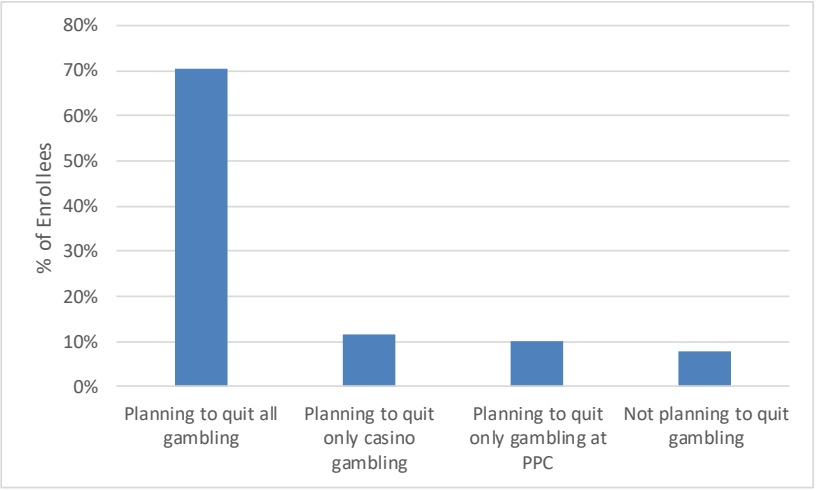
Who Signs Up for MA-VSEP and Why:
Reasons for MA-VSEP Enrollment (n=183)



Note. Categories are not mutually exclusive.

Who Signs Up for MA-VSEP and Why:

Plans to Quit Gambling After MA-VSEP Enrollment (n=183)



21

Who Signs Up for MA-VSEP and Why:

Take-Home Points

- Enrollees tend to be non-Hispanic, White, and in their 40s
- Most enrollees are gambling frequently, both at PPC and elsewhere
  - Subset that have not gambled in over a year
  - Subset gambling and losing significantly >$$ than others
- Many enrollees are experiencing not only significant gambling-related problems, but also mental health problems
- Enrollees' reasons for enrollment tend to involve an inability to control their gambling, but more than 70% intend to quit all gambling upon enrollment

22

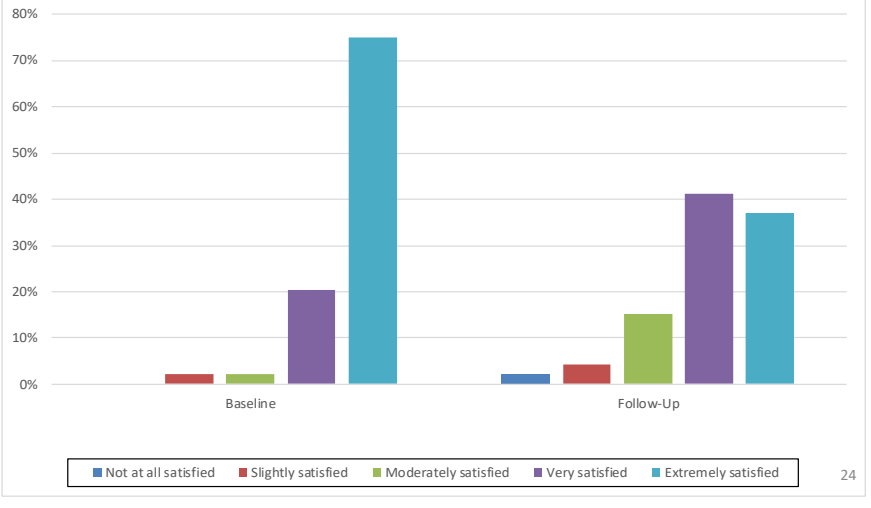
Goal 3: Evaluating Satisfaction and Experiences of MA-VSEP enrollees

- 26% of all enrollees agreed to a one-week check-in call upon enrollment; MCCG was able to reach three quarters of those enrollees
- Among follow-up survey respondents (n=46):
  - 76% had participated in VSE in other states
    - 83% of those indicated their experience with MA-VSEP was better than their experience with other programs

23

Evaluating Satisfaction and Experiences of MA-VSEP enrollees:

MA-VSEP Satisfaction (n=63; n=46)



24

Evaluating Satisfaction and Experiences of MA-VSEP enrollees:

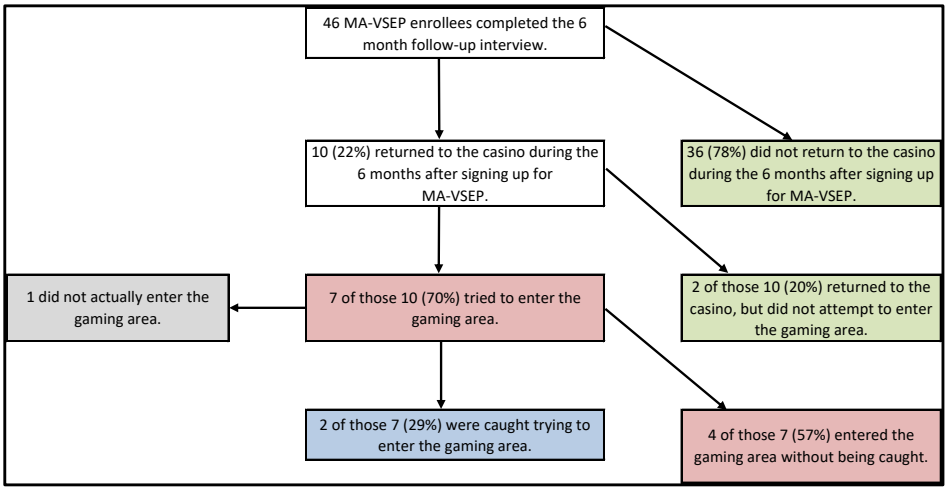
Open Response (n=46)

- How has MA-VSEP helped you?
  - Risk of being caught is a deterrent
  - Support provided is important
- Suggestions for VSE improvement:
  - 63% provided suggestions
    - More follow-up and check-ins from the program
    - Better advertising of the program
    - Regionalization of VSEP
    - Sign-up locations away from gaming floor and casino

25

Evaluating Satisfaction and Experiences of MA-VSEP enrollees:

MA-VSEP Violations (n=46)



26

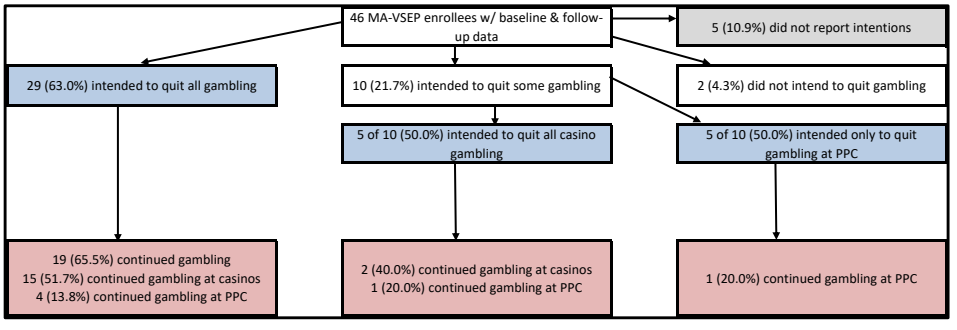
Evaluating Satisfaction and Experiences of MA-VSEP Enrollees:

Take-Home Points

- Enrollees are satisfied with MA-VSEP
  - Appreciate extra support provided
- Only a quarter of enrollees agree to a one-week check-in upon enrollment, but many follow-up respondents wish there had been more check ins provided or did not realize such support was available

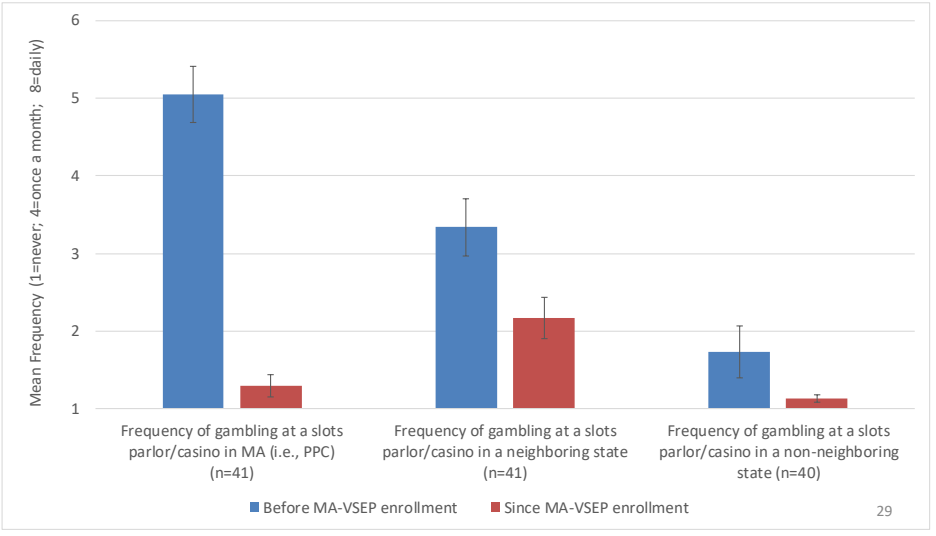
Goal 4:
Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment:

Intentions and Post-Enrollment Behavior (n=46)



Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment:

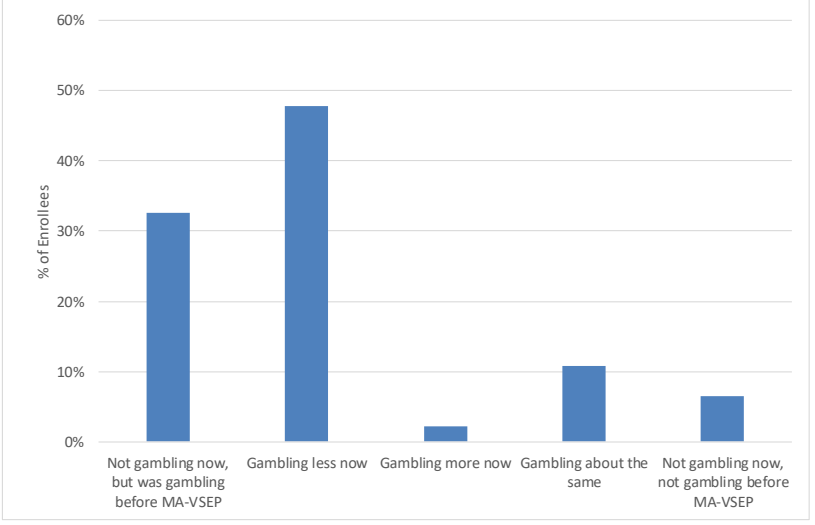
Frequency of Gambling at Casinos (n=46)



29

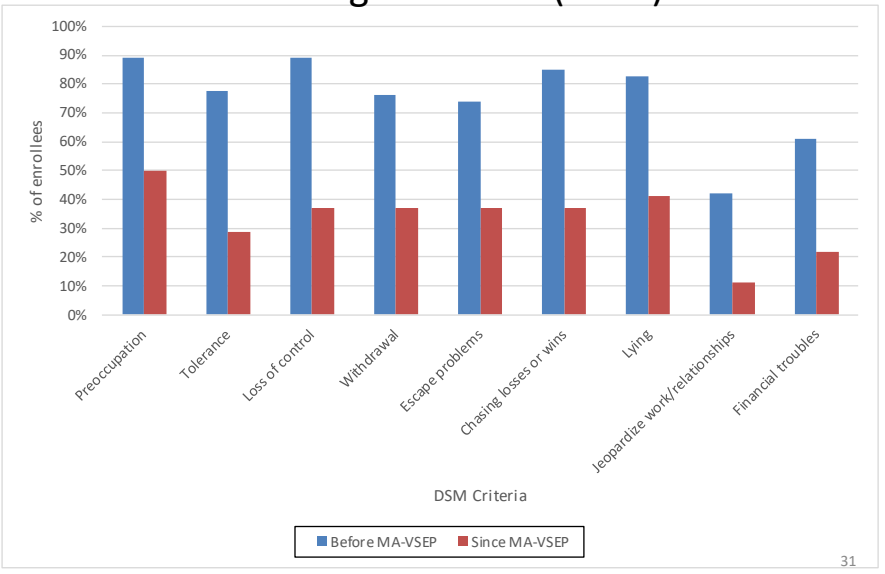
Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment:

Self-Reported Changes in Gambling Behavior (n=46)



30

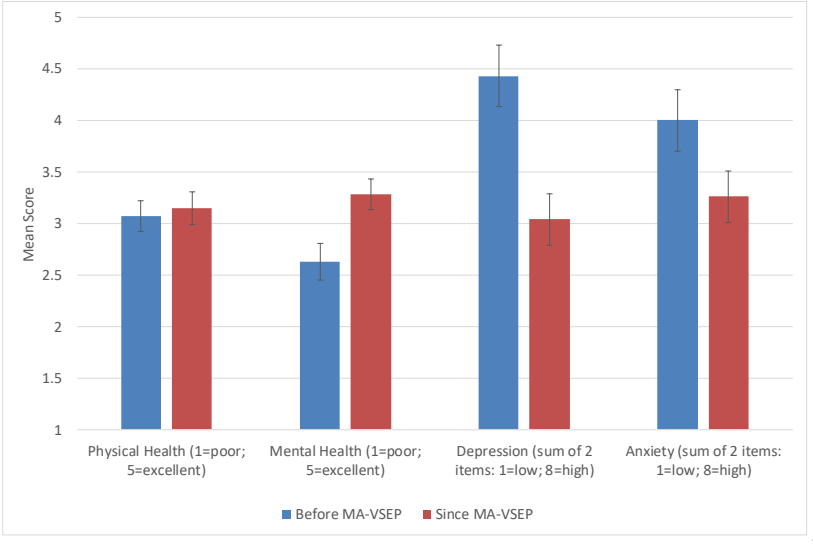
Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment: Gambling Problems (n=46)



31

Note. All reductions significant at the p<.05 level according to McNemar tests.

Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment: Mental Health (n=46)



32

Examining Enrollee Outcomes 6-12 Months after MA-VSEP Enrollment:

Take-Home Points

- Improvements in gambling behavior, gambling problems, and mental health
- The more major the change enrollees intended to make (e.g., quitting all gambling), the less successful they were at accomplishing that change
- *Caveat: Based on follow-up sample of 46*

33

Goal 5: Examining Whether MA-VSEP Enrollment Is a Gateway to Treatment

- 41% of follow-up respondents indicated MA-VSEP influenced them to seek additional help

34

Examining Whether MA-VSEP Is a Gateway to Treatment:

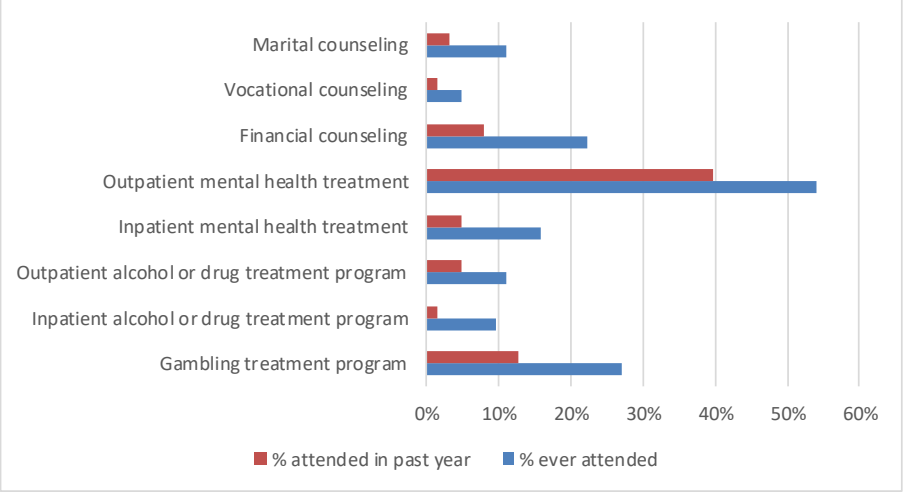
Treatment Prior to MA-VSEP Enrollment (n=63)

- 68% had talked to a doctor or other professional about problems with gambling
- 48% had called a gambling helpline
  - 22% within the past year
- 54% had sought help for gambling problems and reported previous treatment for a mental health or substance use problem

35

Examining Whether MA-VSEP Is a Gateway to Treatment:

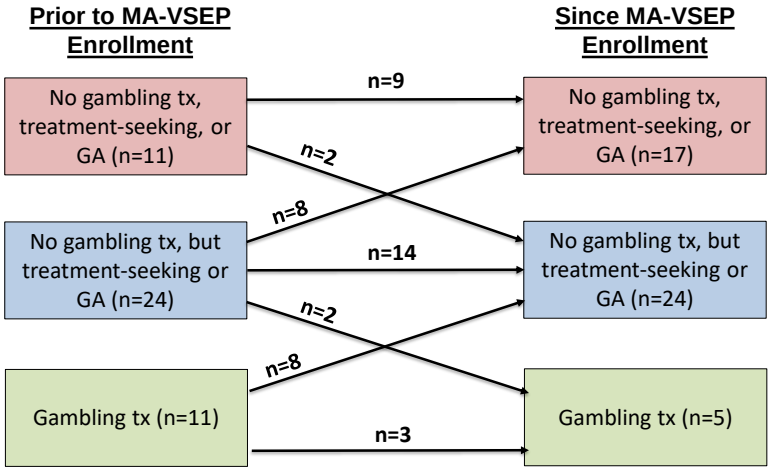
Treatment Prior to MA-VSEP Enrollment (n=63)



36

Examining Whether MA-VSEP Is a Gateway to Treatment:

Gambling Treatment Prior to and After MA-VSEP Enrollment (n=46)

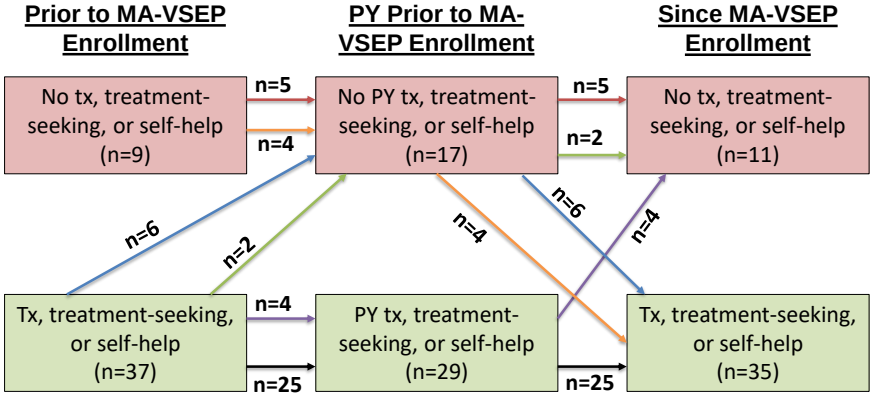


Note. Tx=treatment; GA=Gamblers Anonymous.

37

Examining Whether MA-VSEP Is a Gateway to Treatment:

Treatment Seeking and Self-Help Prior to and After MA-VSEP Enrollment (n=46)



Note. Arrows are color coded to follow cases that move from one bin to another. Tx=treatment; GA=Gamblers Anonymous.

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Examining Whether MA-VSEP Is a Gateway to Treatment:

Take-Home Points

- MA-VSEP enrollment does not appear to serve as a gateway to treatment
  - High number of MA-VSEP enrollees already engaged in treatment
- However, more enrollees were engaged in some way mental health, substance use, or gambling services after enrollment than in the year prior to enrollment
  - MA-VSEP enrollment might have provided a nudge to re-engage with services
- *Caveat: Based on follow-up sample of 46*

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Limitations

- Study design limits ability to draw causal conclusions
- Recruitment rate was low: 24%
  - Compensated for this through use of additional data sources
- Missing data from VSEP applications, check-in forms, and player card database

40

Program Recommendations

1) Visibility

2) Behavioral health channels

3) Follow-up

4) Motivational interviewing training

41

Program Recommendations (cont.)

5) Assess tx history & enrollment goals

6) Provide general MH and SU resources

7) Include Rhode Island resources

8) Simplify enrollment – regional and treatment site options

42

Data Systems Recommendations

1) Relational database

2) Link MA-VSEP electronic application and database

3) Do not allow “optional” responses within MA-VSEP application.

4) Automatic reports

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Continuing Evaluation Recommendations

1) Formalize and standardize information collected during check-in calls and the exit interview for the MA-VSEP

2) Include key domains of interest as mandatory components of the MA-VSEP application

3) Track information about MA-VSEP process

4) Conduct experiments

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Thank You

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http://www.divisiononaddiction.org/

Research Strategy for Gaming in Massachusetts

Objective

The State of Massachusetts has made a commitment to "understand the social and economic effects of casino gambling." The Massachusetts Gaming Commission (MGC) has dedicated substantial funds to this commitment, commissioning the most comprehensive research on this topic in the world. MGC and the Department of Public Health (DPH) have formed the Public Health Trust Fund (PHTF) to provide leadership on a more comprehensive research strategy that will both understand these effects, and inform programming to maximize beneficial and minimize negative impacts of casino gambling in Massachusetts.

Primary Deliverable

Research Strategy – a multi-year plan for the evolution of a comprehensive research program to serve the needs of the Massachusetts Gaming Commission, Massachusetts Department of Public Health and Massachusetts Executive Office of Health and Human Services, as collaboratively represented in the Public Health Trust Fund.

Project sponsor: Mark Vander Linden, Director of Research and Responsible Gaming, Massachusetts Gaming Commission.

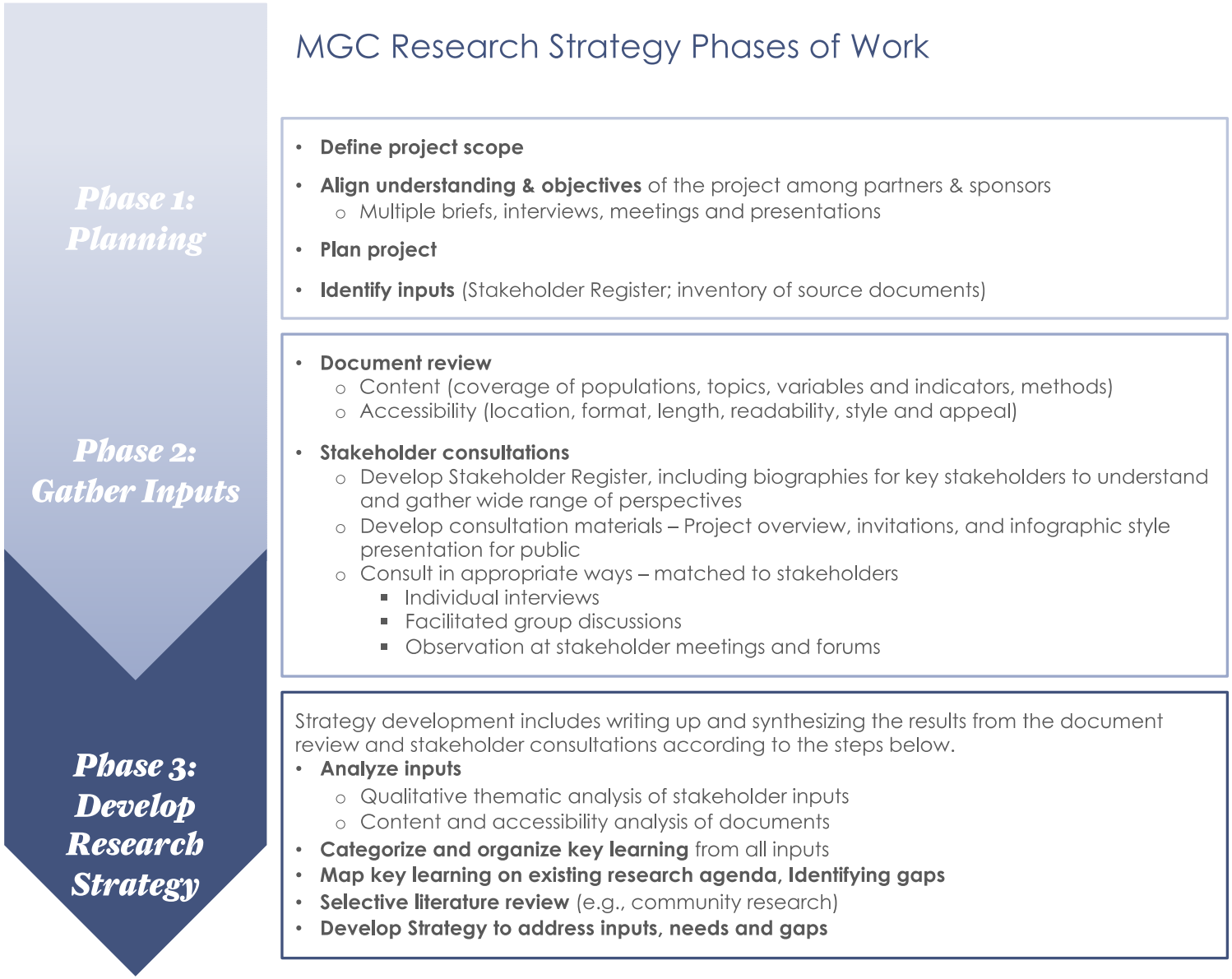
ApproachThe original work plan, based on a six-month project (May 1 to October 31, 2018), was expanded to accommodate a longer project planning phase, increased stakeholder consultations, and vacation schedules (summer and Holiday) of consultant and stakeholders. Anticipated completion is February 2019.

Recommendations are intended to achieve a Research Program for Massachusetts that:

- Builds on the commissioned research to understand the social and economic impacts in Massachusetts, especially the SEIGMA and MAGIC multi-year studies;
- Provides research results that will inform programming to prevent and mitigate gambling-related harm;
- Helps host and surrounding communities to understand the impacts of casinos in their communities, and to develop policy and programs that maximize benefits while minimizing negative impacts.
- Helps at-risk populations and the organizations that serve them to understand the effects in their communities and develop programs and strategies to minimize gambling-related harm.

This project involved three overlapping Phases of work as illustrated in the figure below.

Figure 1. Phases of Work



Research Strategy

Recommendations for a Research Strategy at MGC are laid out in five sections:

1. **Overall:** This section addresses changes to the current Research structure including
    a. Program objectives and guiding principles
    b. Infrastructure and resources, especially human resources
2. **Community-Engaged Research**, specifically the addition of a funding stream for research that is driven by and responsive to community needs
3. **Knowledge Translation**: This section maps out the purpose and structure of a dedicated knowledge translation function as part of the research program
4. **Data Management**: This section describes the need to manage large datasets collected under the current research agenda, and anticipated data from casino operators and other sources
5. **Evaluation**: This section describes some work to facilitate evaluation of MGC's Responsible Gaming initiatives

Section 1. Overall

The Massachusetts Gaming Commission has undertaken the most comprehensive research program in the world to measure and understand the impacts of the introduction of expanded gambling. This section:

- Examines how well the current research agenda meets the goals of the annual research agenda – as stated in The Expanded Gaming Act (2011), and interpreted at MGC in the objectives of the Responsible Gaming Framework; and

Identifies ways to improve the overall structure and approach of the research program.

Recommendations in brief

1. Research goals, objectives and guiding principles
    a. Evolve the interpretation of the Research Goals to extend the use of findings for policy and best practice strategies and methods **to all areas that are impacted by expanded gaming**, beyond the current interpretation to use the findings for gaming policy and regulation and responsible gaming and problem gambling treatment and prevention.
    b. Add a guiding principle for openness and transparency, or rather explicitly extend this principle to the Research Program
2. Infrastructure and resources
    a. Expand the infrastructure currently in place for the Research and Responsible Gaming Program to support the growth of the Research Program

Research goals, objectives and guiding principles

The Expanded Gaming Act requires the Public Health Trust Fund (PHTF) to establish "an annual research agenda" to understand the social and economic effects of casino gambling in Massachusetts. The **Research Goals** are to:

- Understand the social and economic effects of expanded gambling and use findings to inform evidence-based policy and regulation
- Obtain scientific information relative to the neuroscience, psychology, sociology, epidemiology and etiology of gambling
- Inform best practice strategies and methods for responsible gaming and problem gambling treatment and prevention
- Evaluate all responsible gaming initiatives developed by the Massachusetts Gaming Commission

These goals are interpreted in the Responsible Gaming Framework that "aims to create an effective, sustainable, measurable, socially responsible, and accountable approach to gambling." The Research objectives in the Framework are to:

- Inform best practice in responsible gaming strategies and methods, problem gambling prevention and treatment, and responsible gaming messaging.
- Create and translate knowledge to support evidence-informed decision-making about gambling policy and regulation.

A Table mapping the current research program onto the goals expressed in the expanded Gaming Act (2011) is shown on the following pages.

Table 1. Mapping Research Program onto Objectives

Objective	Research	Data Collected
Understand the social and economic effects of expanded gambling and use findings to inform evidence-based policy and regulation	SEIGMA *Social Impacts*	• Gambling & Problem Gambling: Baseline surveys • General population + Online panel • Gambling and Problem Gambling: Impact surveys • General Population + Online Panel
	SEIGMA *Economic Impacts*	• Patron Survey • Operations period impacts • Construction • Employment • Lottery revenue • Real Estate • **Community Economic Profiles** *(see Table 2)*
	Public Safety Impacts	• Baseline: Plainville and Springfield • Impact: Plainville (6m, 1y, 2y)
Obtain scientific information relative to the neuroscience, psychology, sociology, epidemiology and etiology of gambling	MAGIC	• Changes in gambling participation • Changes in Problem Gambling Status • Incidence of Problem Gambling • Transitions, stability and change • Implications for PG Prevention and Treatment
Inform best practice strategies and methods for responsible gaming and problem gambling treatment and prevention	MAGIC	• Transitions, stability and change • Implications for PG Prevention and Treatment
	White Paper	• Combined: Baseline population Survey • Helpline call data • Focus group with MH&A treatment providers
Evaluate all responsible gaming initiatives developed by the Massachusetts Gaming Commission	Voluntary SE	add report name
	GameSense	• Compendium + four reports
	PlayMyWay	add report name

Table 2. Community Economic Profiles

Indicator Type	Indicators
Host community Industrial base & business	Employment, establishments, wages
	Industry Mix
	Business Sales
	Leisure & hospitality
Surrounding communities	Business
Host community Resident	Population
	Demographics
	Unemployment
	Income & poverty
Surrounding communities	Socio-economic
Host community Local area fiscal	Expenditures
	Revenue
	Property values
	Property tax revenue
Surrounding communities	Fiscal

The research goals and objectives could be re-examined to address:

- Challenges in stakeholders' understanding of the expansiveness of the research agenda
- Potential to apply findings far beyond Responsible Gambling and Problem Gambling programs and services in efforts, particularly in reference to the text highlighted in blue for the first and third objective.

Expansion of research objectives to include impacts far beyond RG and PG will require mechanisms to:

- Communicate the expansiveness of the research program
- Communicate these results to a wide range of target audiences, and
- Apply these findings in practice: to policy, regulation, programs, services, further research

This expansion positions the research program as enabler of excellence in other areas of the MGC mandate, and as a fundamental tool for engaging communities to share information and build programs and services.

Guiding principle: Consider adding ***openness and transparency*** as a guiding principle, or rather extending this principle from the larger regulatory approach, e.g., AML requirements, to Responsible Gaming and the Research Strategy. This intended result is that data, data collection and reporting processes of operators would be designed with maximum transparency and serve to increase the *evaluability* of RG programs, tools and approaches. In practice this principle could impact such functions as:

- Data collection and extraction procedures to ensure linking data to individual player behaviour
- Sharing of employee surveys
- Collaborating on patron surveys, or player surveys
- Training and employee assistance programs
- Awareness and referral to GSICs by casino staff

Infrastructure to support the Research Strategy

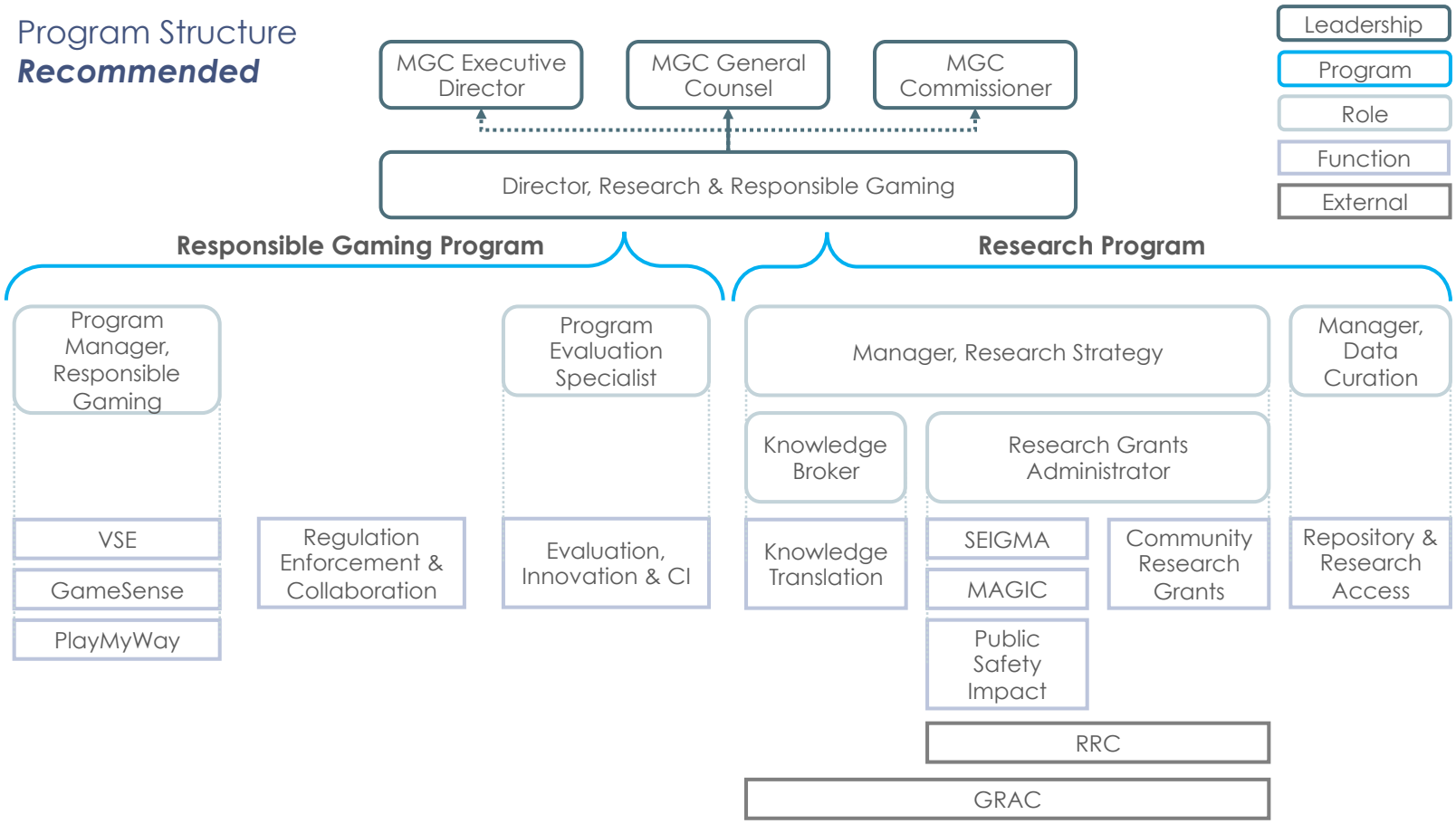
Chronologically, this section was developed after the sections below, to envision the capacity for an expanded Research Program. It is presented here as the foundation necessary to develop and implement the Research Strategy described in subsequent sections. It is remarkable that so much is accomplished by the limited staff resources that are currently dedicated to the Research Program.

The Research Strategy described here requires the addition of substantial resources and capacity. One approach is to add the following Functions and expertise:

- **Research Strategy**: This is a leadership role for the research program. This role should provide research expertise and related topic knowledge to approach the research program from a strategic perspective to envision how the components of the program work together to create and share the required knowledge. This requires understanding why the research is important and to whom, in the internal (regulatory) environment and multiple external environments (responsible and problem gambling services; host communities; health, economic and social service planners and providers at the State, regional and community levels, etc.) to inform a wide range of stakeholders, policies and programs across the State. This role is also envisioned to liaise with the Department of Public Health on their research and knowledge needs.
- **Grants Administration** and Oversight: This role is required to manage the implementation of the research program, providing oversight for solicitations, RFPs, contracts, amendments and deliverables.
- **Knowledge Translation**: A knowledge broker is urgently needed to begin to translate research findings into knowledge products for a wide range of stakeholders. This role is also envisioned to take the next step, that is, to establish collaborations that help drive research findings into policy and practice, both internally to MGC and externally with a wide range of stakeholders.
- **Data Curation and Management**: This role is urgently needed and currently partially filled by Tom Land. There are two primary stages of work here. The first is to establish a data management function and repository, potentially in partnership with other State entities. This stage should also include the development of a data framework for casino operators to ensure data is collected and shared to maximize its utility. The second stage of work is to manage the ongoing collection and storage of data at MGC. This function is described in greater detail in the section on Data Management below.

The figure below illustrates a possible structure for the proposed additions to the Research team.

Figure 2. Infrastructure to support the research program (proposed)



A further recommendation is to review the function of the two committees that were developed to support the research program, the Research Review Committee (RRC) and the Gambling Research Advisory Committee (GRAC). Both of these committees represent a demand on staff resources to manage them (scheduling and logistics, materials preparations, guest presenters, etc.). The roles and expectations of these committees could be examined to clarify whether they are intended to 1) fulfil functions and reduce staff workload, or 2) bring together important stakeholders to keep them apprised of the research program, but as a demand on staff time rather than a support. Considerations could include:

- The Research Review Committee provides quality assessments by research experts. Two minor criticisms arose during consultation. The first is the description of the Committee's function as "independent gaming research peer review" and, the second is the lack of sufficiently deep economic expertise on the committee. The RRC provides a much needed vetting of research reports by researchers with varied expertise. Two minor recommendations are to:
    - Change the description of the committee to remove "independent"; and
    - Recruit additional economic and fiscal expertise to the RRC.
- GRAC was intended to support knowledge translation but appears to function in practice more like a knowledge recipient than a body that assumes responsibility for knowledge translation functions from one meeting to the next. That being said, this does represent an important group of stakeholders who are very close to the research program and so should be knowledgeable about it. This may require a simple shift in thinking to this as a key stakeholder group with whom to share research and that serves as a test group to gather reactions and ideas for more effective knowledge translation to other audiences.

Section 2. Community-Engaged Research

From the outset of the strategic planning process, the Commission wished to explored a program of research that is driven by and responsive to community needs, with a focus on at-risk groups in the communities surrounding the three casinos. Three such pilot projects funded by the Commission in the previous fiscal year are completed or nearing completion:

- Casinos and Gambling in Massachusetts: African-American Perspectives – led by Roldolfo Vega, PhD
- A Study of Gambling Behaviour and Problem Gambling in Boston Chinatown – led by Carolyn Wong, PhD
- Gambling Problems Among Military Veterans: Screening Study in Primary Care Behavioral Health – led by Shane Kraus, PhD

Recommendation in brief

There has been strong support for this component throughout extensive consultation and information gathering. In response to this strong support, the Commission wishes to fast-track a community research program. The recommendation is to launch the program in the current fiscal year, ending June 30, 2019, and to engage in a more extensive and formal launch in the next fiscal year, as detailed below.

This section is adapted from a brief provided to the Public Health Trust Fund in November 2018. This section outlines considerations and options for a community research program that targets social determinants of health in host and surrounding communities.

Terminology

Community-based research (CBR) is a **philosophical approach** that emphasizes collaboration, participation and social justice agendas over the notion that research is, or should be, objective and apolitical (Flicker & Savan, 2006). Many terms are used for research that is conducted with community members. Each term may emphasize different methods, roles and levels of involvement for researchers, service providers and community members. The term "***community-engaged research***" is the term selected by MGC for its emphasis on engaging the community, while allowing for a range of methods, relationships and roles within a collaborative framework.

Objectives and Benefits

CBR has the potential **to more deeply understand and address the impact of the introduction of casino gambling** in Massachusetts's communities.

> Community Based Research is increasingly being recognized as important in yielding concrete knowledge and understanding that can guide policies and programs to reduce health and social disparities (Flicker & Savan, 2006)

Benefits include:

- Suited to research with population groups that are difficult to research with epidemiological or general population studies
- Responsive to communities demand/need for more involvement in research that takes place in their midst
- Targeted to specific groups and related health inequities
- Relevant - Results should be more accessible, accountable and relevant to people's lives
- Capacity-building
- Empowering for all parties, especially community representatives and agencies to make sustainable personal and social change (Wallerstein & Duran, 2003)

Focus

Geographic: Host and surrounding communities where casinos exist or are planned
Target populations: life course (e.g., youth, seniors, parents), ethno-racial, identity groups such as LGBTQ, veterans, etc.
Topics: the relationship of casino gambling with social determinants of health, such as poverty, education, housing, and employment
Outputs: community assessment, evaluation, community awareness, etc.

Team composition

Teams should be composed of some collaboration among:

- Community representative of organization, agency, or assembly of people with a common focus
- Service providers, may be same as above
- Local public health agency or institute

- Academic researcher, with encouragement to include post doctoral or early career researchers to build capacity (balance CBR experience with capacity building)

Each partner should choose the level of involvement at each stage to best accomplish objectives

One sponsoring institution will need to assume responsibility for receiving and administering the grant, with responsibility for

- Managing contract compliance and administering funds for approved budget expenditures
- Monitoring and reporting to MGC
- Overseeing knowledge translation and exchange – Post-research
    - Expectations for presentations, briefings, case studies, and publication
    - Requirements, if any, for advance notice to funder prior to publication
    - Advocacy work for policy and program change

The university of one of the academic team members typically undertakes this role because it requires institutional infrastructure to manage accountability. However, awarding funds to universities or research institutes, which is typical, establishes a power imbalance from the outset. MGC could consider asking the local Public Health Institute or agency to assume this role.

Links to State Level Research and Programming

During consultation a number of stakeholders strongly supported a direct link to the SEIGMA and MAGIC research teams. Two expressed disappointment that the three projects currently underway represented a missed opportunity for the SEIGMA/MAGIC teams to provide research results and suggestions to inform the design and execution of the community research projects. Other stakeholders suggested there be a structure for community research teams to share information with each other at all stages of the research process.

This is consistent with the RG Framework Strategy 6 – Engage the Community "Engaging the community is a way to understand, participate in, and act upon critical workplace, marketplace, and environmental issues." Some structure and support should be provided for communication links among research teams.

Promotion of CBR Program

Publicize and promote CBR Program to key audiences, and **provide resources to maximize successful collaborations**, such as:

- Share promotion of CBR program, possibly with Department of Public Health, MASShire, etc.
- Provide profiles of gambling and gamblers in host and surrounding communities
- Identify resources for CBR – tool kits, web links, case studies, and templates are all available from a range of organizations that specialize in this work. Carefully select a resource inventory.
- Consider workshops in target communities
    - To launch process, bring together potential collaborators, assess readiness and related needs for resources or training to actively participate in CBR
    - Ongoing (annually?) among all teams to establish links and share experiences and learning
- Consider supporting training opportunities
- Consider identifying potential researchers or research institutes that specialize in CBR. Evidence shows that outcomes are best when researchers are experienced in CBR

Funding envelope

Current plan is for $200,000 annually, $185,000 in Year One

- Consistent with the formula of 5% of total research awards budget ($50,000 per $1M) recommended in literature
- Consider cost-sharing final stage work (KTE) with DPH or appropriate public organization; so research and outcomes can be linked

Consider allowing budget items often excluded in traditional research funding guidelines:

- Capacity building opportunities such as training, staff-buy- outs, and administrative overhead
- Items that address barriers to participation, especially for community representatives, such as childcare, translation, transportation, refreshments, etc.
- Limits could be set on the proportion of the total budget for these components

Duration and Structure

Consider funding fewer projects longer term rather than diluting resources (funds, community participation, researchers) across many projects. CBR takes time and longer-term support increases the likelihood of success.

Consider stages of work.

- **Seed grants**: Support development phase to establish relationships, define roles, and develop a research program (identify problem, describe target population, research questions, methods)
- **Project grants:** To conduct research
- **Knowledge translation and exchange**: Basic dissemination could be included in project grant. Advocacy work to affect change may require separate support and could be co-funded with an appropriate public organization.

These stages could be

- Combined into one longer term award that details each stage over 2-3 years,
- Award in stages, conditional on completion of previous, or
- Separate awards that allow a team to apply at any stage of their development.

Grants Procurement and Administration

This refers to the internal function led and managed by MGC, to develop and implement a community-engaged research program. Steps include:

- Establish guidelines
    - Establish frequency and possibly templates for reporting updates and final report (Financial and Research aspects)
- Manage structure and process for (peer) review
    - Establish structure and people for review process
        - Academic peers should include CBR experience
        - Public health
    - Assign and manage peer review, (e.g., matching reviewers to proposals)
    - Assemble recommendations for each funding round
    - Create core team for final decisions – may be same as reviewers or a standing group
- Execute contracts and Award funds
- Provide administrative support and oversight for grantee responsibilities
- Receive grant deliverables (interim, budget and final reports)

Evaluation and Recognition

- Build evaluation requirements into the Grants Program as a whole, to ensure consistency and reduce burden on individual grant teams
- Establish objectives that match anticipated outcomes (building relationships and capacity, satisfaction with process, satisfaction with results, dissemination of results, changes advocated and implemented), including outcomes that are specific to each stage
- Build assessment of some objectives into grant reporting process, e.g., brief confidential survey of team members
- Establish a reasonable period for results to manifest, and consider evaluating different aspects in stages. For example, seed grants could be evaluated on their own criteria almost immediately, as opposed to changes in policy or programs, which may take three years or more.
- Potential Outcomes:
    - Working relationships and new coalitions
    - Community capacity
    - Plans for future projects
    - Changes in agency programming
    - Changes in government policy
- Support and reward agencies for effectively using research to improve their program and advocacy objectives

Section 3. Knowledge Translation

Knowledge translation is one term used to describe the process of putting research findings to practical use. Terms such as *implementation science*, *knowledge mobilization*, *translational research* and *research utilization* are used to describe similar approaches. These concepts refer to the process and steps needed to ensure that new research findings are made known to the right people and used to inform the relevant policies, programs and services. The definition developed by the Canadian Institutes for Health Research is widely used and inserted below:

> Knowledge Translation is defined as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of [individuals], provide more effective health services and products, and strengthen the health care system.
> Retrieved from http://www.cihr-irsc.gc.ca/e/29418.html#6 January 4, 2019.
>
> NOTE: This definition has been adapted by others, including the United States National Center for Dissemination of Disability Research and the World Health Organization (WHO).

MGC has committed to using the knowledge from the commissioned Research to inform planning and funding allocation, advance the quality of policy and programs, and inform future research – as outlined in the excerpt below from *Report on the Research Agenda of the Massachusetts Gaming Commission, December 18, 2013.*

> **Utility of the Research Findings**
> The Massachusetts Gaming Commission is committed to fully understand the impacts of expanded gaming in the Commonwealth. The research findings will be essential in developing a strategy to

minimize gambling-related harm and bring the greatest possible benefit to the people of the Commonwealth. These findings will:

- Inform how monies from the Public Health Trust Fund (Section 58) are expended;
- Assist in assessing community-level impacts and inform decisions about expenditures from the Community Mitigation Fund (Section 61);
- Improve problem gambling prevention;
- Advance the quality, effectiveness and efficacy of treatment of gambling disorders;
- Inform the ongoing MGC research agenda;
- Provide quantitative and qualitative assessments of a broad range of impacts of expanded gaming; and
- Provide all of the stakeholders in Massachusetts with a neutral database for strategic analysis and decision-making.

Recommendation in brief

The recommendation is to develop the explicit function, expertise and resources at both MGC and DPH Office of Problem Gambling Services to engage in strategic knowledge translation and fully exploit the substantial knowledge being generated by the research program.

The case for an explicit knowledge translation function and resources at MGC is clear. The complexity and volume of knowledge being generating by the MGC Research Program is substantial. In addition, the quality of this evidence is perhaps unparalleled because of the commitment to gold standard methods such as the large-scale cohort study, Massachusetts Gambling Impact Cohort (MAGIC), and the Social and Economic Impact of Gambling in Massachusetts (SEIGMA) study.

It is not surprising that we heard many ideas for knowledge translation, because we asked stakeholders to tell us what impact they wanted the research to have and on whom – framing the questions as use-of-research. The consultation provided extensive detail on potential uses for research findings and a strong appetite for same. The need for the knowledge generated by the MGC Research Program to be translated into useable forms was expressed in many ways throughout the stakeholder consultation.

- **MGC** – Commissioners identified many ways to use research knowledge, including to complete the communications loop with the community stakeholders they consulted – to demonstrate that the Commission listened and developed a rigorous regulatory framework to maximize benefits and minimize negative impacts, and provided communities with funding to target concerns and improve their readiness for casinos. Research evidence showing the success of these readiness efforts should be shared with the original stakeholders.
- **Department of Public Health (DPH)** – in the early stages of consultation considerable time and effort were dedicated to understanding the knowledge needs of DPH leadership, and helping the research team to analyse data and interpret findings in ways that align with the needs of DPH to design, develop, implement and evaluate policy and programs that address health and social inequities

- **Host communities** – **Health and Social Service** agencies and their staff, including public health representatives expressed strong desire to understand the scope and scale of the research program and to receive research findings in ways that would help inform their decision-making and planning
- **Host communities** – **Hospitality and Leisure, Business associations** such as Chambers of Commerce – These organizations described the need for timely information regarding the impact of casinos so they could adjust to maximize economic benefits and minimize negative impacts for the member businesses they represent (hotels, restaurants, tourist attractions, financial institutions, and others). These associations, often have limited or no capacity to conduct complex research to provide meaningful insight to their members and develop resources to help them succeed in changing business climates.
- **Public safety** – stakeholders identified this body of research as having, to a great extent, built in the knowledge translation process by establishing collaborative relationships to collect, analyse and interpret the data. This model of engaging knowledge users suits this type of research where the same stakeholders are the source of the data and the ultimate users of the information in their work. Police forces who work with the primary investigator on this work, Christopher Bruce, work in the communities that are hosting expanded gambling and can use the findings immediately to provide training and policing that is responsive and appropriate. They also worked with the investigator to modify reporting processes to improve the usefulness of the data.

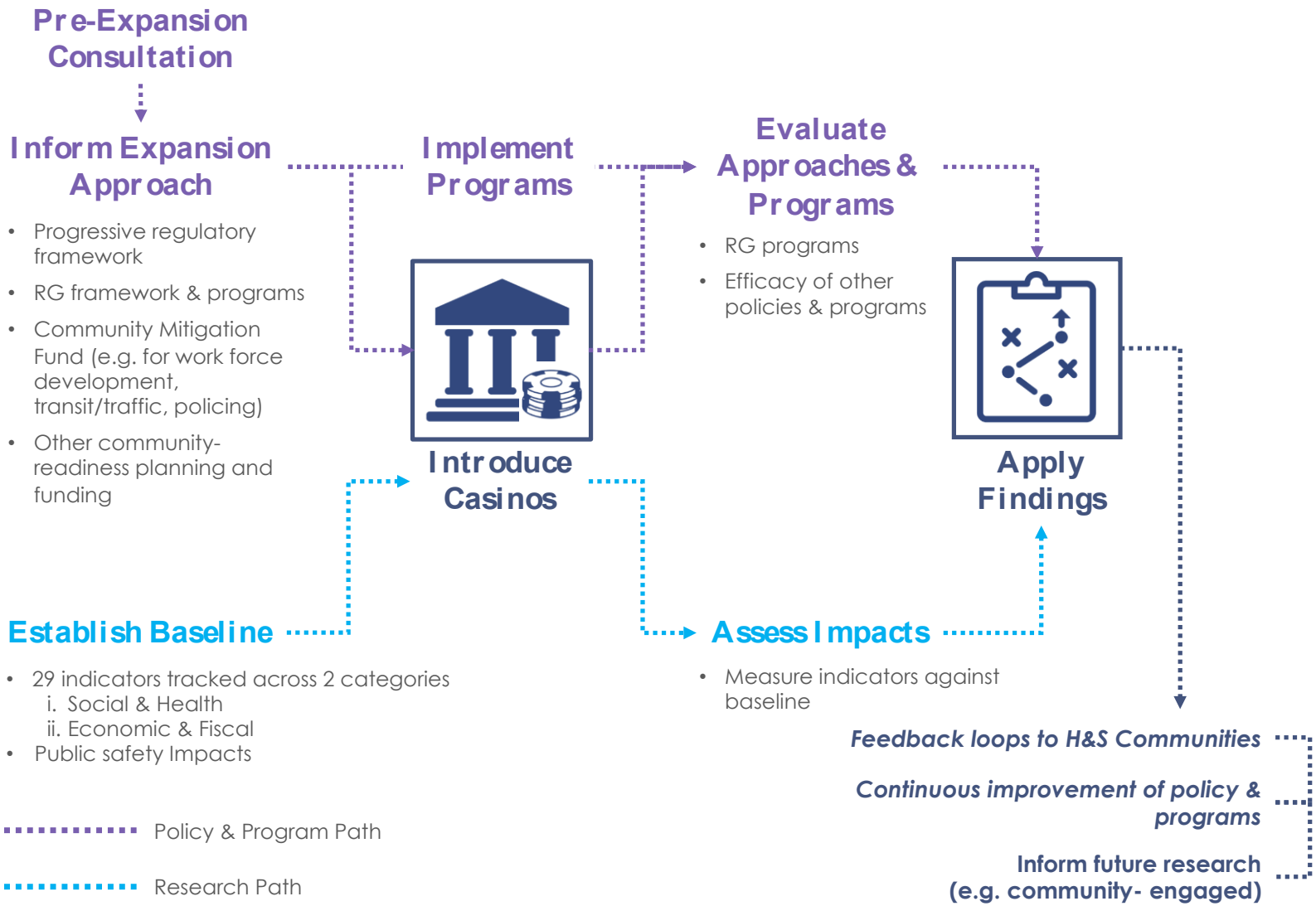
Not surprisingly, each stakeholder we consulted identified people or organizations that need to know the results of this research to do their jobs better.

To illustrate the parallel paths of research, and the development of policy and programs and how the research findings can and should be applied to both of these pathways we have illustrated these relationships in the figure below**, Figure 3. Knowledge Paths**.

This figure below notes feedback loops in the lower right corner for three important uses:

- **Host and surrounding communities** – Research knowledge should be communicated for a number of purposes, such as to demonstrate the impact of readiness efforts; to provide monitoring and early alerts to changes in their communities; and to inform future work to sustain and build on positive impacts and reduce negative ones. For example, the Western Massachusetts Casino Health Impact Assessment detailed several concerns; a feedback loop should outline how these concerns are being addressed and the effectiveness of those efforts
- **Policy and programs** – This includes Internally for the MGC and DPH to advance that the regulatory approaches and ensure the quality and effectiveness of the public health services. Externally almost every organization providing health and social services in host communities would benefit from the research findings. The same is true of economic stakeholders, especially those representing local business and economic development
- **To inform future research** – The findings should make clear what future research is needed, including the deeper and finer grained research that can be undertaken in community-engaged research projects

Figure 3. Knowledge Pathways



The capacity to undertake knowledge translation is envisioned as part of the role of a strategic research leader to understand the potential of the research knowledge, the range of knowledge users who would benefit working with a knowledge broker to develop knowledge products and work with internal staff and external organizations to drive knowledge into practice.

Section 4. Data Management

Data management refers to a series of steps to store and maintain data as a valuable resource, and potentially provide access to the data for other research. Work is already underway at MGC to develop a data management function. To reiterate a point made above in the section on Knowledge Translation, the complexity and volume of data being generating by the MGC Research Program is substantial. In addition, the quality of this data is perhaps unparalleled because of the commitment to gold standard methods such as the large scale cohort study, Massachusetts Gambling Impact Cohort (MAGIC), and the Social and Economic Impact of Gambling in Massachusetts (SEIGMA) study.

Recommendations in brief

The recommendations are to:

1. Continue to support the rather complex development of a data management function at MGC, which may include partnership with DPH or other State level organization on the infrastructure for a data repository
2. Provide ongoing resources to maintain and build this data management function at MGC
3. Explore, once the data management function is up and running, a research access program that allows external researchers in Massachusetts, and in broader research fields and jurisdictions to maximize the use of the data being generated by the research program

Some key components of a data management function are:

- **Data repository** for commissioned research and player account data – forming potentially the richest source of gambling-related research data in the world
- **Data management framework** – This refers to a structure for collecting, recording, extracting and providing data to MGC and should be applied to all research funded by MGC. This is particularly important for the management of player account data that is to be provided to MGC by Casino operators. In other jurisdictions, such as New Jersey, difficult lessons have been learned about receiving, cleaning, integrating and using player account data. Extensive issues with data quality, completeness and the lack of identifiers to enable researchers to link and compare data across databases, and even for the same player at different times or in different databases. Developing this framework in collaboration with casino operators will be an important step in the data management process
- **External research program** to maximize the value of the data assets for Massachusetts and the field of responsible gaming. Specific recommendations for the structure of an external program should be developed. There are a number of roganzations in the gamlbign research field that have developed data management functions w

The support for a data management function was expressed by stakeholders in different ways. For example, researchers wanted to be able to use the data being generated, communities wanted both topic-specific synthesis and, in some cases, raw data to inform their work, and other stakeholders described data management functions and tools that could be substantially enhanced by the integration of the data form the MGC research program.

In their report the Western Massachusetts Casino Health Impact Assessment (2014), the authors requested annually posting MGM data on: employment and workforce development, traffic and transportation, PG rates, to make it possible to assess and track the value of collaborations and strategies designed to maximize positive impacts such as employment, and minimize negative ones.

In their report to MGC, the *Preliminary Study of Patrons' Use of the PlayMyWay Play Management System at Plainridge Park Casino: June 8, 2016-January 31, 2017*, the authors from the Division on Addiction, Cambridge Health Alliance, detailed many data issues, including quality, missing data and the inability to link patron data across play behaviour and their use to he PlayMyWay system to manage their spending limits. The authors suggest that the poor data quality seriously compromises transparency and the ability to conduct meaningful analyses, including evaluating the impact of RG initiatives and tools. This leads to one of the most important uses of research data, to evaluate the effectiveness of policy, programs, services and tools, as outlined in the next section.

Section 5. Evaluation

MGC has committed to the evaluation of its three RG programs (GameSense Information Centres, PlayMyWay, and Voluntary Self-exclusion) and engaged researchers from the Division on Addiction, Cambridge Health Alliance to conduct preliminary evaluations of each. The reports for these evaluations were reviewed for this project. While these reports offer important information on the implementation of these programs, improvement is needed to achieve program evaluation excellence.

Recommendations in brief

Develop an evaluation framework in collaboration with DPH to ensure a shared and rigorous approach to program evaluation, continuous improvement and innovation of the responsible gaming programs and problem gambling interventions across the State.

Develop an evaluation function and expertise at MGC, to manage evaluation and continuous improvement of its programs, and to coordinate program evaluation with DPH for shared learning and innovation.

Based on a review of the evaluation reports to date, the following critique is offered:

- Program managers did not do some of the important work identify a framework for continuous improvement and program evaluation, or develop logic models for each program to guide the evaluation work. NOTE: Logic models map the path from a program's inputs to the desired

objectives (program outputs and outcomes), and are considered an important program planning and evaluation tool.

- Program managers did not identify clear metrics and measures by which success could be evaluated, nor targets / thresholds for those metrics, e.g., Patrons' use of GameSense Centres is targeted at 2% of patrons for Year One, growing to 4% in Year Two.
- In the absence of this pre-existing work, evaluation teams and program managers would normally work collaboratively to select a suitable evaluation framework, and decide on program objectives and measures, before evaluation began. This does not appear to have taken place.
- The evaluation teams did not appear to include program evaluators or researchers with program evaluation expertise.
- Inconsistent evaluation frameworks and methodologies were used across programs.
- The GameSense evaluation team selected the RE-AIM framework, despite the fact that an evaluation framework, including a logic model, has been developed and validated for this purpose since 2013 (Responsible Gaming information Centres Evaluation Framework, 2013) and subsequently used to evaluate GameSense Centres in a number of jurisdictions. This potentially limits the usefulness of the evaluations because the results cannot be compared with those in other jurisdictions.
- There is no learning across program evaluations. Normally the same overall framework would be used to evaluate all of the programs in an organization, particularly when the objectives of each program converge on a similar goal, in this case to support responsible play in casinos. It appears each report was done in isolation with no learning drawn across and among programs.
- Reports are not accessible to a lay reader, in terms of content and format. This expectation should have been communicated to the evaluation teams, given the high bar for openness and transparency set for MGC.

Recommendations in more detail

This section briefly outlines some work that could be done to ensure the quality and usefulness of future evaluations. In addition to ensuring good quality data is available, it is important to clearly state what each program is trying to achieve and what success would look like.

To support and provide structure for future evaluations, program managers at MGC and the DPH Office of Problem Gambling Services could:

- Select a shared overarching evaluation approach or framework for continuous improvement that applies to all of the responsible gaming programs and problem gambling interventions at MGC and at DPH, Office of Problem Gambling Services. This will enable the two organizations to coordinate work toward common goals in maximizing benefits and minimizing harm from expanded gaming in Massachusetts.
- Refine specific **Objectives** for each program. (What does success look like?) The program goal and objectives may be aspirational and therefore unachievable, but should inspire excellence and continuous improvement.

- Develop a **logic model** for each program, mapping the path from the program activities to achievement of the desired objectives
- Identify:
    - **Measures/metrics** that can be used to determine achievement of objectives, (What outcomes can we assess to measure the effectiveness of the program?) and
    - **Data sources** for these metrics, such as counts, surveys, and patron player data.
- Set **targets** for one to three years. (What are our targets or thresholds for success?) While the objectives may be aspirational, targets should be achievable, and should evolve over time as the program is established and longer-term impacts have time to manifest. For example,
    - Year 1 targets may be strictly related to awareness, use and satisfaction with service, such as
        - 50% of patrons are aware of GSICs,
        - 3% of patrons use GSICs,
        - 75% of users are satisfied with the service,
        - 68% of casino staff are aware of and comfortable making referrals to the GSIC, as assessed in an employee survey
    - Year 2 targets may
        - Increase previous year targets and
        - Add impact of GSIC interaction on patrons' gambling knowledge, as assessed in a patron survey.
    - Year three targets may
        - Use more complex measures of impact on both gambling knowledge and play behaviour, and
        - Add the exploration of data sources to track what happens when GS Advisors make a referral to a helping agency;
        - Add metrics to assess changes before and after a visit to the GSIC in uptake of RG tools.

When you clearly set out the objectives, metrics and targets for success you can track these metrics annually, in addition to conducting formal program evaluations every few years. This supports continuous improvement.

Some program-specific ideas for a more comprehensive evaluation program are suggested below:

- GameSense: An evaluation framework developed in Canada maps out components and data sources. MGC could consider using this framework for future evaluations, adding any desired elements, in order to maximize comparability across jurisdictions to inform objectives, measures/metrics and targets, and program improvements.
- Credit Use by patrons: MGC has put rigorous requirements in place for this, such as credit applications include a PG self-assessment; credit officers obtain verbal confirmation that patrons are willing to lose the amount requested in credit; credit card transactions not permitted for the purposes of gambling; and rules on impairment and credit. Together

these requirements represent a program aimed at reducing the risk of gambling with credit, and an evaluation of these initiatives could provide important information on how well these are working.

- New and emerging policy: Patron impairment is an emerging issue with cannabis legalisation and operators may need guidance on how to identify and respond appropriately to impairment. Any new initiatives developed for this purpose should be evaluated, especially given the lack of scientific consensus on assessing impairment.
- DPH is in the process of developing and implementing programs to prevent and mitigate gambling-related harm. Using a shared evaluation framework at MGC and DPH will make it easier to transfer learning in an efficient and coordinated way from research studies and from program evaluations to the policies and programs of both organizations.

In closing

This strategy attempts to build on the very powerful research agenda already undertaken to understand the impact of the introduction of casinos in Massachusetts. More detailed information on the stakeholder consultation and document review is available in appended reports. This strategy envisions making the key connections among the research projects and teams, operators, communities and their stakeholders to ensure that the valuable knowledge is being gathered and applied to minimize gambling-related harm and negative impacts and maximize the positive impacts across the Commonwealth.

Expanded Gaming in Massachusetts
Research Strategy

Project Sponsor:

Mark Vander Linden
Director of Research and Responsible Gaming
Massachusetts Gaming Commission

January 2019

Introduction

- *Background*
- *Project Goal*
- *Primary Deliverable*

Background

- The State of Massachusetts has made a commitment to "understand the social and economic effects of casino gambling."
- The Massachusetts Gaming Commission (MGC) has dedicated substantial funds to this commitment, commissioning the most comprehensive research on this topic in the world.
- MGC and the Department of Public Health (DPH) have formed the Public Health Trust Fund to provide leadership on a more comprehensive research strategy to meet this commitment.

Project Goal

To develop a comprehensive research strategy that will:

- Understand the social & economic effects of gambling
- Inform programming to maximize beneficial and minimize negative impacts of casino gambling in Massachusetts.

Primary Deliverable: **Research Strategy**

A multi-year plan for the evolution of a comprehensive research program to serve the needs of MGC, DPH, and Massachusetts Executive Office of Health and Human Services, as collaboratively represented in the Public Health Trust Fund.

Approach

- *Recommendations Approach*
- *Phases of Work*
- *Strategy Outline*

Recommendations Approach

Recommendations are intended to achieve a Research Program for Massachusetts that:

- **Builds on the commissioned research** to understand the social and economic impacts in Massachusetts, especially the SEIGMA and MAGIC multi-year studies.
- Provides research results that will **inform programming** to prevent and mitigate gambling-related harm.
- **Helps host and surrounding communities to understand** the impacts of casinos in their communities, and to develop policy and programs that maximize benefits while minimizing negative impacts.
- **Helps at-risk populations and the organizations that serve them to understand** the effects in their communities and develop programs and strategies to minimize gambling-related harm.

Phases of Work

Phase 1: Planning

- **Define project scope**
- **Align understanding & objectives** of the project among partners & sponsors
- **Plan project**
- **Identify inputs** (Stakeholder Register; inventory of source documents)

Phase 2: Gather Inputs

- **Document review**
  - Content
  - Accessibility
- **Stakeholder consultations**
  - Develop Stakeholder Register; Consultation Materials
  - Conduct consultations
    - Individual interviews
    - Facilitated group discussions
    - Observation at stakeholder meetings and forums

Phase 3: Develop Strategy

- **Analyze inputs**
  - Qualitative thematic analysis of stakeholder inputs
  - Content and accessibility analysis of documents
- **Categorize and organize key learning** from all inputs
- **Map key learning on existing research agenda, identifying gaps**
- **Selective literature review** (e.g., community research)
- **Develop Strategy to address inputs, needs and gaps**

Strategy Outline

The Strategy is presented in five sections:

1. Overall	Outlines changes to the current research structure including: • Program objectives and guiding principles • Infrastructure and resources, especially human resources
2. Community-Engaged Research	Outlines the addition of a funding stream for research that is driven by, and responsive to, community needs.
3. Knowledge Translation	Maps out the purpose and structure of a dedicated knowledge translation function as part of the research program.
4. Data Management	Describes the need to manage large datasets collected under the current research agenda, and anticipated data from casino operators and other sources.
5. Evaluation	Describes some work to facilitate evaluation of MGC's Responsible Gaming initiatives

Section 1: Overall

- *Recommendations Summary*
- *Research Goals, Objectives, and Guiding Principles*
- *Infrastructure and Resources*

Recommendations Summary

Overall recommendations fall into **two key areas**:

1 Research Goals, Objectives, and Guiding Principles

- **Evolve** the interpretation of the Research Goals to extend the use of findings for policy and best practice strategies and methods, **to all areas that are impacted by expanded gaming**.
- **Add** a guiding principle for openness and transparency, or rather explicitly extend this principle to the Research Program.

2 Infrastructure and Resources

- **Expand** the infrastructure currently in place for the Research and Responsible Gaming Program to support the growth of the Research Program.

Research Goals and Objectives

Research Goals *(Expanded Gaming Act, 2011)*

- Understand the social and economic effects of expanded gambling and use findings to inform evidence-based policy and regulation.
- Obtain scientific information relative to the neuroscience, psychology, sociology, epidemiology and etiology of gambling.
- Inform best practice strategies and methods for responsible gaming and problem gambling treatment and prevention.
- Evaluate all responsible gaming initiatives developed by the Massachusetts Gaming Commission.

Research Objectives *(Responsible Gaming Framework)*

- Inform best practice in responsible gaming strategies and methods, problem gambling prevention and treatment, and responsible gaming messaging.
- Create and translate knowledge to support evidence-informed decision-making about gambling policy and regulation.

Table 1. Mapping Research Program onto Goals

Goal	Research	Data Collected
Understand the social and economic effects of expanded gambling **and use findings to inform evidence-based policy and regulation**	SEIGMA *Social Impacts*	• Gambling and Problem Gambling: Baseline surveys • General population + Online panel • Gambling and Problem Gambling: Impact surveys • General Population + Online Panel
	SEIGMA *Economic Impacts*	• Patron Survey • Operations period impacts • Construction • Employment • Lottery revenue • Real Estate • **Community Economic Profiles** *(see following slide)*
	Public Safety Impacts	• Baseline: Plainville and Springfield • Impact: Plainville (6m, 1y, 2y)
Obtain scientific information relative to the neuroscience, psychology, sociology, epidemiology and etiology of gambling	MAGIC	• Changes in gambling participation • Changes in Problem Gambling Status • Incidence of Problem Gambling • Transitions, stability and change • Implications for PG Prevention and Treatment
Inform best practice strategies and methods for responsible gaming and problem gambling treatment and prevention	MAGIC	• Transitions, stability and change • Implications for PG Prevention and Treatment
	White Paper	• Combined: Baseline population Survey • Helpline call data • Focus group with MH&A treatment providers
Evaluate all responsible gaming initiatives developed by the Massachusetts Gaming Commission	Voluntary SE	
	GameSense	• Compendium + four reports
	PlayMyWay	

Table 2. Community Economic Profiles

Indicator Type	Indicators
Host community *Industrial base & business*	Employment, establishments, wages
	Industry Mix
	Business Sales
	Leisure & hospitality
Surrounding communities	Business
Host community *Resident*	Population
	Demographics
	Unemployment
	Income & poverty
Surrounding communities	Socio-economic
Host community *Local area fiscal*	Expenditures
	Revenue
	Property values
	Property tax revenue
Surrounding communities	Fiscal

Research Goals and Objectives – ***Key Recommendations***

Research Goals – *re-examine to address*:

- Challenges in stakeholders' understanding of the expansiveness of the research agenda.
- Potential to apply findings far beyond Responsible Gambling and Problem Gambling programs and services in efforts, particularly in reference to highlighted text in Table 1.

Research Objectives – *expand to include impacts far beyond RG and PG*:

- Communicate the expansiveness of the research program.
- Communicate these results to a wide range of target audiences.
- Apply these findings in practice: to policy, regulation, programs, services, further research.

Guiding Principle – ***Key Recommendation***

Add Guiding Principle – **Openness and Transparency**

Data, data collection and reporting processes of operators would be designed with maximum transparency and serve to **increase the evaluability of RG programs, tools and approaches**.

In practice this principle could impact such functions as:

- Data collection and extraction procedures to ensure linking data to individual player behaviour
- Sharing of employee surveys
- Collaborating on patron surveys, or player surveys
- Training and employee assistance programs
- Awareness and referral to GSICs by casino staff

Infrastructure and Resources – ***Recommended Added Functions & Expertise***

Manager, Research Strategy

- Leadership role for the Research Program.
- Provide research expertise and topic knowledge to approach program from a strategic perspective.
- Requires understanding why research is important and to whom, in the internal (regulatory) and multiple external environments, to inform a wide range of stakeholders, policies and programs across the State.
- Liaise with the DPH on their research and knowledge needs.

Research Grants Administration and Oversight

To manage the implementation of the Research Program, providing oversight for solicitations, RFPs, contracts, amendments and deliverables.

Infrastructure and Resources – ***Recommended Added Functions & Expertise***

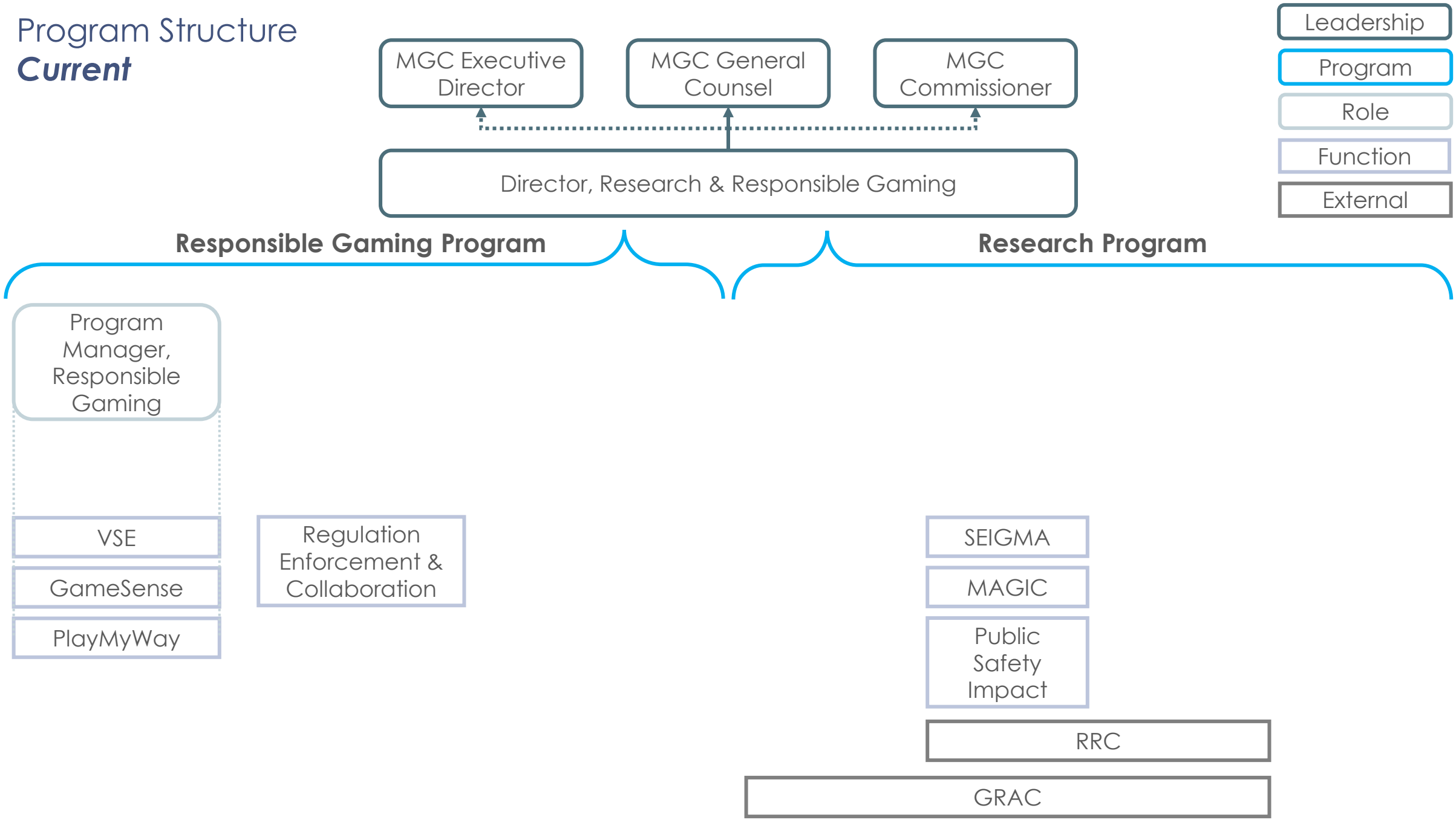
Knowledge Translation (Knowledge Broker)

- Urgently needed to begin to translate research findings into knowledge products for a wide range of stakeholders.
- Establish collaborations that help drive research findings into policy and practice, both internally to MGC and externally with a wide range of stakeholders.

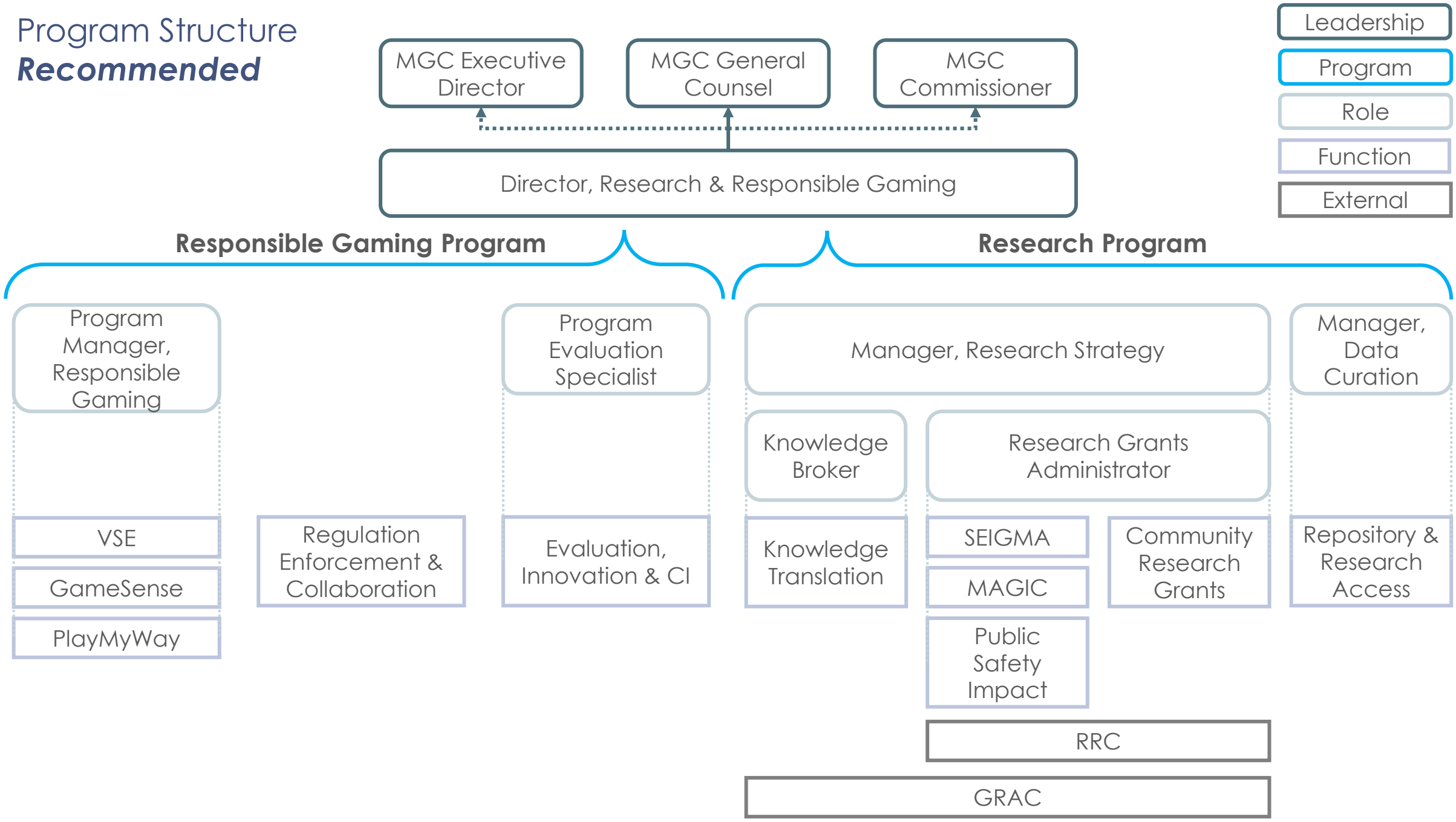
Data Curation Management

- Urgently needed and currently partially filled.
- Two primary stages of work:
    1. Establish a data management function and repository, potentially in partnership with other State entities; should also include the development of a data framework for casino operators to ensure data is collected and shared to maximize its utility.
    2. Manage the ongoing collection and storage of data at MGC.

Program Structure
Current



Program Structure
Recommended



Infrastructure and Resources – ***Additional Recommendation***

Review the function of the two committees that were developed to support the research program:

- Research Review Committee (RRC)
- Gambling Research Advisory Committee (GRAC)

} *Demand on staff resources (scheduling, logistics, materials preparations, guest presenters, etc.)*

Roles and expectations could be examined to clarify whether they are intended to:

1) Fulfil functions and reduce staff workload, **or**
2) Bring together important stakeholders to keep them apprised of the research program, but as a demand on staff time rather than a support.

Considerations include:

RRC: change the description of the committee to remove "independent"; and recruit additional economic and fiscal expertise.

GRAC: shift in thinking to this as a key stakeholder group with whom to share research, and that serves as a test group to gather reactions and ideas for more effective knowledge translation to other audiences.

Section 2: Community-Engaged Research

- *Recommendations Summary*
- *Program Overview*

Recommendation Summary

- MGC wishes to explored a program of research that is **driven by and responsive to community needs**, with a focus on at-risk groups in the communities surrounding the three casinos.
- There has been **strong support** for this component throughout extensive consultation and information gathering.
- In response to this strong support, the Commission wishes to **fast-track** a community research program.

Key Recommendation:

Launch the program in the current fiscal year, ending June 30, 2019, and engage in a more extensive and formal launch in the next fiscal year.

Program Overview – Key Benefits

Community-engaged research has the potential **to more deeply understand and address the impact of the introduction of casino gambling** in Massachusetts's communities.

Key Benefits

- Suited to research with **population groups that are difficult to research** with epidemiological or general population studies
- **Responsive to communities** and their demand/need for more involvement in research that takes place in their midst
- **Targeted** to specific groups and related health inequities
- **Relevant** – results should be more accessible, accountable and relevant to people's lives
- **Capacity-building**
- **Empowering** for all parties, especially community representatives and agencies to make sustainable personal and social change (Wallerstein & Duran, 2003)

Program Overview – Areas of Focus

Focus Areas

Geographic	Host and surrounding communities where casinos exist or are planned.
Target Populations	Life course (e.g., youth, seniors, parents), ethno-racial, identity groups such as LGBTQ, veterans, etc.
Topics	Relationship of casino gambling with social determinants of health, such as poverty, education, housing, and employment.
Outputs	• Community assessment • Evaluation • Community awareness

Program Overview – Team Composition

Community representative
(of organization, agency, or assembly of people with a common focus)

Academic researcher

Service provider

Community Research Team

Local public health agency or institute

***Each partner should choose the level of involvement at each stage to best accomplish objectives.**

Program Overview – Team Composition

Sponsoring Institution

Responsible for…

- Managing contract compliance and administering funds for approved budget expenditures
- Monitoring and reporting to MGC
- Overseeing knowledge translation and exchange – Post-research
- Expectations for presentations, briefings, case studies, and publication
- Requirements, if any, for advance notice to funder prior to publication
- Advocacy work for policy and program change

NOTE: The university of one of the academic team members typically undertakes this role because it requires institutional infrastructure to manage accountability. However, awarding funds to universities or research institutes, which is typical, establishes a power imbalance from the outset. MGC could consider asking the local Public Health Institute or agency to assume this role

Program Overview – Links to State-Level Research and Programming

Community Research Team + Existing Research Efforts

Program Overview – Promotion of Community-Engaged Research Program

Program Promotion

- Share promotion of program, possibly with DPH, MASShire, etc.
- Provide profiles of gambling and gamblers in host and surrounding communities
- Identify program resources – tool kits, web links, case studies, and templates are all available from a range of organizations that specialize in this work.
- Consider workshops in target communities.
- To launch process, bring together potential collaborators, assess readiness and related needs for resources or training to actively participate in program.
- Ongoing (annually?) among all teams to establish links and share experiences and learning.
- Consider supporting training opportunities.
- Consider identifying potential researchers or research institutes that specialize in community research. ***Evidence shows that outcomes are best when researchers are experienced in CBR.***

Program Overview – Funding Envelope

- **Current plan:** $200,000 annually, $185,000 in Year One
- Consistent with best-practice formula of **5% of total research awards budget** ($50,000 per $1M)
- Consider **cost-sharing final stage work (KTE)** with DPH or appropriate public organization; so research and outcomes can be linked

Consider allowing budget items often excluded in traditional research funding guidelines:

- **Capacity building opportunities** such as training, staff-buy-outs, and administrative overhead
- **Items that address barriers to participation**, especially for community representatives, such as childcare, translation, transportation, refreshments, etc.
- Limits could be set on the proportion of the total budget for these components

Program Overview – Duration and Structure

Funding Considerations…

Fewer projects longer term, rather than diluting resources (funds, community participation, researchers) across many projects. **CBR takes time and longer-term support increases the likelihood of success.**

Possible stages of work…

Stages could be…

- Combined into one longer term award that details each stage over 2-3 years
- Awarded individually, conditional on completion of previous
- Separate awards that allow a team to apply at any stage of their development

Program Overview – Grants Procurement and Administration

MGC leads development and implementation of a Community-Engaged Research Program

Steps include…

1. Establish guidelines; frequency and possibly templates for reporting updates and final report (Financial and Research aspects)
2. Manage structure and process for (peer) review
   I. Establish structure and people for review process
      i. Academic peers should include CBR experience
      ii. Public health
   II. Assign and manage peer review, (e.g., matching reviewers to proposals)
   III. Assemble recommendations for each funding round
   IV. Create core team for final decisions – may be same as reviewers or a standing group
3. Execute contracts and Award funds
4. Provide administrative support and oversight for grantee responsibilities
5. Receive grant deliverables (interim, budget and final reports)

Program Overview – Evaluation and Recognition

Program Evaluation

- Build evaluation requirements into the Grants Program as a whole, to ensure consistency and reduce burden on individual grant teams.
- Establish objectives that match anticipated outcomes, including outcomes that are specific to each stage.
- Build assessment of some objectives into grant reporting process (e.g., brief confidential survey of team members).
- Establish a reasonable period for results to manifest, and consider evaluating different aspects in stages.

  Example: seed grants could be evaluated on their own criteria almost immediately, as opposed to changes in policy or programs, which may take three years or more.
- Support and reward agencies for effectively using research to improve their program and advocacy objectives

Section 3: Knowledge Translation

- *Recommendations Summary*
- *Function Overview*

Recommendation Summary

MGC has committed to using the knowledge from the commissioned Research to **inform planning and funding allocation, advance the quality of policy and programs, and inform future research**.

Findings will…

- Inform how monies from the Public Health Trust Fund (Section 58) are expended;
- Assist in assessing community-level impacts and inform decisions about expenditures from the Community Mitigation Fund (Section 61);
- Improve problem gambling prevention;
- Advance the quality, effectiveness and efficacy of treatment of gambling disorders;
- Inform the ongoing MGC research agenda;
- Provide quantitative/qualitative assessments of a broad range of impacts of expanded gaming;
- Provide all of the stakeholders in Massachusetts with a neutral database for strategic analysis and decision-making.

Key Recommendation:

Develop the explicit function, expertise and resources at both MGC and DPH Office of Problem Gambling Services to engage in strategic knowledge translation and fully exploit the substantial knowledge being generated by the research program.

Function Overview – Stakeholder Feedback

Commissioners identified many ways to use research knowledge, including to complete the communications loop with the community stakeholders they consulted – to demonstrate that the Commission listened and developed a rigorous regulatory framework to maximize benefits and minimize negative impacts, and provided communities with funding to target concerns and improve their readiness for casinos. Research evidence showing the success of these readiness efforts should be shared with the original stakeholders.

In the early stages of consultation considerable time and effort were dedicated to understanding the knowledge needs of DPH leadership, and helping the research team to analyse data and interpret findings in ways that align with the needs of DPH to design, develop, implement and evaluate policy and programs that address health and social inequities.

Function Overview – Stakeholder Feedback

Host communities – Health and Social Service agencies and their staff, including public health representatives expressed strong desire to understand the scope and scale of the research program and to receive research findings in ways that would help inform their decision-making and planning

Host communities – Hospitality and Leisure, Business associations such as Chambers of Commerce – These organizations described the need for timely information regarding the impact of casinos so they could adjust to maximize economic benefits and minimize negative impacts for the member businesses they represent (hotels, restaurants, tourist attractions, financial institutions, and others). These associations, often have limited or no capacity to conduct complex research to provide meaningful insight to their members and develop resources to help them succeed in changing business climates.

Function Overview – Stakeholder Feedback

Public safety – stakeholders identified this body of research as having, to a great extent, built in the knowledge translation process by establishing collaborative relationships to collect, analyse and interpret the data. This model of engaging knowledge users suits this type of research where the same stakeholders are the source of the data and the ultimate users of the information in their work. Police forces who work with the primary investigator on this work, Christopher Bruce, work in the communities that are hosting expanded gambling and can use the findings immediately to provide training and policing that is responsive and appropriate. They also worked with the investigator to modify reporting processes to improve the usefulness of the data.

Function Overview – Research and Knowledge Pathways

Pre-Expansion Consultation

Inform Expansion Approach

- Progressive regulatory framework
- RG framework & programs
- Community Mitigation Fund (e.g. for work force development, transit/traffic, policing)
- Other community-readiness planning and funding

Implement Programs

Introduce Casinos

Establish Baseline

- 29 indicators tracked across 2 categories
  - i. Social & Health
  - ii. Economic & Fiscal
- Public safety Impacts

Evaluate Approaches & Programs

- RG programs
- Efficacy of other policies & programs

Assess Impacts

- Measure indicators against baseline

Apply Findings

Feedback loops to H&S Communities

Continuous improvement of policy & programs

Inform future research (e.g. community-engaged)

Policy & Program Path

Research Path

Section 4: Data Management

- *Recommendations Summary*
- *Function Overview*

Recommendation Summary

Key Recommendations:

- Continue to support the rather complex development of a data management function at MGC, which may include partnership with DPH or other State level organization on the infrastructure for a data repository.
- Provide ongoing resources to maintain and build this data management function at MGC.
- Explore, once the data management function is up and running, a research access program that allows external researchers in Massachusetts, and in broader research fields and jurisdictions to maximize the use of the data being generated by the research program

Function Overview – Key Components

Data Repository for commissioned research and player account data – forming potentially the richest source of gambling-related research data in the world

Data Management Framework – This refers to a structure for collecting, recording, extracting and providing data to MGC and should be applied to all research funded by MGC.

External Research Program to maximize the value of the data assets for Massachusetts and the field of responsible gaming

Function Overview – Stakeholder Feedback

The support for a data management function was expressed by stakeholders in different ways. For example, researchers wanted to be able to use the data being generated, communities wanted both topic-specific synthesis and, in some cases, raw data to inform their work, and other stakeholders described data management functions and tools that could be substantially enhanced by the integration of the data form the MGC research program.

In their report the Western Massachusetts Casino Health Impact Assessment (2014), the authors requested annually posting MGM data on: employment and workforce development, traffic and transportation, PG rates, to make it possible to assess and track the value of collaborations and strategies designed to maximize positive impacts such as employment, and minimize negative ones.

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Section 5: Evaluation

- *Recommendations Summary*
- *Recommendations in Detail*

Recommendation Summary

MGC has committed to the **evaluation of its three RG programs (GameSense Information Centres, PlayMyWay, and Voluntary Self-exclusion)** and Division on Addiction, Cambridge Health Alliance (DOA) to conduct preliminary evaluations of each.

Existing evaluations have several perceived shortcomings including:

- Absence of adequate CI/program evaluation frameworks, logic models, clear metrics, etc.
- Lack of collaboration in selecting evaluation framework.
- Lack of program evaluator/researchers with program evaluation expertise.
- Inconsistent evaluation frameworks and methodologies used across programs, Lack of learning across evaluations.
- Evaluation reports inaccessible to lay readers, in terms of content and format.

Key Recommendations:

1. Develop an evaluation framework in collaboration with DPH to ensure a shared and rigorous approach to program evaluation, continuous improvement and innovation of the responsible gaming programs and problem gambling interventions across the State.
2. Develop an evaluation function and expertise at MGC, to manage evaluation and continuous improvement of its programs, and to coordinate program evaluation with DPH for shared learning and innovation

Recommendations in Detail

To support and provide structure for future evaluations, program managers at MGC and the DPH Office of Problem Gambling Services could…

- Select a shared overarching evaluation approach or framework for CI that applies to all of the responsible gaming programs at MGC and at DPH, Office of Problem Gambling Services.
- Refine specific Objectives for each program. (What does success look like?)
- Develop a logic model for each program, mapping the path from the program activities to achievement of the desired objectives
- Identify:
    - Measures/metrics that can be used to determine achievement of objectives, (What outcomes can we assess to measure the effectiveness of the program?)
    - Data sources for these metrics, such as counts, surveys, and patron player data.

Recommendations in Detail

Set targets for one to three years. (What are our targets or thresholds for success?), for example…

Year 1 targets may be strictly related to awareness, use and satisfaction with service, such as

- 50% of patrons are aware of GSICs,
- 3% of patrons use GSICs,
- 75% of users are satisfied with the service,
- 68% of casino staff are aware of and comfortable making referrals to the GSIC, as assessed in an employee survey

Year 2 targets may

- Increase previous year targets and
- Add impact of GSIC interaction on patrons' gambling knowledge, as assessed in a patron survey.

Year 3 targets may

- Use more complex measures of impact on both gambling knowledge and play behaviour, and
- Add the exploration of data sources to track what happens when GS Advisors make a referral to a helping agency;
- Add metrics to assess changes before and after a visit to the GSIC in uptake of RG tools.

When you clearly set out the objectives, metrics and targets for success you can track these metrics annually, in addition to conducting formal program evaluations every few years. This supports continuous improvement.

Recommendations in Detail – Evaluation Program Enhancements

Some program-specific ideas for a more comprehensive evaluation program are suggested below:

GameSense: An evaluation framework developed in Canada maps out components and data sources. MGC could consider using this framework for future evaluations (w/ modifications as needed).

Credit Use by patrons: MGC has put rigorous requirements in place for this. Together these requirements represent a program aimed at reducing the risk of gambling with credit, and an evaluation of these initiatives could provide important information on how ell these are working.

New and emerging policy: Patron impairment is an emerging issue with cannabis legalisation and operators may need guidance on how to identify and respond appropriately to impairment. Any new initiatives developed for this purpose should be evaluated, especially given the lack of scientific consensus on assessing impairment.

DPH is in the process of developing and implementing programs to prevent and mitigate **gambling-related harm**. Using a shared evaluation framework for responsible gambling programs at both MGC and DPH will make it easier to transfer learning in an efficient and coordinated way from research studies and from program evaluations to the policies and programs of both organizations.

In Closing

This strategy attempts to build on the very powerful research agenda already undertaken to understand the impact of the introduction of casinos in Massachusetts. More detailed information on the stakeholder consultation and document review is available in appended reports. This strategy envisions making the key connections among the research projects and teams, operators, communities and their stakeholders to ensure that the valuable knowledge is being gathered and applied to minimize gambling-related harm and negative impacts and maximize the positive impacts across the Commonwealth.

SEIGMA SOCIAL AND ECONOMIC IMPACTS OF GAMBLING IN MASSACHUSETTS

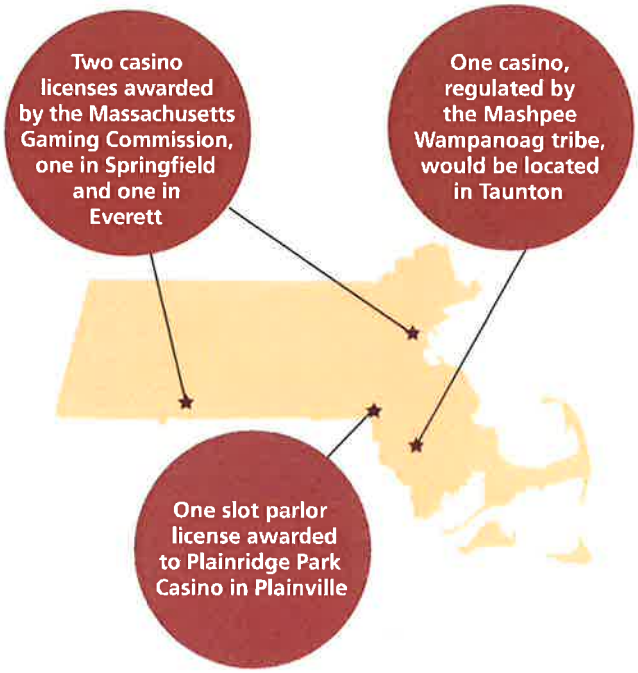
UNIVERSITY OF MASSACHUSETTS SCHOOL OF PUBLIC HEALTH AND HEALTH SCIENCES

SEIGMA
FACT SHEET
Number 01
June 2016

Casino-Style Gambling Introduced in Massachusetts

In November 2011, legislation passed permitting casino-style gambling in the state for the first time.

The Massachusetts Gaming Commission (MGC) has awarded two casino licenses. One license was awarded to Wynn for a $1.7 billion development in Everett near Boston. The second license was awarded to MGM for a $950 million development in Springfield in Western Massachusetts. The MGC has also awarded one slot parlor license to Plainridge Park Casino in Plainville. A third casino, owned by the Mashpee Wampanoag Tribe, has been proposed for Taunton in the Southeastern region of the Commonwealth.



The casino law in Massachusetts is unique in making the role of research central to improving responsible gambling and reducing problem gambling in the Commonwealth. Section 71 of the Expanded Gaming Act includes three important parts:

1. Understanding the social and economic effects of expanded gambling
2. Carrying out a study of problem gambling and the existing prevention and treatment programs that address its harmful results, before any casinos open in Massachusetts
3. Collecting scientific information about the neuroscience, psychology, sociology, and public health impacts of gambling

Section 71 requires the MGC to establish research goals and make annual recommendations to the Legislature. The research funded under the Expanded Gaming Act is important to fully understanding the effects of expanded gambling in the Commonwealth. The findings will be used in the development of interventions to minimize gambling-related harm and to increase responsible gambling in Massachusetts.

SEIGMA PROJECT OVERVIEW

SEIGMA is a project that uses experts from several disciplines to carry out the different parts of the MGC research effort. The project team is dedicated to working closely with many other groups throughout the Commonwealth. The study uses a state-of-the art design, rigorous data collection and research methods, and a careful analytic approach to establish the effects of casino gambling at state, regional, and local levels. The SEIGMA team collects its own data as well as using data gathered by other organizations. The SEIGMA study is funded by the Massachusetts Gaming Commission.

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SEIGMA
FACT SHEET
Number 02
June 2016

First-of-kind Gambling Monitoring System in Massachusetts

In March of 2013, the Massachusetts Gaming Commission (MGC) selected a research team based at the School of Public Health and Health Sciences at the University of Massachusetts Amherst to carry out research required by the Expanded Gaming Act that allowed casinos in Massachusetts for the first time.

The Social and Economic Impacts of Gambling in Massachusetts (SEIGMA) project is led by three experienced investigators with backgrounds in gambling research, psychology, sociology and biostatistics. Two of the lead investigators are based at UMass Amherst while the third is based in Canada. The lead investigators work with a much larger group of researchers with backgrounds in economics, public health, public policy, and hospitality and tourism.

SEIGMA TEAM MEMBERS

UMass Amherst
Provides leadership of the project and collects and analyzes social and health data

Williams & Associates
Provides technical expertise on the project

UMass Donahue Institute
Leads economic and fiscal data analyses

NORC at the University of Chicago
Collects the project's general population surveys

IPSOS Public Affairs
Conducts an online panel survey component of the study

Market Street Research
Assists in qualitative data collection

The SEIGMA study involves a range of research activities. One important activity is doing surveys to measure gambling attitudes and participation in the population. Another important activity is collecting information about construction and employment from the casinos and the MGC. The project also includes interviewing state and city officials and treatment providers. These different activities all contribute to the three main research areas of the SEIGMA study.

The three research areas of the SEIGMA project form the basis for a first-of-its-kind gambling oversight system. This system will provide the residents of Massachusetts with the following:

- Neutral information for decision-making
- Early warning signs of changes connected with new and existing forms of gambling in the Commonwealth
- Help in reducing gambling-related harm and improving services for problem gamblers and their families

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Gambling Participation

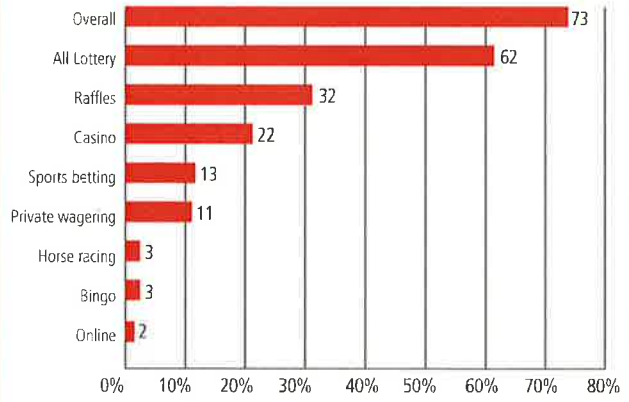
SEIGMA FACT SHEET NUMBER 03 JUNE 2018

Three-Quarters of Massachusetts Residents Gamble Before Massachusetts Casinos Open

With the passage of the Expanded Gaming Act, Massachusetts will host three casinos and a slot parlor. The SEIGMA team took a "snapshot" to understand how Massachusetts residents participated in gambling prior to casinos and the key demographic groups who are more likely to gamble. Here, we summarize findings from SEIGMA's *Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey* based on responses from approximately 10,000 Massachusetts adults.

In 2013, nearly three-quarters of Massachusetts residents reported participating in one or more of these gambling activities in the past year:

Gambling Participation by Activity Prior to MA Casinos



- A quarter of the Massachusetts adult population did not gamble, 35% gambled yearly, 20% gambled monthly, and 18% gambled weekly
- Approximately 6 in 10 people reported playing the lottery
- Just under a quarter (22%) of Massachusetts adults reported visiting casinos to gamble. Over half of people who did so (66%) visited casinos in Connecticut

Despite not having any casinos in 2013, the past-year casino participation rate in Massachusetts was similar to participation rates in some other U.S. jurisdictions with newly introduced casinos, including Maryland and Ohio. The past-year casino gambling rate was higher in U.S. states with mature casino industries compared with Massachusetts, such as Connecticut and Iowa.

Who is more likely to gamble in Massachusetts?

- Men are more likely to gamble than women (77% of men vs.70% of women)
- Middle-aged adults (25-64) are more likely to gamble than younger adults (75% of middle aged adults compared to 55% of young adults)
- Those who identify as White are more likely to gamble than those who identify as Hispanic, Black, or Asian (76% of Whites compared to 63% of Hispanics, 66% of Blacks, 56% of Asians)

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Casino Patrons

SEIGMA
FACT SHEET
NUMBER 04
JUNE 2018

First-of-its-Kind Patron Survey at Plainridge Park Casino: Who is Spending and How Much?

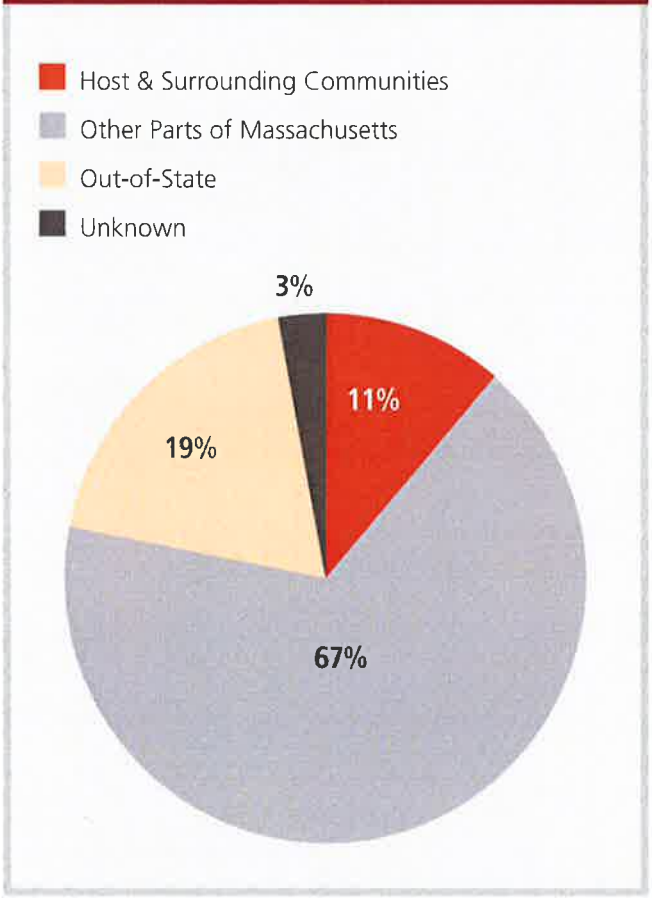
In 2016, the SEIGMA research team conducted a patron survey at Massachusetts' first casino, Plainridge Park Casino (PPC). The efforts to make this PPC patron sample as representative as possible make this research first-of-its-kind.

The *Patron and License Plate Survey Report: Plainridge Park Casino 2016* sheds light on where patrons come from, how much they spend, and whether it is being redirected from other MA businesses.

The results showed:

- The majority of PPC patrons were from Massachusetts
  - 11% from Plainville or nearby towns
  - 67% from other Massachusetts communities
- 19% of patrons were from outside the Commonwealth
- Nearly 90% of PPC patrons had visited casinos in other jurisdictions in the past year
  - The majority visited Connecticut (72%) and Rhode Island (56%) casinos
- Massachusetts residents spent appoximately $135 million on gambling at PPC. Non-Massachusetts residents spent approximately $37 million on gambling at PPC
- 58% of gambling spending and 50% of non-gambling spending was "recaptured" (patrons would otherwise have spent these dollars at an out-of-state casino)
- 26% of gambling spending by Massachusetts residents was "reallocated" from other goods and services in the Commonwealth

Geographic Origin of Plainridge Park Casino Patrons in 2016



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Casino Employees

SEIGMA FACT SHEET NUMBER 05 JUNE 2018

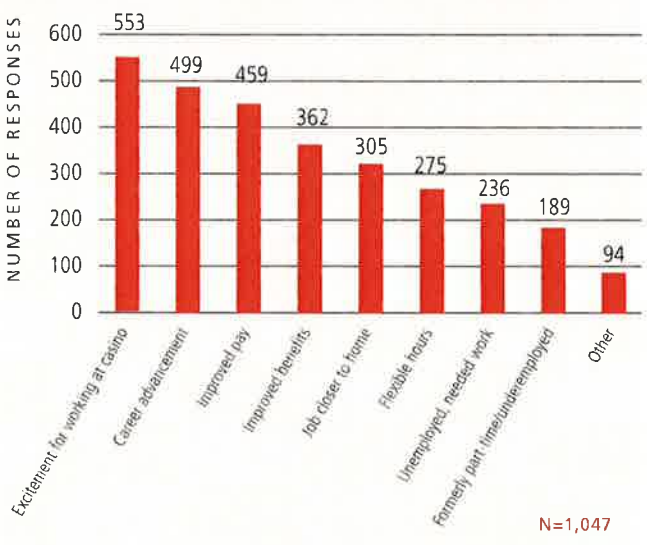
Half of People Hired at Plainridge Park Casino Previously Worked Part-Time or Unemployed

The UMass Donahue Institute's Economic and Public Policy Research team, a part of the larger SEIGMA team, strives to understand the economic and fiscal impacts of the introduction of casinos on the people and economy of the Commonwealth. Part of this is to understand the sort of jobs casinos provide in Massachusetts, who they are employing, and whether casino employment represents an improvement to these workers' livelihoods. Future reports will further flesh out the demographic characteristics of the workforce.

Our findings from SEIGMA's *New Employee Survey at Plainridge Park Casino: Analysis of First Two Years of Data Collection* reveal several important characteristics of new hires at Plainridge Park Casino and the emergent casino workforce in Massachusetts:

- Over 500 new positions were created at Plainridge Park Casino
- Major reasons new employees sought employment at Plainridge Park Casino were career advancement, improved pay, and improved benefits
- Plainridge Park Casino is creating employment opportunities for the unemployed and underemployed
  - 50% previously worked part-time or were unemployed
- Casino jobs are accessible for those who have little or no experience or training
  - 86% had no prior gaming experience and nearly 75% were without pre-employment training
- Plainridge Park Casino is hiring mostly local Massachusetts residents
  - 93% did not move to take their jobs at the casino
  - Of those who moved to take their jobs at the casino, most relocated to Plainville and its surrounding communities

Reasons for Seeking Employment at Plainridge Park Casino



Note: Respondents were allowed to select more than one reason for seeking employment so response totals for this question will exceed the total number of respondents.

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Gambling Attitudes
SEIGMA
FACT SHEET
NUMBER 06
JUNE 2018

Massachusetts Residents Have Mixed Opinions on Gambling Expansion in Massachusetts Prior to Casinos

The Massachusetts Legislature passed an Act Establishing Expanded Gaming in the Commonwealth in November 2011. This permits the introduction of casinos and slot parlors in Massachusetts for the first time. Prior to the establishment of casinos, the SEIGMA team took a "snapshot" of how Massachusetts residents felt about gambling. Here, we summarize findings from SEIGMA's *Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey*, based on responses from approximately 10,000 Massachusetts adults in 2013/2014 before casinos were open.

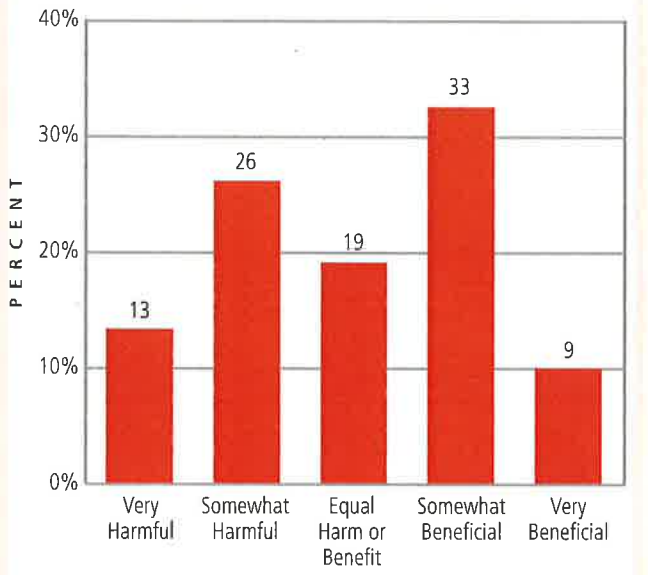
Massachusetts residents have a range of opinions on gambling:

- Over half of the population (55%) believes that some forms of gambling should be legal and some should be illegal, with only a third (32%) reporting that all forms should be legal, and a tenth (13%) reporting that all forms should be illegal
- Nearly two-thirds (61%) believe that the level of gambling availability in the Commonwealth is acceptable prior to casino expansion
- Over half (61%) perceive the impact of gambling expansion on the state to be neutral, beneficial, or very beneficial while 39% perceive the impact to be somewhat or very harmful

Massachusetts residents had mixed opinions about the impact of the planned introduction of casinos and a slot parlor *in the state*:

- Almost equal numbers of people believe it would be harmful (39%) and beneficial (42%)

Perceived Impact of Expanded Gambling in Massachusetts



People viewed the impact of having a new casino or slot parlor *in their own community* somewhat more negatively than they perceived the general impact for Massachusetts:

- 43% believe it would be harmful compared to 31% who believe it would be beneficial

SEIGMA PROJECT OVERVIEW

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Casino Operations

SEIGMA
FACT SHEET
NUMBER 07
JUNE 2018

What are the Economic Impacts of Plainridge Park Casino (PPC)?

When PPC opened in June 2015, the UMass Donahue Institute (UMDI), as part of the SEIGMA team, set out to capture the economic impacts of PPC's first year of operation. These findings are detailed in *Plainridge Park Casino First Year of Operation: Economic Impacts Report.*

While PPC created approximately 556 new jobs at the casino, these account for only a fraction of its total economic impact. Additional economic impacts include:

- New employees spend new wages in their communities, supporting new economic activity
  - PPC paid approximately $18 million in wages in 2016
- Casino purchases goods and services from other vendors
  - Public sector and private sector activity spurred by the casino created or supported approximately 2,400 jobs
- State and local governments collect taxes and other assessments from the casino
  - $81 million in gaming taxes in 2016 was collected from PPC—the largest single source of new economic activity
  - Cities and towns received approximately $66 million in the form of local aid from these funds

Like any new attraction, some of PPC's revenue is coming from consumers who previously spent their money at other Massachusetts businesses. For instance:

- 21% of spending at PPC is reallocated spending by in-state patrons (i.e., would have spent dollars on other goods and services)

Plainridge Park Casino Monthly Gross Gaming Revenue and Collected Taxes, 2016*

Source: Massachusetts Gaming Commission
**All estimates reported are for Fiscal Year 2016, which begins July 2015 and ends June 2016.*

SEIGMA PROJECT OVERVIEW

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Lottery
SEIGMA
FACT SHEET
NUMBER 08
JUNE 2018

Lottery Sales Unhurt by Plainridge Park Casino

As casino gambling expands in Massachusetts, the Commonwealth has made protecting the state lottery a priority. In determining whether an applicant would receive a license, the MGC evaluated how each applicant proposed to protect the lottery from adverse impacts, including developing cross-marketing strategies and increasing ticket sales to out-of-state residents. As part of the SEIGMA research team, the UMass Donahue Institute's Economic and Public Policy Research team is monitoring lottery sales to assess potential impacts. Detailed findings can be found in *Lottery Revenue and Plainridge Park Casino: Analysis After Two Years of Casino Operation*.

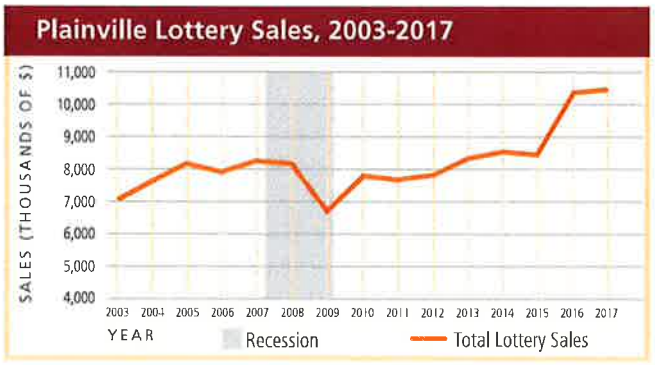
Lottery revenues are the largest source of unrestricted local aid and the second largest source of all local aid in Massachusetts. For instance:

- The lottery's net profit in 2017 was approximately $1 billion — an all-time high
  - Almost all of these dollars went to Commonwealth municipalities as direct local aid
- The Town of Plainville, which hosts Plainridge Park Casino, received approximately $700,000 from the lottery and other direct local aid sources in 2017
  - This represents 17% of the Town's total state aid and 2% of total receipts

Analyses of agent-specific lottery sales data suggest:

- No large, significant decline in lottery sales can be attributed to Plainridge Park Casino
- No pattern between lottery sales growth and proximity to the casino
  - Sales have not uniformly increased at greater distances from the casino
- Lottery sales in Plainville increased approximately 25% in the first year after Plainridge Park Casino opening
  - Remained at that level in the second year of operation
- No notable decline in lottery sales in Plainville since the opening of Plainridge Park Casino

Source: MA Lottery, FY2003-2017, nominal dollars.



Source: MA Lottery, FY2003-2017, nominal dollars.

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Gambling Harm

SEIGMA
FACT SHEET
NUMBER 09
JUNE 2018

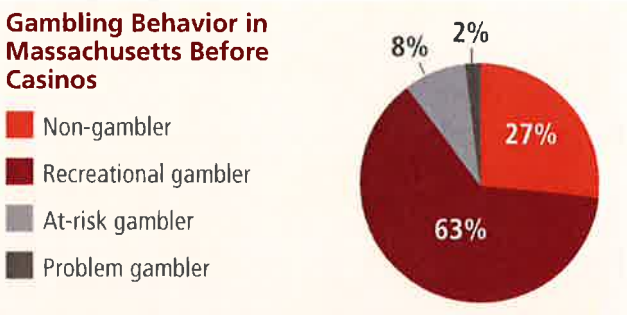
Who is Experiencing Gambling Harm before Massachusetts Casinos?

The Expanded Gaming Act permits the introduction of casinos and slot parlors in Massachusetts for the first time. A primary concern surrounding expanded gambling is its impact on problem gambling. The SEIGMA team took a "snapshot" of what problem gambling looked like in Massachusetts prior to casinos. A primary aim of the baseline study is to understand the demographic characteristics (race, income, gender, age, etc.) which make some people more or less at risk of experiencing harm from gambling. Based on responses from approximately 10,000 Massachusetts adults, we summarize findings from SEIGMA's *Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey.*

People were classified as:

- Non-gamblers (have not gambled in the past year)
- Recreational gamblers (gamble because they enjoy these activities)
- At-risk gamblers (betting more than planned, spending more time than intended, etc.)
- Problem gamblers (experience significant impaired control over gambling and negative consequences)

Gambling Behavior in Massachusetts Before Casinos



- Based on the percentages in the pie chart, we estimate that approximately 110,000 adult residents are experiencing problems with gambling and approximately 440,000 adult residents are at risk of experiencing problems with gambling
- The amount of problem gambling in Massachusetts is very similar to the amount identified in other U.S. states

Who is more vulnerable to experience harm from problems with gambling?

- Men are 3 times more likely than women
- Persons who identify as Black are 4 times more likely than persons who identify as White
- Individuals with only a high school diploma are 3 times more likely than individuals with a college degree

When at-risk gamblers and problem gamblers are compared to recreational gamblers, survey results showed that those at risk of experiencing harm from a gambling problem and those experiencing harm from a gambling problem are more likely to report:

- Serious problems with depression, anxiety, and other mental health problems
- Using tobacco
- Consuming large amounts of alcohol at one time

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MAGIC MASSACHUSETTS GAMBLING IMPACT COHORT STUDY

UNIVERSITY OF MASSACHUSETTS SCHOOL OF PUBLIC HEALTH AND HEALTH SCIENCES

Cohort Transitions
MAGIC
FACT SHEET
NUMBER 01
JUNE 2018

The First Major Gambling Cohort Study in the US

In 2015, the MAGIC team launched the first adult longitudinal cohort study of gambling and problem gambling in the US. With a sample of 3,139 Massachusetts residents, the MAGIC study surveys the same individuals over time. This provides information on how gambling and problem gambling develop, progress, and remit, and will identify demographic groups particularly at risk of experiencing gambling related harm. This research also highlights risk and protective factors important in developing effective prevention, intervention, treatment, and recovery support services. The stability and movement in and out of different gambling behaviors is a key focus of the MAGIC study and is further detailed in *Analysis of MAGIC 2: Incidence and Transitions.*

Transitions between Gambling Behavior Groups from Wave 1 to Wave 2

		WAVE 2									
		Non-Gambler		Recreational Gambler		At-Risk Gambler		Problem or Pathological Gambler		Shift	
	GAMBLING STATUS	N	%	N	%	N	%	N	%	N	%
WAVE 1	Non-Gambler	298	64.4	158	34.1	*7*	*1.5*	0	0.0	165	35.6
	Recreational Gambler	177	8.3	1,723	80.3	223	10.4	22	1.0	422	19.7
	At-Risk Gambler	*8*	*2.0*	201	50.9	148	37.5	38	9.6	247	62.5
	Problem or Pathological Gambler	–	–	16	20.3	23	29.1	39	49.4	40	50.6
	TOTAL	484		2,098		401		99			

Note: Cells with sample size of 5 or less are blank
Note: Italics indicates estimates are unreliable, relative standard error > 30%

Key findings:

- Recreational Gamblers and Non-Gamblers display the most stable pattern of gambling behavior
  - 80% of Recreational Gamblers stayed Recreational Gamblers
  - 64% of Non-Gamblers remained Non-Gamblers
    - A sizable portion transitioned into Recreational Gambling
- Only 49% of Problem or Pathological Gamblers stayed in this category
  - Sizable portions transitioned into At-Risk Gambling and Recreational Gambling
- At-Risk Gamblers display the most unstable pattern of gambling behavior
  - Only 37% remained in this category
  - Most transitioned to Recreational Gambling
  - A significant minority transitioned to Problem or Pathological Gambling

MAGIC PROJECT OVERVIEW

MAGIC is a project that uses experts from several disciplines to elucidate the incidence and etiology–the cause or causes of a disease or condition–of problem gambling, which is central to the Massachusetts Gaming Commission's research effort. The project team is dedicated to working closely with many other groups throughout the Commonwealth. The study uses state-of-the-art design, rigorous data collection and research methods, and a careful analytic approach to understand the effects of casino gambling on gambling behavior. The MAGIC team collects its own data and is funded by the Massachusetts Gaming Commission.

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Public Health Trust Fund: FY 20 Draft Budget Plan and Timeline

January 23rd 2019

- Introduce FY 20 budget plan, format and timeline with EC members
- Propose additional budget meeting for April of 2019

March 27th 2019

- Introduce outline of the first draft of FY 20 Budget
- Introduce areas for propose work and receive feedback from EC members
- Victor and Mark will meet with EC members to review and follow up

April- TBD

- Introduce the final draft of the FY 20 budget
- Revise budget based on feedback from EC members

May 22nd 2019

- Vote on the FY 20 budget

**Draft for Policy Conversation Only*