



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:

**Monday, November 18, 2019
2:00 p.m.**

Massachusetts Gaming Commission
101 Federal St, 12th Floor
Boston, MA 02110

- 1) Call to Order & Introductions
- 2) Approval of the Minutes from July 24th- **VOTE**
- 3) Research Presentation – *Talking about Casino Gambling: Community Voices From Boston Chinatown* – Carolyn Wong, UMass Boston and Giles Li, Boston Chinatown Neighborhood Association
- 4) Gap Analysis Presentation - *Gambling Treatment Services Gap Analysis: Treatment Capability Gaps* - Drs. Sarah Nelson, Debi LaPlante, and Heather Gray, Division on Addiction, Cambridge Health Alliance, Harvard Medical School
- 5) DPH Communications Campaigns Presentation - Caitlin Dodge, Think Argus
- 6) Standing Items
 - a. PHTF Budget
 - i. FY19 End of Year and FY20 First Quarter
 - ii. FY21 Projection and FY21 Budget Timeline
 - b. MGC Updates
 - i. Procurements
 - ii. Building capacity for Knowledge Transfer and Exchange (KTE)
- 7) Public Comment
- 8) Agenda items for future meetings
- 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@sec.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

Original Date Posted to Website:



Massachusetts Gaming Commission



Public Health Trust Fund Executive Committee (PHTFEC) Meeting Minutes



Date/Time: July 24, 2019 - 2:00 p.m.

Place: **Massachusetts Department of Public Health**
Public Health Council Room
250 Washington St
Boston, MA 02108

Executive Committee Members Present:

Lindsey Tucker, Co-Chair, Associate Commissioner, Massachusetts Department of Public Health
Enrique Zuniga, Co-Chair, Commissioner, Massachusetts Gaming Commission
Michael Sweeney, Executive Director, Massachusetts State Lottery Commission
Carlene Pavlos, Executive Director, Massachusetts Public Health Association
Angela Davis, Assistant Undersecretary for Law Enforcement and Criminal Justice, Executive Office of Public Safety and Security

Call to Order

2:08 p.m. Co-Chair Tucker called to order the Public Health Trust Fund Executive Committee (PHTFEC) Meeting and welcomed all members. Victor Ortiz, Director of the Office of Problem Gambling Services, introduced Alice Byrd, the new Planning & Development Coordinator for the Office of Problem Gambling Services; Co-Chair Zuniga introduced Cathy Judd-Stein, the Chair of the Massachusetts Gaming Commission.

Presentations

2:15 pm Rachel A. Volberg, Research Associate Professor of Biostatistics and Epidemiology at UMASS Amherst presented on operationalizing gambling-related harm. (See Document 8.)

The Executive Committee raised questions and concerns about the definition of gambling harm. Michael Sweeney asked about the fact that the majority of these studies and efforts have happened in Canada. Members asked whether the studies are comparable to the United States. Mr. Sweeney also raised concerns about identifying thresholds of harm and whether they are applicable to all gamblers.

3:10 pm Rebecca Bishop of the Education Development Center presented on the Massachusetts Ambassador Project. Personal commentary was also provided by program ambassadors and program directors leading the project. (See Document 4.)

Carlene Pavlos mentioned that this program is an example of a real public health program and would like to see programs like this that also involve women. Michael Sweeney commended the authenticity of the programs and suggested expanding the program and work that the ambassadors do and emphasized the importance of getting more boots on the ground. Co-Chair Zuniga expressed continued interest in the feedback that comes back from these programs in order to take further action.

Overall, the ambassadors received high praise for bringing an authentic and real voice to the work of mitigating harms associated with gambling.

Routine Updates

4:00 p.m. Co-Chair Zuniga updated the committee on the GameSense RFR. A notice of intent to issue was posted on July 2nd and shared with seventy different vendors. The RFR will be issued between July 29th and July 31st. Responses will be due by September 9th. Evaluations and reviews will be scheduled around September 18th to 20th. Contracting should be completed by the end of September or beginning of October.

Carlene Pavlos asked whether the contract will be issued to one vendor or if it is possible that multiple vendors will be awarded. Co-Chair Zuniga responded that the RFR is flexible and there is a possibility that multiple contracts will be awarded.

Co-Chair Lindsey Tucker commented that the September 18th-20th and October 1st deadlines are tight. Co-Chair Zuniga responded that an extension can be asked for if need be, and that due diligence was done by sending out the notice of intent to issue in early July.

Carlene Pavlos referred back to the discussion from the last meeting and added that the short timeline for scoring and review may create a lack of competition. Co-Chair Zuniga acknowledged that the alternative could have been to extend the timeline, but due to the Committee's request of re-procuring the contract in Q1 this is not possible.

Mark Vander Linden presented on the research RFR. He stated that responses are due by August 28th. The goal is for a contract start date of January 2020.

In addition, Mark Vander Linden asked for final feedback on the strategic plan (see Document 7). The plan was presented to the Gaming Policy Advisory Committee as required; no feedback was given. He will present the final plan to the Gaming Commission for approval. He asked whether the Committee wanted to vote for approval of the strategic plan. Co-Chair Zuniga did not feel it was necessary to vote on the plan. Co-Chair Tucker agreed and suggested an "endorsement" rather than a vote. Carlene Pavlos and Michael Sweeney agreed that a vote was not necessary.

Co-Chair Tucker asked whether the strategic plan is a living document. Co-Chair Zuniga confirmed that it is flexible enough to change accordingly if necessary. The strategic plan will be evaluated in 2 years.

The budget (see Document 3) was shared with committee members. Carlene Pavlos asked for an annotated FY20 budget for the next meeting.

Co-Chair Zuniga presented on Encore's opening. It was considered successful and the concerns about traffic did not come to fruition. Encore's projected revenue is high in comparison to MGM's revenue projection.

Mark Vander Linden shared an updated on GameSense: during the period between June 23 and July 22, GameSense advisers completed training for 3,504 Encore employees. Employees filled out over 700 evaluations, rating the training program positively. GameSense advisers also had 1,545 interactions with customers regarding responsible gambling and voluntary self-exclusion. Mark Vander Linden also shared information on GameSense advisers' diversity – for example, advisers at Encore speak 8 different languages.

Co-Chair Zuniga provided an update on voluntary self-exclusion: 506 people are self-excluded and 19 recently enrolled at Encore. The Massachusetts Gaming Commission had done outreach in Everett that has been helpful.

Co-Chair Zuniga mentioned that he would like to hold a PHTFEC meeting in Springfield later this year or in early 2020. He would like community members in that area to be able to attend a PHTFEC meeting.

Approval of Minutes

Angela Davis noticed a typo in the first line of the paragraph of the budget discussion on the word "request".

Co-Chair Zuniga asked that the minutes be updated to reflect the total budget of \$11,278,000 - including the addition of \$700,000 - that was approved for FY20. Additionally, he asked that the minutes reflect that the GameSense line item be marked as funding for Q1 only, with funding for Q2 through Q4 to be determined.

Co-Chair Zuniga made a motion to approve minutes, Michael Sweeny seconded. All members were in favor of approval.

Public Comment

4:51 pm Tom Land asked whether logic models and reports for programs will be made available to the group.

Motion to End the Meeting

4:59pm Co-Chair Tucker asked for a motion to end the meeting. Michael Sweeney motioned, Carlene Pavlos seconded. All were in favor.

List of Documents and Other Items Used

1. Public Health Trust Fund Executive Committee, Notice of Meeting and Agenda dated July 24, 2019
2. Public Health Trust Fund Executive Committee, Meeting Minutes dated May 22, 2019
3. FY19 Budget Overview Spreadsheet
4. Massachusetts Ambassador Project presentation dated July 24, 2019
5. Think Argus MADPH Problem Gambling Performance Snapshot dated July 11, 2019
6. Gaming Research Strategic Plan dated July 24, 2019
7. A Research Strategy for Gaming in Massachusetts dated May 2019
8. Implementing an International Approach to Measuring Gambling Harm in Massachusetts dated May 22, 2019



Public Health Trust Fund Executive Committee (PHTFEC) Meeting Minutes



Date/Time: May 22, 2019 - 2:00 p.m.

Place: **Massachusetts Gaming Commission**
Public Meeting Room
101 Federal St, 12th fl.
Boston, MA 02110

Executive Committee Members Present:

Lindsey Tucker, Co-Chair, Associate Commissioner, Massachusetts Department of Public Health

Enrique Zuniga, Co-Chair, Commissioner, Massachusetts Gaming Commission

Michael Sweeney, Executive Director, Massachusetts State Lottery Commission

Carlene Pavlos, Executive Director, Massachusetts Public Health Association

Angela Davis, Assistant Undersecretary for Law Enforcement and Criminal Justice, Executive Office of Public Safety and Security

Call to Order

3:05 p.m. Co-Chair Tucker called to order the Public Health Trust Fund Executive Committee (PHTFEC) Meeting and welcomed members. She introduced Angela Davis, who joined the committee and recognized Jennifer Queally who was recently nominated for a judgeship and departed the committee. Co-Chair Zuniga noted that Commissioner Cathy Judd-Stein is determining her role with the Committee going forward.

Co-Chair Tucker introduced the main item in the agenda – the FY20 budget. She stated Co-Chair Zuniga would provide updates on Wynn and the budget.

Approval of Minutes

3:13 p.m. Michael Sweeney made the motion to approve minutes for the April 24, 2019 meeting, Carlene Pavlos seconded. The minutes were approved.

Routine Updates

3:15 p.m. Co-Chair Zuniga gave an update on the budget, including the status of the projections for FY20, as well as the expenses from FY19, and the projected revenue from the \$35 million fine on Encore. 5% of the fine will be deposited into the Public Health Trust Fund, as with any other tax revenue. This is tentative as Encore has not communicated on whether they will appeal the fine or not; Co-Chair Zuniga stated

that Encore has 30 days to appeal the fine or any decisions that have been made; the money from the fine will be placed in escrow.

Co-Chair Zuniga presented the total budget, which included DPH and MGC programs, and detailed the expenses MGC had FY in19 and the expected projection for FY20 as well as highlighted categories where there were changes.

Co-Chair Tucker asked Co-Chair Zuniga whether or not the total projection includes the \$5M licensing assessment. He confirmed it does.

FY20 Proposed Budget Discussion

3: 28 pm Mark Vander Linden commented on the budet request increase for GameSense. He compared the difference in size between each facility, pointing to that as the reason why additional funds are needed for Encore vs the other sites. Funding will cover training casino staff and salaries. He confirmed that part of the role of GameSense is to provide trainings to employees so that the casinos understand the issues of problem gambling.

Mark Vander Linden moved on to describe MGC's work with veterans. He addressed the fact that veterans & the elderly community are at higher risk for problem gambling. MGC would like to focus on a partnership with veterans services to provide educational services and would like to recognize this by having a separate initiative. He requested increasing the budget to \$30,000 from \$15,000.

Co-Chair Tucker asked how the money will be used. Mark Vander Linden responded that the money will be used for trainings for veteran services staff, for regional statewide conferences, and for the Chelsea's Children's Home. Co-Chair Zuniga added that the increase came about as a response to a conversation with Secretary Ureña. Mark Vander Linden suggested directing the money towards training employees at the Soldiers' Field Home and providing intervention services for the residents.

Carlene Pavlos stated that MGC should explore the possibility of aligning their work with the Department of Veteran Services and with DPH, in particular with regard to existing initiatives, such as the SAVE program and suicide prevention broadly. Ms. Pavlos expressed a desire to ensure that any upcoming conversations do not duplicate existing structures and that they focus on capacity building.

Victor Ortiz agreed with Ms. Pavlos' suggestion and added that there are existing initiatives and that getting a baseline would be useful in determining where investments make sense.

Co-Chair Zuniga agreed to follow up and committed to helping in the discussions.

Carlene Pavlos moved onto another item in the budget. She expressed concern that there is no procurement in place to support the level of investment slated for GameSense in FY20. She stated that she did not feel a sense of urgency from the Gaming Commission to put a plan in place for re-procurement.

Co-Chair Zuniga and Mark Vander Linden confirmed that they will re-procure the contract during the summer as their current procurement process for SEIGMA has tied up some of the resources. Once that procurement is done, MGC will execute the GameSense procurement.

Ms. Pavlos responded that she would like to see more concrete efforts in the planning of a procurement for GameSense. She stated that this is an urgent matter, as the current contract does not meet established guidelines of the Operational Services Division. She mentioned that while the initial procurement was for \$120,000, the new figure for FY20 is 24 times that.

Co-Chair Zuniga stated that there will be no documents or timelines until a budget is finalized. He suggested that MGC may hire a consultant to speed up the process of the procurement. Ms. Pavlos asked when a contract would be in place. Mark Vander Linden said it would be in place in Q1.

Ms. Pavlos stated that according to guidelines the procurement must be posted for at least 40 days for a contract over \$460,000; and that the timeline needs to be realistic for a formal review process. Mr. Vander Linden responded that they can create a timeline that takes OSD guidelines into consideration.

Michael Sweeney asked when the contract expires, as he is under the impression that it ends in September 2019 because it was initiated in 2014. He expressed concern that this is an aggressive timeline. Co-Chair Zuniga stated that the agency can still work with the vendor after the contract expires. As with SEIGMA, MGC can do a one-time extension with the current vendor, provided that a procurement has been started.

Carlene Pavlos responded that unlike SEIGMA, the original GameSense procurement was not sound. She expressed concern about the vendor's name being in the narrative of the budget because it appears as if the current vendor will be the vendor in FY20. She stated that she cannot vote on the budget because there is substantial conflict with the standards of an open and competitive procurement process.

Mark Vander Linden said he understood Ms. Pavlos' concerns and stated that the budget narrative could be edited to address that issue.

Co-Chair Zuniga suggested postponing the vote on the budget and reconvening after putting together a document that would allow more time for the procurement to be reviewed. He stated that they postpone until the next month in order to help ease the concerns expressed by Carlene Pavlos.

Co-Chair Tucker responded that the DPH needs a signed budget to proceed with operations. She proposed voting on part of the budget now and voting on the other parts when Carlene Pavlos questions are answered.

Mark Vander Linden asked whether Carlene would be willing to vote on the budget if the minutes of the meeting reflect the changes she would like to see.

Carlene Pavlos responded that she is not comfortable with a contract extension for this year due to the length of time that it takes to finalize the procurement. She felt that the question is whether there is a competitive procurement and stated that there is a credibility problem when the vendor is named without an official budget.

Co-Chair Zuniga acknowledged Ms. Pavlos' point but stated that a similar approach had been taken with programs on the DPH side. He stated that the two agencies needed to agree on the general funding available. Ms. Pavlos responds that the budget names a vendor for which there is no valid contract, which creates a credibility issue. It is different in that other programs in the budget list the vendors as TBD.

Mr. Sweeney echoed concerns about the procurement process. He stated that there are \$1.2 million dollars allocated to a procurement that was out for 12 days and had a maximum obligation of \$120,000. He suggested that if other organizations had known that there was potential for millions of dollars, more would have applied for that procurement. He declared that he would not vote for the budget as currently presented and that he was open to bifurcating or voting for certain things.

Mark Vander Linden stated that there are incredible efforts to ensure that GameSense advising is culturally sensitive and linguistically representative of communities.

Teresa Fiore added to Mr. Vander Linden's comments that many of the people hired in the casino do come from the same background and population of the people being served. She also stated that the concern about removing the vendor name from the budget is that it could result in a possible lapse in service. She added that GameSense advisers are representative of the communities and asked whether the procurement should be more of a collaborative effort with DPH.

Michael Sweeney countered that the concern is not about the vendor, but about the original contract. He did not sense urgency around a new procurement and would like to see a robust document that takes into account the comments of the committee members.

Carlene Pavlos added that she will not vote on the budget if there is a possibility of an extension. She made a suggestion regarding how the budget should be labeled and divided. She stated that an open and fair procurement should be a robust document that reflects a commitment to equity and cultural competence. She stated that the purpose is to have an open, fair, and honest procurement and quality that is reflective of that.

Mark Vander Linden acknowledged those points and stated that MGC will do everything in its power in terms of committing to a timeline that will produce results.

Co-Chair Zuniga asked for clarification regarding how Ms. Pavlos came up with the calculations mentioned. Ms. Pavlos suggested that the budget should reflect Quarter 1 only. She added that if there is a need for the contract to be extended, then MGC should present that to the committee.

Co-Chair Zuniga agreed to move forward with a budget that reflects Q1 spending for GameSense associated programs. This resulted in a differential of \$2 million and confirmed the committee was in agreement.

Michael Sweeney then commented that he is unclear as to why the committee cannot put additional money to use. He challenged the committee to be bolder and to put money through use in areas where they can interweave problem gambling with other issues impacting veterans. He expressed a desire to engage different communities in order to supplement existing efforts. He stated that the Commonwealth should be able to absorb the money and hire more people if necessary. He expressed a desire to explore the option of having multiple vendors support the budget and felt that it is lacking the multi-cultural and mental health pieces.

Co-Chair Zuniga responded that they have funded a lot of the initiatives Mr. Sweeney discussed and that DPH has initiated a good number of them.

Michael Sweeney responded that it is not that they are not doing anything, but that they are not doing enough. Mr. Sweeney recommended that MGC contract a vendor to write procurements if it is a capacity issue and that more efforts should be made by the committee to put to use any surplus funds.

Co-Chair Zuniga stated that there was previously a much smaller budget and it was important to keep certain things prioritized. He accepted constructive criticism and thanked Mr. Sweeney. He noted that more can be done now that there is a larger budget.

Co-Chair Tucker responded to Mr. Sweeney's comments and agreed that there is the ability to be bolder now that there are more funds to support the work. She added that per the MOU for the Public Health Trust Fund, the funding ratios will shift over time – resulting in 25% of funds going to MGC and 75% to DPH. Co-Chair Tucker stated that supplemental budgets will be presented after DPH on-boards new staff.

Co-Chair Tucker asked Victor Ortiz to explain the adjustments to the FY20 DPH budget request.

Mr. Ortiz commented that the original budget was for \$4.1 million. Photovoice which currently has 2 existing projects had 3 new applications for its procurement instead of 4, resulting in a \$50,000 reduction. OPGS also made adjustments to the personnel line, resulting in \$29,000 savings. Mr. Ortiz added that office is working to onboard new support staff.

Carlene Pavlos wanted to know more about the community health workers training and that the timeline for that procurement. Victor confirmed that it is in progress and offered to share a procurement timeline with the committee.

Co-Chair Zuniga stated he expects to see more supplemental budget requests in the next few months. He asked whether the committee was ready to vote.

4:43 Carlene Pavlos moved to change the FY20 budget to reflect Quarter 1 funding for GameSense in Regions A, B, C, including indirect costs. She also proposed that there be a second listing for Regions A, B, C, support, and indirect costs with no vendor listed. This would reflect that there is a procurement planned for that contract.

Co-Chair Zuniga stated that he will bring back a procurement timeline for the next meeting.

Michael Sweeney proposed a second amendment to the motion. He suggested that \$250,000 be allotted to DPH for veteran services. He proposed that the same amount be directed towards organizations across the Commonwealth working with multi-cultural communities. He also requested that \$200,000 be allotted to the Department of Public Safety for programs and initiatives.

Co-Chair Tucker stated that there is not a funding mechanism for EOPSS and suggested that DPH work with EOPSS on areas of shared priority for programs to use the \$200,000. The total amount allocated to DPH would be \$700,000 for programmatic work addressing issues related to public safety, veterans' health and the needs of racial minority groups.

Co-Chair Tucker asked for public comment before the vote.

Public Comment

4:51 pm Tom Land stated that logic models with clearly defined outcomes should be presented for the additional \$700,000 awarded.

Giles Li from the Boston Chinatown Neighborhood Center commented that prevention activities totaled about \$4.1 million and that GameSense makes up for \$2.1 million of that. He pointed out that it is a big percentage. He asked what success looks like and added that the public should be able to see and measure that. He stated that he looks forward to his agency working in the prevention efforts going forward.

Motion to Approve the Budget

4:54 **The Public Health Trust Fund Executive Committee voted in favor of approving the FY20 total budget of \$11,278,819. This number reflects MGC's total budget of \$6,544,100 and DPH's budget of \$4,734,719.**

The DPH FY20 budget total reflects the \$700,000 that is recommended to be utilized for programming connected to veterans' health, public safety issues, and communities of color / minority-serving organizations. In addition, the budget is approved contingent upon MGC updating budget documents to reflect that the current GameSense vendor is funded until September 30, 2019. It must also reflect that the remaining FY20 budget and program vendor will be determined by the outcome of the MGC procurement for GameSense.

Programmatic Discussion

4:47pm Mark Vander Linden stated that there was little time for the presentation and the committee could discuss the topic at the next meeting.

Motion to End the Meeting

4:58 pm Michael Sweeney motioned to end the meeting, and Angela Davis seconded. All were in favor, and the meeting concluded.

List of Documents and Other Items Used

1. Public Health Trust Fund Executive Committee, Notice of Meeting and Agenda dated May 22, 2019
2. Public Health Trust Fund Executive Committee, Meeting Minutes dated April 24, 2019
3. FY19 Budget Overview Spreadsheet
4. FY20 Proposed Budget Materials
5. DPH Office of Problem Gambling Programmatic Update, dated May 13, 2019
6. The Research Strategic Plan Update, dated May, 2019
7. Implementing an International Approach to Measuring Gambling Harm in Massachusetts power point, dated May 22, 2019

Talking about Casino Gambling: Community Voices From Boston Chinatown

A report prepared by

Carolyn Wong, Ph.D.

Institute for Asian American Studies, University of Massachusetts Boston

Giles Li, M.P.A.

Chief Executive Officer, Boston Chinatown Neighborhood Center

For the Massachusetts Gaming Commission

October 24, 2019

Acknowledgments

The authors thank members of the research team for their collaborative guidance, meticulous work, and generosity in contributing time and expertise. Yanhua Li provided leadership in the articulation of our research questions, conceptual framework, writing of interview questions, protocols, interpretation of interview data, and training of the research team. Yoyo Yau, Director of Family and Community Engagement at the Boston Chinatown Neighborhood Center, advised in all phases of the research, including interview methods and analysis of interview data. Pong Louie and Terry Yin conducted, transcribed, and translated interviews, and contributed to the analysis of the interview data, with the assistance of Fengqing (Tina) Wang, Lawrence Li, Alan Xie, Charlie Phan, Long Long, Hsin-ching Wu, and Abigail Yu. Carolyn Rubin read the entire report and suggested improvements.

The Gaming Research Advisory Committee of the Massachusetts Gaming Commission provided valuable suggestions on the design of this research project. The Massachusetts Council on Compulsive Gambling applied their prior experience in community education in Chinatown and other Asian American communities to make useful recommendations. We thank Victor Ortiz, Director of Problem Gambling Services, Massachusetts Department of Public Health, who advised on community engagement approaches. Chien-chi Huang, Executive Director of Asian Women for Health, offered suggestions on community-based research and approaches to gambling education. The Asian American Commission gave support and advice on research goals.

We thank the Massachusetts Gaming Commission and the Public Health Trust Fund Executive Committee for their support of this project.

Executive Summary

This pilot study examined the casino gambling practices of residents and workers in Boston Chinatown. Our aim was to learn about the trajectory and life context of individual participants' gambling activity, including how individual participants describe their motivation, nature and frequency of gambling, and its effects on self and family. The research was conducted by a university based research team in partnership with the Boston Chinatown Neighborhood Center, and with the assistance of the Massachusetts Council on Compulsive Gambling.

Twenty-three individuals participated in face-to-face interviews. Most participants were low-wage workers or retirees from the food and services industries in Chinatown. All but three had limited English proficiency and spoke in their preferred Chinese dialect. The three who preferred to interview in English had some college education. The convenience sample included individuals whose self-reported behavior indicated they were recreational gamblers or at risk for problem gambling. Researchers followed strict protocols to protect confidentiality of participants. No names, phone numbers, or addresses of participants were ever revealed to researchers.

The stories told by our participants illustrate multiple and overlapping risk factors for problem gambling. Our conceptual approach took into account the dynamic interaction of risk factors from multiple sources: stressors in participants' daily lives rooted in socio-economic conditions, exposure to targeted marketing aimed at Chinese immigrants inside and outside the casino, casino inducements, family contexts, and individual-level psychological and/or emotional factors. Protective factors include the support of social networks or families.

It is known that cultural influences in immigrant communities are complex and varied, affecting individuals differently from varied generational, age, gender, and place of origin backgrounds. Our approach and findings challenge erroneous notions found in popular media and some misinformed academic writings that homogenize and reify culture by depicting Chinese as "gamblers". Many of interviewees described varying degrees of dependency on gambling in casinos to relieve the drudgery of work in low-paying jobs in the food service industry, and the isolation of life in linguistically isolated neighborhoods with few alternative opportunities for recreation.

Participants expressed concern about increased risk for problem gambling with the establishment of the new Encore Boston Harbor casino. There are no culturally-appropriate prevention and treatment programs in Chinatown. Interview themes point to why there is an urgent need to fill this gap: concentrated poverty, social isolation, language and cultural difference, lack of recreational alternatives, and the longstanding practice of casino targeted advertising to Chinatown community members. The need for evidence-based and culturally appropriate prevention and treatment programs is shared by other low-income Asian American communities in Massachusetts.

The research team recommends that the Massachusetts Gaming Commission and Public Health Trust Fund support:

Culturally appropriate prevention and services for Asian Americans

- (1) Public health campaigns, including youth and adults.
- (2) Treatment services and culturally appropriate wellness programs.
- (3) Preventive education and services for casino workers of Asian descent and immigrant background.
- (4) Provision of state-supported reimbursement for services.
- (5) Training of professional counselors in community settings.

Participatory deliberation in regulatory process:

- (6) Engagement of community-based organizations and professionals knowledgeable about Asian American communities in goal-setting for reducing the negative impact of legalized gaming on the low-income Asian populations.
- (7) Community engagement at the grassroots level in public policy deliberations.
- (8) Formation of a regulatory advisory committee to review the ethics of targeted ethnic marketing practices toward vulnerable populations, including low-income, racial-ethnic minority and immigrant communities.

Expanded scope of collaboration and services:

- (9) A co-learning and mutual support pan-Asian American coalition of community-based organizations that provide family support and wellness programs for immigrant and refugee communities in the region.
- (10) Community-based efforts to provide healthy and culturally appropriate recreational alternatives to casino gambling in local neighborhoods.

A five-year research program to develop:

- (11) Increased understanding of social-economic impacts of legalized casino gaming in ethnically diverse Asian Americans communities.
- (12) Culturally appropriate health communication approaches for research dissemination and implementation in Asian American communities.
- (13) Methods to obtain representative samples for hard to reach populations.
- (14) Expansion of research on Asian Americans prioritizing for next steps study of gambling problems, prevention, and treatment in communities of low-income Vietnamese and Cambodians residing in Dorchester, Quincy, Lowell, Malden, and Worcester.

Part 1: Research Aims and Methods

The primary purpose of this project was to learn about casino gambling and risk factors for problem gambling among ethnic Chinese individuals who are patrons of Connecticut casinos and work in low-wage jobs in or near Boston Chinatown. The process of examining risk factors led to a complementary exploration of protective factors. The university-based research team developed the research design and implementation in close collaboration with a community partner, the Boston Chinatown Neighborhood Center (BCNC), and with the assistance of the Massachusetts Council on Compulsive Gambling (MCCG).

The research strategy used qualitative methods to learn about gambling behavior and risk, as well as effects of casino gambling on individuals and families. We recruited a convenience sample of primarily low-wage workers and their spouses and conducted in-depth, face-to-face, interviews in the language dialect of their preference. Most individuals worked in Chinatown and lived in Chinatown or a neighborhood in an accessible location and with a concentration of Chinese immigrant residents. To diversify the sample, we also recruited a small number of college educated professionals.

Collecting qualitative data from face-to-face interviews had two distinct advantages. First, the semi-structured interviews allowed research participants to communicate information about their gambling activity and thoughts about its effects on their lives using their own frameworks of thinking and preferred language idiom, rather than responding to pre-established conceptual concepts and fixed categorical answers. Second, oral interviews fit the communication style of many residents of Chinatown with limited formal education. To realize these two research advantages, we ensured that participants could communicate in their preferred language dialect, providing interviewers proficient in the three Chinese dialects spoken by most Chinatown residents and workers: Cantonese, Mandarin, or Taishanese. Recruitment and interviewing in participants' preferred dialects helped establish trust, which was critical in seeking candid information on the very sensitive subject of gambling and gambling problems.

Many of the Chinese immigrant patrons constitute a population group vulnerable to gambling problems because of their disadvantaged work, turbulent family life, small social networks, and limited neighborhood-based resources for recreation.

Why Prioritize Chinatown for Gambling Research?

Boston Chinatown is a neighborhood of concentrated poverty with many residents employed in low-paying jobs and lacking proficiency in English (Asian Americans Advancing Justice, 2013; Boston Public Health Commission, 2013). It is commonplace to see sizeable groups of service workers and residents gathering to ride Chinatown buses to casinos, which depart every couple of hours, seven days a week. Many of the Chinese immigrant patrons constitute a population group vulnerable to gambling problems because of their disadvantaged

work, turbulent family life, small social networks, and limited neighborhood-based resources for recreation (Fong, 2005).

Proximity to the new Encore Boston Harbor casino in Everett, MA, has raised concern in the Chinatown community, including among several of our research participants, about increased risk exposure of community members vulnerable to gambling problems. The casino is easily accessible from Chinatown and the Chinese enclaves in Quincy and Malden. From Chinatown residents can take the Orange MBTA line to Malden Center, where a free casino shuttle takes customers directly to the casino. A couple weeks after the casino opening, our researchers took this route mid-day on a weekday, riding on a full shuttle bus with persons who appeared to be 95% of Asian descent. The proximity of the new Everett casino to Boston Chinatown will vastly increase access to gambling activities for casino patrons from Chinatown, as well as other Asian Americans, including Vietnamese, Cambodians, and Chinese in Quincy, Dorchester, Malden, and Lowell.

Chinatown is often the first destination point for work and residence for immigrant workers and the elderly (Asian Americans Advancing Justice, 2013). Among immigrants, many have enjoyed games combining varied degrees of skill and chance in private social settings as a form of socializing and leisure in their communities of origin in China. The social games were typically not commercialized and there was no lure from sophisticated and targeted ethnic marketing campaigns conducted by large gambling enterprises to “win big”. Because in China, casinos are not present outside of Macau and most gambling is illegal, for most first generation immigrants from China their first exposure to casino gambling is likely to be in the U.S. unless they were able to visit Macau where gambling is legal. In the U.S., casino gambling is legal in many cities and suburban areas. Casinos are often accessible by a low-cost bus ride from places of work or residence.

Concentration of Low-Income Residents, Social and Linguistic Isolation: Our study targeted low-wage immigrant workers with limited English proficiency. We prioritized this population sector because of its vulnerability to gambling problems (Fong, 2005; Kong et al., 2013; Welte, Barnes, Tidwell, & Hoffman, 2011; Welte, Barnes, Wiczorek, Tidwell, & Parker, 2004). Nineteen (nine males, ten females) of our twenty-three research participants fit this socio-demographic profile. Two of these twenty-three participants were spouses of gamblers and spoke about family effects; these two persons did not reporting gambling much themselves. Two other persons among the twenty-three participants were both the female spouses of individuals who engaged in casino gambling and also took part in this gambling activity themselves.

The Boston Health Commission has compiled census data comparing socio-economic indicators across the city’s neighborhoods. In 2010, Chinatown’s population numbered 12,843 persons and over the previous decade had experienced the largest population growth (39.7 percent) of all Boston neighborhoods (the next largest was in South End (21.6 percent). The 2006-2010 American Community Survey (ACS) estimated that 24 percent of all families in Chinatown had incomes below the poverty level, while comparable percentage for all families in Boston remained under 20 percent. In Chinatown 35 percent of the population 26 years and older had less than a high school diploma, compared to 14 percent in Boston as whole (Boston Public Health Commission, 2013).

Beyond socio-economic disadvantages, other factors have been shown to increase the risk for gambling disorders among immigrants and racial-ethnic minorities (Fong, 2005). For many immigrants employed in restaurants, eateries, and other ethnic businesses, there is little time for recreation after working long hours in physically demanding and low-paying jobs. Economic disadvantage and cultural difference lead to social isolation, which is increased when immigrants experience prejudice and discrimination, heightening distress, loneliness, and alienation. Recreational gambling can be one of the few outlets for entertainment available to immigrants and is often benign in its effects on financial and general well-being. However, the risk of gambling becoming compulsive and going untreated by professional health providers is increased in Chinatown because of the lack of culturally appropriate treatment. Furthermore, many residents have difficulty navigating complex healthcare and insurance systems or obtaining health information from sources widely used by people who are English and computer proficient. Although the largest community health clinic in Chinatown provides behavioral health services, for persons concerned about gambling problems insurers require clinical diagnosis of gambling disorder according to DSM-5 criteria. At this site, state-supported treatment for gambling problems is not available.

In Boston Chinatown, moreover, there are few programs and little space for residents to engage in recreational activities. The only outdoor public space for sports is a small asphalt area next to Highway 93, where heavy vehicular traffic emits toxic air pollution (Community Assessment of Freeway Exposure and Health, 2017). Although many of the nonprofit organizations in Chinatown cultivate strong communities among their service population, these circles are tight-knit and often need-specific. The underemployed, elderly, at-risk youth, and mothers of children with special needs constitute the major sub-groups of the Chinatown population. There are opportunities for them to support each other, but the lack of a “third space” in Chinatown, and the relative disinvestment from state and local government have led to a loss of cohesion among community-members, and as a result, less social connectedness and resilience. Notably, several of our research participants reported that they did not engage in casino gambling until coming to the U.S. and living in this context, which is not surprising because casino gambling is illegal in China outside of Macau.

Targeted Advertising and Casino Patronage: The practice of targeted ethnic marketing to attract Chinese customers to casinos is well-honed and widely practiced. Because our study focused on Chinatown residents and workers who gambled at the Foxwoods and Mohegan Sun casinos in Connecticut, we note the following comments of the senior vice president of marketing at Mohegan Sun, quoted in the Connecticut Courant in 2007.

The practice of targeted ethnic marketing to attract Chinese customers to casinos is well-honed and widely practiced.

Asian American customers represent about 25 percent of the casino's table game revenue, and that clientele has grown by about 45 percent over the past two years, said Anthony Patrone, senior vice president of marketing at Mohegan Sun. Although many casinos cater to an Asian clientele, Patrone said he believes none has gone this far, especially for the day-trip customers who arrive on one of 48 daily buses catering to the Asian customers... "It is our most robust segment in terms of growth," Patrone said. "It is easy to spend capital on a fast-growing market." (Peters, 2007)

In a similar vein, an article in a tourism trade journal reported that Foxwoods, the biggest casino in the world based on gambling floor space, estimates that at least one-third of its 40,000 customers per day are Asian. Mohegan Sun says Asian spending makes up a fifth of its business and has increased 12 per cent during the first half of this year alone (Simpson, 2006).

The targeted marketing toward Asians is evident from the online marketing webpages of Foxwoods and Mohegan Sun casinos. Both have specialized “Asian webpages”, which advertise transportation options: On July 16, 2019, 18 Asian line runs were listed from the Boston metropolitan area and Lawrence to Mohegan Sun; and 27 to Foxwoods. The webpage ads are written in Chinese but not Spanish or any other minority language. Inside the casino, another marketing device targeted Chinese customers is clear on the electronic gaming machines: among the techniques are display of brightly colored Chinese themed images and game themes on the screens.

The purpose of the present study was not to examine advertising practices of the casino industry. However, published standards of corporate social responsibility for the gaming industry (Chóliz, 2018) and a recent report by the Massachusetts Gaming Commission (Marotto, n.d.) point to the need for close scrutiny of advertising messages that inflate chances of winning or getting rich or saturate media venues (United States Chamber of Commerce Foundation, 2019), especially in communities of vulnerable populations.. In Canada and Europe, there is widening discussion of standards for socially responsible casino advertising. For example, one professor of gambling studies in the United Kingdom wrote: "Most of us who work in the field of responsible gambling agree that all relevant governmental gambling regulatory agencies should ban aggressive advertising strategies, especially those that target people in impoverished individuals or youth (Griffiths, 2015). Opposition to aggressive advertising targeting ethnic Chinese markets among community leaders has recently grown in Ontario, Canada, as illustrated by one local news story with this headline: “Ontario, Canada Gaming Campaign Lures Chinese Gamblers, Despite Indications of High Risks for Addiction” (Smith, 2018).

Need for Education on Problem of Reifying Chinese Culture: The playing environment for Chinese social games in immigrant communities stands in stark contrast to the commercialized casino setting, where some table games are derived from traditional Chinese games and slots machines feature Chinese themes. Among Chinese immigrants, playing social games, including Chinese card or tile games, such as Mahjong, in homes, private parks, and other community spaces is a popular recreational pastime. (Kim, 2012; Loo, Raylu, & Oei, 2008; Raylu & Oei, 2004). Recent research indicates healthy Mahjong playing among elderly may have positive effects by promoting social engagement and cognitive activity. (Kim, 2019) Mahjong as a social game has served to build social and community bonds not only among Chinese immigrants but also in Jewish American communities since the early 20th century (Walters, 2013). In contrast, playing Chinese themed table or electronic machine games in casinos can easily heighten the risk of addiction, especially when fast repeat play is a feature of electronic games, sophisticated marketing messages encourage players’ dreams of huge winnings, and free drinks are served.

Some studies have examined gambling behavior among people of varied cultural backgrounds (Oei, Raylu, & Loo, 2019). Published research provides no

The playing environment for Chinese social games in immigrant communities stands in stark contrast to the commercialized casino setting, where some table games are derived from traditional Chinese games and slots machines feature Chinese themes

scientific data that culture is a causal factor giving rise to gambling problems among cultural-minority populations. Our approach to investigating cultural factors among Chinese immigrants is informed by a long tradition of cultural studies that critiques reification of culture, which turns abstractions into physical entities (Adams & Markus 2002) and cultural essentialism, which categorizes groups of people according to supposed “essential” qualities. This literature shows that cultural traditions, thinking, and attitudes are malleable and intertwined with complex multi-layered historical, social and psychological factors (Meyer & Li & Karakowsky, 2002; Meyer & Geschiere, 1999). As Lee (2018) points out, essentialized myths of the “Chinese gambler” imagine a supposed “Chinese personality”, a media-driven image that love of gambling is somehow in-born. Our own interviews challenge that false notion.

Our interviews demonstrate the need to educate public health researchers about the reality of changing and multi-faceted Chinese cultural influences interacting with socio-economic conditions shaping the daily lives of our research participants. It is important, moreover, to educate public health providers, academic researchers, and the general public about the falsity of claims such as the following, provocatively stated in the opening sentence of a recently published academic article’s abstract: “The Chinese have always been identified as gamblers, and they accept this” (Papineau, 2013). No evidentiary support is given for this claim which should be at least dubious to readers on face value. To the contrary, our interviews point to wide diversity of culturally-influenced thinking and attitudes and beliefs about gambling among ethnic Chinese. The Chinese immigrants are part of an ethnic group with heterogeneous viewpoints, generational and educational backgrounds, income levels, regions of origin, immigrant experiences, and differences in young people’s exposure to gambling in home or community settings.

The Chinese immigrants are part of an ethnic group with heterogeneous viewpoints, generational and educational backgrounds, income levels, regions of origin, immigrant experiences, and differences in young people’s exposure to gambling in home or community settings.

Investment in Culturally Appropriate Prevention and Treatment: Problems related to lack of services cannot be solved by simply adding funds to existing programs. Prevention and treatment of problem gambling require cultural attunement and nuanced understanding of the complex immigrant experience (Lee, 2015; Lee & Awosoga, 2015; Lee, Kellett, Seghal, & Van den Berg, 2018; McComb, Lee, & Sprenkle, 2009; Reichel, & Morales, 2017).

In Chinese communities, understanding and respecting family inter-relationships is vital in prevention and treatment. One promising approach emphasizes family systems as a social determinant of health and conceptualizing problem gambling as a family issue (McComb, Lee, & Sprenkle). In Part III in our discussion of participants’ views on prevention and our recommendations, we elaborate on the applicability of the BCNC’s extensive practice in family services to problem gambling prevention and counseling.

In Chinese communities, understanding and respecting family inter-relationships is vital in prevention and treatment. One promising approach emphasizes family systems as a social determinant of health and conceptualizing problem gambling as a family issue.

It is also critically important that health providers understand culturally influenced views toward mental health

services. In data derived from the National Latino and Asian American Study (2002-2003), researchers found that Asian Americans seek mental health services at lower rates than the general population. U.S. born Asian American used these services at a higher rate than immigrants (Abe-Kim et al, 2007). Examining help-seeking behavior specifically in a Chinese minority population, one survey found that persons who were less culturally adapted to the dominant culture are often most in need of education about the utility of mental health service (Ying & Miller, 1992). Underlying low rates of usage of mental health services is fear of losing respect (Loo, Raylu, & Oei, 2008).

Research Precedents: Our study aims and approach build on results from prior research on gambling among Asian Americans. The ethnic Chinese population is heterogeneous in Massachusetts. Some Chinese live in predominantly low-income neighborhoods, including Boston Chinatown; others reside alongside neighbors of diverse racial-ethnic minority background and in communities with varying income levels; still others live in dispersed patterns in relatively affluent suburbs. Stories of the economic success of relatively prosperous and well-educated Chinese often lead to misinformation about the status of Chinese Americans and Chinese immigrants, hiding the prevalent poverty in low-income neighborhoods. For survey research, obtaining representative samples of the entire Chinese population is expensive. It is necessary nonetheless to conduct research sensitive to the differences in segments of the ethnic population.

In a still emerging area of research, several published studies have found that Asians may gamble less frequently than whites but have a higher rate of problem gambling (Kong et al, 2013; Welte, Barnes, Tidwell, & Hoffman, 2011; Welte, Barnes, Wiczorek, Tidwell, & Parker, 2004). However, estimates of prevalence of problem gambling are not consistent. A recent study at one large southern university found that a significantly larger proportion of Asian students met probable pathological gambling criteria and at-risk gambling criteria than Caucasian, African American/Black, or Hispanic/Latino(a) students (Rinker, Rodriguez, Krieger, Tackett, & Neighbors 2016). An early study conducted in five states found that Asian American university students had the highest rates of pathological gambling of all racial-ethnic groups (Lesieur et al, 1991). In contrast, a California study found that lifetime rates of problem and pathological gambling among Asian and Pacific Islanders was low (Volberg, Nysse-Carris, & Gerstein, 2006). The reasons for such variable estimates may arise from methodological problems. For those studies that report estimates for subgroups described as “Asians”, “Asian Americans”, or “Asians and Pacific Islanders”, data for diverse ethnic groups are aggregated under the umbrella racial category. However, it is known that demographic, socio-economic, and health conditions (such as chronic diseases) differ across the major Asian ethnic groups, such as Chinese, Asian Indian, and Vietnamese (Islam, et al., 2010; Wong, Hosotani, & Her, 2012). Within ethnic groups, moreover, differences in economic attainment and resources are the source of health disparities.

In other countries, research on gambling among Asian populations provides a wider lens than the U.S.-based literature alone. In Australia, the Victorian Casino and Gaming Authority (2000) found that individuals who spoke Chinese, Vietnamese, Arabic, or Greek had lower rates of gambling than others in the general population, but rates of gambling disorder were five to seven times higher than in the general population, as indicated by scores on the South Oaks

Gambling Screen of 5 or more. Abbott and Volberg (1994) found that individuals in New Zealand who identify as Maori or Chinese are at high risk of gambling problems. Devlin and Walton (2012) report that Maori (2.7%), Asians (2.4%), and Pacific Islanders (0.6%) had a higher rate of gambling disorder than Caucasians (0.2%).

Despite progress in the study of gambling among Asian Americans, including Chinese, disaggregation of Asian American data by ethnicity is rarely performed and may reveal important differences. At one study conducted at a public university, for example, undergraduate respondents self-identifying as Chinese gambled less frequently than whites. But among those Chinese students who gambled frequently there was a larger proportion at high risk for gambling disorder than among white students who gambled frequently. The Vietnamese students did not share the same patterns of gambling behavior as the Chinese (Wong & Wu, 2019). Focusing on Southeast Asians, two studies of adult Cambodian refugees revealed high rates of problem or disordered gambling, rates which may be related to the trauma of the refugee experience (Petry, Armentano, Kuoeh, Norinth, & Smith, 2003; Marshall, Elliott, & Schell, 2009).

Obtaining representative samples of specific Asian ethnic groups (disaggregated by ethnicity) in large-scale population surveys in Massachusetts would require oversampling strategies and administration in Asian languages. Public agencies have found the costs to be prohibitive. Taking into account the amount of funding available for this study and the costs of alternative strategies, our research approach focused on a single community site in Chinatown, where there is pressing need for understanding of risk and protective factors for problem gambling and provision of culturally appropriate treatment.

In its 2015 baseline study, the Social and Economic Impacts of Gambling in Massachusetts (SEIGMA) estimated the prevalence of problem gambling in the Massachusetts population. The study left gaps in knowledge about problem gambling in Asian American and other vulnerable population groups (Volberg et al, 2015). Recognizing these limitations, the Massachusetts Gaming Commission and the Massachusetts Department of Public Health called for research specially tailored to improve understanding of the problem gambling in certain vulnerable populations, including their exposure to potential harms of expanded gaming and how these can be mitigated. In a Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts, a key stakeholder is quoted on the lack of culturally appropriate services: “There are not many providers that are trained [with] cultural competence and the language skills to work with [diverse populations]...xxx [It’s] hard to find information and even harder to find treatment in Asian languages.” (Department of Public Health & MA Gaming Commission 2016). In particular, it was noted, community-level interventions are needed that will aid development of evidence-based pro-grams for delivery of preventive education and treatment services (Boston Public Health Commission, 2013).

The sampling strategy used in the SEIGMA study did not produce a subgroup of Asian Americans large enough to generate meaningful data about the prevalence of problem gambling. Thirty-five percent of Asian Americans in Massachusetts have limited English proficiency, reporting that they speak English less than well; however, the survey was not administered in any Asian languages. Accuracy of data on Asian Americans was further reduced because it was not disaggregated into ethnic subgroups. Despite these limitations, the SEIGMA findings concerning the influence of socio-economic disadvantage provide a useful departure point for designing

specialized research on Asian Americans and other vulnerable populations. In particular, the SEIGMA study found that individuals with a high school education or less are more than twice as likely to be at-risk gamblers compared to those with a college degree; in addition, individuals with annual incomes less than \$15,000 are nearly twice as likely to be at-risk gamblers compared to those with incomes of \$50,000 or more” (Volberg et al, 2015). Our one-year pilot intervention focused on an economically disadvantaged segment of the ethnic Chinese population in Massachusetts. In Massachusetts, there were 131,846 persons who identified as Chinese (alone or in any combination with other categories) and 349,768 persons who identified with one or more Asian subgroups in the 2010 census. Hereafter, the term “ethnic Chinese” or “Chinese” refers to the subpopulation of persons who identify either as Chinese or Chinese Americans including the foreign born and U.S. born persons and spanning multiple generations of immigrants and their descendants.

Part II: Research Approach

A team of academic researchers closely collaborated with the Boston Chinatown Neighborhood Center (BCNC) in each phase of the project. This academic-community partnership combined the multi-faceted expertise of a professional counselor experienced in treating gambling problems among low-wage Chinese workers, the director of family services at the BCNC, a university-based social scientist, and a team of community health educators with deep roots in Chinatown.

For research on the sensitive subject of gambling, it is difficult to recruit and interview members of our study population, who are low-wage workers both vulnerable to gambling problems and hard-to-reach. As a result, we refined our methods through iterative discussion and evaluation. The first step was to assemble a qualified research team. Second, we engaged the entire research team in the development of our interview questions and protocol. Third, we refined the protocol to ensure adherence to ethical standards for research with human subjects, receiving approval of the protocol from the University of Massachusetts Boston Institutional Review Board. The fourth step was to develop a recruitment strategy, which evolved in phases as initial plans were tried, evaluated, and revised. Fifth, we analyzed the interview transcripts.

Our recruitment methods were designed to reach out to prospective participants in a private and discreet manner, and to ensure confidentiality in the method of initial contact, the process of obtaining informed consent, and in the interview and reporting process. We did not use flyers or posters so that our researchers in the field could keep a very low profile. Persons interested in participating could talk to them, but the absence of public advertisements would lessen the chance that bystanders or family members who might overhear the conversation between researcher and prospective participants would know that research on gambling was being discussed. Rather than distributing a flyer, we distributed recruitment cards in sealed envelopes at bus stops and at community agencies and through their networks. Our research team members briefly explained that this was a research study and asked people who took the envelope to open and read it. To answer questions and discuss participation, the prospective participant was asked to call a phone number and not give their name. Prospective participants were screened over the phone for eligibility, which required going to a casino at least once in the past 60 days. We did not ask for names or phone numbers; thus, our team did not know the name of any participant. Informed consent was obtained verbally on the phone.

A cash incentive of \$100 was given to each interview participant if they completed the entire interview, and each participant did finish the interview. The amount of the cash incentive was chosen in consideration of the value of time spent by individuals in the population segment, considering that most restaurant workers in this community have typically only one off-day each week after working 10 hours a day for 6 days under demanding physical conditions. Cash payment was chosen instead of a gift coupon because many participants in low-income immigrant communities may not make purchases with gift coupons on otherwise popular online sites, such as Amazon, or buy at a store allowing redemption, such as Target.

Approximately 40 sealed envelopes were distributed at bus stops and only one person provided an interview from this venue. Our estimate is that approximately 90 percent of persons waiting for the busses were not interested in taking the sealed invitation. Our research assistant had his cellphone in receive-mode from 9 am to 5 p.m. most days and from 9 am until midnight on the several days after we distributed invitations at bus stops. We did not ask for callers to leave phone numbers on voice mail for return calls because this would likely reveal their identity to us. As a result, we estimate that we missed about four calls. Approximately 70 sealed invitations were distributed at agencies and community associations. After encountering little interest in participation at the bus stops compared to relatively more success at a community agency in the first months of recruitment, we turned to focus only on outreach through social service agency and community association networks. We do not have an estimate of how many people would not take the invitation if contacted through networks of the community agencies, but among those who took the invitation, we estimate that the participation rate was about 40 percent.

The research team. We designed qualitative research methods that would enable everyday residents and workers to describe and reflect on their own or family member's gambling experience in their own words. We ensured they could use their preferred dialect. We carefully recorded and transcribed their spoken word to Chinese text to capture nuances of language idioms. We aimed to conduct the interviews in a private and relaxed setting, giving participants due time to let a conversation unfold. Prior to developing our research approach, we consulted archived records of a survey and focus groups from a 2008 study of gambling at the BCNC, led by Chien-chi Huang, who had coordinated community outreach for Asian Americans at the Massachusetts Council on Compulsive Gambling.

We employed male and female Chinatown-based research assistants with extensive experience in community engaged research and professional experience in community health education. The team included a health navigator at a local hospital in Chinatown, a community-based bilingual education teacher, and social service professionals experienced in working with the elderly, youth, and working age clients. We planned to draw from our experience in outreach and interviewing methods to develop recommendations for how researchers might reach out to larger samples of people in this population and others. We also expected that our findings might shed light on what types of community-based preventive education projects could be effective.

The community educators had diverse age backgrounds, ranging from the late 20s to 60s, and were assisted by college students from China and Taiwan. This age and gender diversity on the team helped our recruitment of research participants from various age groups and increased our flexibility in assigning interviewers whose language-dialect and experience best fit the different experiences, perceptions of gambling, and communication styles. Finding younger and middle-aged workers was more difficult due to their limited free time.

Writing of interview questions. We asked individuals to describe their own history of gambling, their motivations, and the effects of gambling on themselves and family members in their own words. Some Chinese expressions can be translated in one of several ways into English. Multiple consultations took place among our translators about meanings, which can change according to the place of origin and immigrant experience of the speaker. We were careful to recognize the internal diversity of even a small Chinatown neighborhood in Boston.

Multiple language dialects, age and generational backgrounds affect use of language. In general, workers in Chinatown live not only in Chinatown but also in Quincy, Malden, Charlestown, and other areas in the metropolitan Boston area. They are part of a heterogeneous and dispersed ethnic population whose members may identify more or less strongly with the historical experience of Chinese in the U.S. dating from the 19th century, subsequent immigrant waves, or with the Chinese homeland.

We used a collaborative process led by the family counselor and principal investigator to write interview questions. The questions may be found in the Appendix. The professional family counselor trained the interviewers to elicit information and comments about gambling behavior that placed the individual's experience in the context of a life story. This required experienced interviewers or family counselors familiar with the population. Members of the research team held multiple discussions to identify terms hard to translate from Chinese to English because of cultural and historical contextual meanings, and how their usage may have changed over time and context. For example, there are nuanced meanings of Chinese terms for "luck" as it relates to gambling, and concepts of emotional well-being and stress differ between the Chinese and English languages.

Educational component. We provided brief information on healthy gambling practices in the form of a three to five minute presentation as an educational benefit at the start of the interview. This helped the interviewer break the ice and explain our research purpose. Initially, we considered recruiting participants by inviting them to small group presentations on healthy gambling and arranging interviews individually with participants after this session. However, all participants preferred to meet individually, and we inferred this was because of their desire to preserve their privacy. In choosing to include this educational component we considered the possibility that the interviewer's early introduction of basic concepts and terms to describe problem gambling may have influenced participant responses in a manner that introduced bias. Although such bias may have been present in some responses, such as in answers to short screening questions, our analysis of interviews took this potential problem into account and focused on thematic material that emerged from life stories and narratives of specific experiences. We weighed the potential disadvantages against the benefits of starting a conversation by providing useful health information, which could assure the research participant in the professionalism of the research project and also break the ice on a difficult subject.

Analysis of interviews. We qualitatively analyzed the interviews using in vivo coding to identify major themes. This process entailed line-by-line examination of each transcript to identify patterns in the responses and consider individual responses in the context of the whole interview. For each of the transcripts, at least two coders performed this line-by-line examination, identifying categories of expressed information and questions about ambiguous or uncertain meanings so that the team could discuss interpretation. The coding was performed in the language of the interview. Since all Chinese transcripts were translated to English and two translators consulted on the translation, a different research assistant was able to perform a separate coding of the English version. The themes identified by coders were discussed by four different team members, including those who had conducted the interviews. In addition, the transcripts were examined by staff representatives at the BCNC, who also assisted in research design and provided comments on the proposed themes and additional insights. This iterative

process produced the list of themes and illustrative interview excerpts reported in the next section.

Part III: Interview Findings

This section reports the findings from our interviews. Section A consists of profiles of selected participants, including three recreational gamblers, who are low-wage immigrant workers; three at-risk or problem gamblers, who are low-wage immigrant workers; two college educated professionals, whose risk level is not identified.

Section B describes and illustrates themes from the interviews: One set of themes focus on social-level risk factors: stressors from low income, difficult jobs, and social-linguistic isolation. A second set of themes concerns risk from exposure to casino business practices: targeted marketing and factors in the casino environment that make it difficult for casino patrons to maintain self-control of their gambling. A third set of themes describe participant's emotional and psychological relationship to gambling, and their efforts to cope or maintain self-control. A fourth set of themes focused on the effect of gambling on families. Family members provide crucial support for members with gambling problems, sometimes going to great lengths to monitor the spouse's behavior. The interviews described instances of devastating financial loss, family strife, and deceptive behavior. Finally, we describe themes that emerged from participants' comments on how cultural factors may influence gambling, views on the opening of a new casino in Everett, and participant recommendations on prevention.

A. Profiles of Selected Participants

Three Recreational Gamblers, Low-wage Immigrant Workers

We classified three interview participants, participant 6, participant 20, and participant 10, as recreational gamblers because they said they engaged in casual gambling activities at the casinos and had their gambling under control. Their visits to casinos in Connecticut were primarily for leisure or social purposes, and each answered all four questions on the NODS-PERC brief screen in the negative. They enjoyed the Chinese food, shopping areas, and found the environment conducive to socializing with friends.

- Participant 6 is a young adult immigrant from Southern China who came to the U.S. two and a half years ago. She works at a restaurant and is a high school graduate.

If you go with \$200 and gamble it and you have time before the bus comes back, what do you do?

It takes about 2 hours to get there, then you have 3 hours there. When we get there, we don't gamble right away. We walk around, sit and chat, play a couple of rounds, eat buffet. If I have \$200, I save \$50. I won't bet it. We don't go to gamble, just to have fun, be happy. We spend \$200, at least we get free buffet and have some fun. They have stores at Mohegan Sun.

- Participant 20 is a middle aged woman, born in Southern China, where she received a high school education. She has lived in the U.S several years and said “*I don’t know English, I haven’t fully adjusted yet. Don’t know about schools, what the teachers are saying*”. She works in food service and lives in Quincy. In response to the third question in the brief NODS-PERC screen:

“Has there ever been a period when, if you lost money gambling one day, you would return another day to get even? ”

No, there’s no time for it. I have to take care of the kids. We might go twice a year. I’ve only gone a few times since I came.

What do you play if you gamble?

Slot machines. One time I played 21, but it wasn’t fun. I lost, so we walked around the stores, ate and left.

- Participant 10 is a middle aged man, originally from Southern China. He lives in Chinatown and works in a kitchen. He has lived in the U.S. for a little more than 10 years, a length of time he says is “Oh, not new, but not that long. I’m used to it now, but don’t know English.”

Let’s talk about gambling.

I don’t gamble much. I’ve only gone a few times since I came here. I bet 2 or 3 hundred. If I lose, so what. I don’t expect to win. It’s just to try it and see. I play mah jong too, but only on my day off. I buy scratch tickets too, but not all the time, only if I have a little extra pocket money, then I’ll buy one. Win or lose, it’s fine. I won’t buy more.

Three At Risk or Problem Gamblers, Low-wage Immigrant Workers

Several individuals are likely at risk or problem gamblers from the responses they gave in the interviews, although we did not conduct a clinical assessment. Three persons illustrate difficulties they had in getting control of a known gambling problem. The average age of the three persons who answered negatively to all four NODS-PERC screening questions was younger than the average age of others who answered with at least 1 positive answer to the four screening questions. It is useful to notice this age-related pattern in our small sample, where younger workers in food-service occupations appeared to be at less risk for problem gambling than older workers in similar occupations. The older workers may be at higher risk as a result of longer lifetime exposure to the stress of low-wage, difficult jobs, and social isolation. However, we cannot generalize about the effects of age because the sample is small and not representative of the community population as a whole.

- Participant 17 is a middle aged woman from Southern China where she graduated from middle school. She immigrated to the U.S. 20 years ago, lives in Charlestown, and works in a restaurant. She identified her limited education and poverty as factors when talking about why she gambles:

Tell me about your educational background?

You can say that I graduated from middle school... I’m not a good student. I like to gamble. We were poor, wanted to go work and earn money.

How do you feel when you're gambling? Are you really happy?

Yes, I forget everything.

How do you know about casinos and how to go?

My friends took me. When you're a new immigrant, people take you to the casinos. In China, there's Macau, but we couldn't go there. At home, with family and friends, we played, but couldn't go to Macau or Hong Kong. It's too far, no money to go. When I came here, friends said, we'll take you to the casino, so I was very excited. That's how I started.

So you generally go with friends.

Yeah, but I've gone alone before too. Sometimes, there's something bothering me and I don't want to go to work, I've thought about going to the casino. I know it's wrong, but it's hard. (Chinese saying) It's like this if you're sick and you gamble, then you become very alert. A lot of people say that.

Have you lost a lot of money and borrowed money to continue?

Yes, with friends. You brought an amount like \$2000 and lost, so you borrow. I've used my (credit) card and I've borrowed from friends. Not a lot, just a thousand something. When I get home, I pay them back.

Have you experienced that you weren't able to pay them back?

No, not yet.

Are there other things to do, besides gambling at the casinos?

No, you go you want to win money. That's what everyone wants, is to win money. Some people say they go, but not gamble, just watch. Who can just go to watch. Of course you have to gamble. I know that some people go and walk around, but I never do that. I want to gamble. I can't help it. If you go and don't gamble, why go?

Do you sometimes forget to eat?

Yes, that happens. You get into the gambling. If I run out of money, then I have no choice. I have to stop. If you're winning, you're happy and want to win more. If you're losing, you want to win back the loses.

What do you usually play at the casino?

Mostly 21, blackjack. I tried playing pai gau. I've also played baccarat, but I'm better at 21. It's fast. You bet \$50 and count the points. Baccarat, the people do this and do that and you have to think about the cards. Pai Gau too. 21 is fast.

- Participant 14 is an elderly man, who came to the U.S. over 10 years ago. He works in a restaurant, formerly in construction and other jobs, and described his English as limited.

When did you start going to casinos?

It wasn't until I came back to Boston. I went with friends. I started with the slot machines, then big/small. I started out betting small, but as I played more, I bet bigger.

So you went with your restaurant co-workers?

No, I didn't work in a restaurant then. I went with my construction workers friends.

Did you gamble in China? Did you go to Macau?

No, I didn't even gamble in New York. I never went to Macau. You start small, but if you lose, you want to get the money back, so you bet bigger. If you lose, you usually feel

defiant about it and you want to get the money back, so you bet bigger. The type of mentality people has when going to casino is that you want to at least win a little Of course, you don't want to lose. If you lose, of course you feel upset. The more you lose, the more upset you get.

Have you won more or lost more?

Overall, I've lost more. If you win today, you'll lose it all again tomorrow.

So you've lost more then you've won.

Yeah, 98% of people lose more.

Now, how does your wife look at it?

She's very angry. She doesn't like it. When I'm off, she has to go with me. She just let me play the slots, not the other games.

Have the 2 of you argued about it?

Yeah, what woman likes her husband to gamble? No one likes it.

Have you ever tried to listen to her and not gamble?

I tried for a while. We went together. If I lost \$50, I got another hundred and lost it too. I thought I could win it back by gambling few more times, yet I lost even more.

When did you realize that it was a problem?

You start small for fun, and as you play more, you bet more. The bigger you bet, the more you lost. If you lose, you usually feel defiant about it and you want to get the money back, so you bet bigger. The type of mentality people have when going to casino is that you want to at least win a little. Of course, you don't want to lose. If you lose, of course you feel pissed off. The more you lose, the more pissed-off you get.

- Participant 3 is a middle aged woman who has lived in US for more than 25 years. She lives in Chinatown and works part time. Participant 3 answered “yes” to all four questions in the NODS-PERC brief screen.

Why do you go so much?

First, I don't have much else to do. My part time work isn't regular. Some is regular, but at night. They call me when they need me. Otherwise, I go to community meetings ... I only get called to work maybe once or twice a week, so I have time and my friends ask me to go, so I go. If I stay at home, it's useless. It's a cheap ticket to go, cheaper than eating buffet. I went with them the first time and then I started going regularly. At first, I told them I'd go if I had time and I went maybe once a week. Now I go 2 or 3 times a week.

Why do you go so much?

First, I don't have much else to do. My part time work isn't regular.

If there were other things for you to do, would you still go so often?

It depends on what it is. It has to be something I'm really interested in, something that really makes me happy. The most important thing is to be happy.

What kinds of things would make you happy?

If there's a trip, I would go. If there's some volunteer opportunity. You have to give back to the community. You should help people. After a few decades, your attitude changes, you become more Americanized.

What languages do you speak? *Cantonese. English? I can get by. Mandarin? I can get by.*

NODS-PERC Question 2:

Yes, before, but not now. Maybe because I've retired, there's less pressure and my son is older. Before, it was like, yeah let's go gamble and I don't have to deal with everything. I don't really have problems now. My only problem now is not to eat so much, I'm too fat. Now I go with friends, pass the time, eat buffet.

So do you try to eat less and do you exercise?

Yes, I go to the YMCA to swim, but it's not enough to offset what I eat.

NODS-PERC Question 3: You already said this before that if you lost, you wanted to win back the money.

Yeah, I couldn't accept losing. I needed money for expenses. Jobs aren't necessarily stable. You can be laid-off anytime. My son was young and needed my support. Now, my finances are stable. My son supports himself. Now I don't have that pressure. If I lose, I lose. Before, I had to win it back. If I won, I was greedy and wanted to win more. Now, I'm older, my attitude is different. If I lose, I lose. If I win, I eat more.

NODS-PERC Question 4: Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends?:

Yes, my friends too. We went together and it happened to all of us. You lose, you're not happy. If you're not happy, you make mistakes at work and get yelled at. You can get depressed and not be able to sleep.

When you go, what do you play?

Slot machines, sometime baccarat, sometimes, big/small, sometimes roulette. There are a lot of things to play there. There's a lot of people at the casino. If they're playing big stakes, I don't want to play. If they're playing small stakes, there are a lot of people and you can't get in.

On gambling causing serious or repeated problems in relationships with family members or friends (NODS-PERC 4)

*Yes, my friends too.
We went together and it happened to all of us.*

You lose, you're not happy. If you're not happy, you make mistakes at work and get yelled at.

You can get depressed and not be able to sleep.

College Educated Professionals, U.S. Born, Risk Level Not Identified

- Participant 23, a young adult, is male, born near Boston Chinatown, and completed a college degree. His preferred language is English but speaks some Cantonese. His answer to the NODS-PERC and interview questions suggest that he might be at some risk for problem gambling, but he describes success in controlling his gambling.

NODS-PERC, question 1: Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?

Sometimes, but I try to stop at my limit of \$200.

NODS-PERC, question 2: Have you ever gambled as a way to escape from personal problems?

No

NODS-PERC, question 3: Has there ever been a period when, if you lost money gambling one day, you would return another day to get even?

Yes, but I set a limit.

NOD-PERC, question 4: Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends?

No, but yes for my dad.

When did you start gambling?

I was 18 and there was a casino on a cruise I went on. I liked it for the thrill and, I guess, the greed.

How often do you go to casinos?

I go to Foxwoods three times a year. I've been to Twin Rivers, but not Mohegan Sun. I go with my friends. I'm tempted to go to Wynn when it opens. It's so close, so convenient, but I can control it. I set a limit and I stop even if my friends continue.

When you don't go to the casino, what do you do for fun?

I do investments in stocks. I play safe. It's safer than gambling.

- Participant 1, a young female adult, was born in Boston. She grew up speaking mostly Cantonese, attended bilingual education classes in elementary school and later gained a good command of English in high school. She has a college degree, a professional occupation, and spoke English for the interview.

When did you start going to the casino?

Probably when I was 15. We go after midnight and they don't really check IDs. It's pretty bad. I went with friends, they were older. We worked in the same restaurant. After work, we said, "Oh, what do you want to do?" "Oh, let's visit a friend in Connecticut, so you always end up in a casino and we just forgot about the friend and spent all the time in the casino. Yeah, sometimes, we'd be there until morning. Like we would go on the weekend, we would go on Saturday until Sunday, then we'd come back. I was a waitress. I was 15 and \$100 a night was a lot of money, so that's what happened, it went to the casino.

How often do you go?

Now, not so much anymore, maybe once a month. It depends too, we go to New York, we like to stop by along the way or on the way back. ...I used to go a lot. Yeah, I miss it, all the time. Well, now I look at stocks. I look at it all the time. It's still a form of gambling. Safer? Stocks, it depend on if you play options or not. I'm starting to learn. I don't go overboard. I always set a limit and I always stick to it, so if I lose, I don't feel too bad. I don't lose a thousand dollars. I lose like a hundred, two hundred versus like some people's limit is like a thousand dollars

Lose a lot?

Yeah, I did. My twenty-first birthday actually.

Yeah, after that I always stick to my limit.

A problem?

No it won't become a problem because I have friends who have a problem with gambling. I saw what it did to them. Still can't help him now. His parent shipped him back to China to go to school because in China, gambling is illegal. So like if you're not a local, you would never be able to find the place, but he came back and he still does it.

It's really bad. I don't think he found a way to gamble in China. He was occupied. I think he was scared because if you lose a lot of money in China, there can be a lot of problems. I think he was OK, but when he came back, he was tempted again. He'd work the whole week, the weekend, he'd just disappear.

His parent shipped him back to China to go to school because in China, gambling is illegal. So like if you're not a local, you would never be able to find the place, but he came back and he still does it. It's really bad.

I don't think he found a way to gamble in China.

B. Themes from the Interviews

1. At Risk From Low Income, Job Stress, and Social-Linguistic Isolation

Many restaurant workers in Chinatown work long hours with little time. For example, it is commonplace for many to work 10 hours a day with one day off per week, without legal avenues to advocate for labor rights or fair treatment. Traveling to a casino is low cost, admission is free, and areas designated for Chinese-themed game tables can provide a culturally accessible environment, staffed by Chinese speaking dealers, alongside Chinese buffet or fast food offerings. The Chinese-style ambience in sections of the casinos and at times performances by Chinese performers attract Chinese customers who can play together in groups as a form of social entertainment.

The presence of many Chinese patrons is apparent in any large casino accessible to Chinese immigrants from cities throughout the U.S. Less obvious to the casual observer are the conditions of work and everyday living of the low-wage workers from Chinatown; their work is often hard and physically grueling. Several individuals said they chose to go to casinos to gamble because they have a perception that there are no other entertainment opportunities they can enjoy in Chinatown, although they may not recognize the many existing opportunities to be active and civically engaged in

Why do you think Chinese people like to go to casinos?

Because people of lower class, whether they work or not, don't know English. People speak Taishanese, Hakka dialect, Northern dialects such as Mandarin. Where can people go?

And they want to make more money. At first, they think they could use the money won from the casino to earn more money. Then, when they lose, they start using their own money to gamble.

Chinatown. Understanding this perception means recognizing that casino gambling not only provides something to do, but also provides something that distracts them from the drudgery of their daily life in which they may be mistreated by bosses, may argue with their spouse, or may face discrimination and other complex societal challenges.

Some respondents said they may have played games such as Mahjong in small private settings as a social pastime in China before immigrating to the U.S., but now they were more likely to get bored or feel socially isolated, risk factors for mental health problems and reasons they gave to go regularly to the casino in the U.S.

1.1. Difficult, Low-wage Jobs

- Excerpts from transcript of participant 17 :

Why do you think so many Chinese get into gambling after coming to the US?

Maybe because they work so hard and make so little. They go to the casino and sit and relax, where they can eat something and gamble. You win or you lose. Someone who's lucky might win over \$10,000, but someone who's not lucky will lose. However, most of those who lost never think of the consequence, about where the money comes from, how to repay the money. I want to go too. Our jobs are hard and we make little after working for more than 10 hours daily. We have to take a lot of flak. You go to the casino, you get to gamble and get a free meal. It's enjoyment.

Why do you think you are having this problem? You tried to quit once.

I tried many times. Gambling has taken place for thousands of years.

Why is gambling attractive?

Its attraction comes from the fact that people want to make money without working hard. Particularly, lower middle class workers who don't really speak English think of it this way. Even if you just win a couple dozen dollars. It's still better than working so hard. This is particularly what the restaurant workers would think.

1.2. Language Isolation

- Excerpts from transcript of participant 14:

Why do you think Chinese people like to go to casinos?

Because people of lower class, whether they work or not, don't know English. People speak Taishanese, Hakka dialect, Northern dialects such as Mandarin. Where can people go? And they want to make more money. At first, they think they could use the money won

Why do you think so many Chinese get into gambling after coming to the US?

Maybe because they work so hard and make so little...

Our jobs are hard and we make little after working for more than 10 hours daily. We have to take a lot of flak.

You go to the casino, you get to gamble and get a free meal.

It's enjoyment.

from the casino to earn more money. Then, when they lose, they start using their own money to gamble. They lose again, the more they lose, the more they want to get it back. Some ladies bet over a thousand at a time without blinking like they've lost their mind.

Are there any advantages with a new casino?

Yes. First of all, it provides a place for shopping. I think the stores at the casinos get the latest fashion faster. If you're not addicted to gambling, going to casino for recreational gambling offers a comfort for the mind. If you just go for two to three times a year, spend two to three hundred dollars, it is pretty good. If you win, nice, go have fun, eat, and shop. If you lose, it is not a big deal. It helps to release pressure and distract you.

1.3. No other Entertainment Opportunities: Fewer in Boston Chinatown than in China

- Excerpts from transcript of participant 5:

If you go with friends, do you come back together too?

Yeah, my friends aren't problem gamblers either. Some people are addicted, but I don't go with them. I think maybe the other people, in 40s, 50s, might be addicted. They were here longer with no other recreation, so they gamble more.

If there are more other recreational activities for Chinese people, do you think they would gamble less?

Yes, like in China. Not many people are addicted. Here, there are really a lot. They just work in a restaurant with no recreational activities available. We need more other things like stores, buffet, hot pot, Chinese movie theaters, dim sum. People can go eat, shop and have no time to go to casinos. There are places like that in China and Hong Kong. You can spend a lot of time there. You have to take the bus a couple of hours to the casino, it's tiring.

Are there casinos in China?

No, people go to Macau In China, friends get together to gamble. A lot of times, people work together against a new person. Those are really dangerous. You think you've become a friend and before you know it, you've lost everything you have. I have never participated in that.

Is gambling fun?

It depends on how you see it. If it's a recreation, then yes. But if you're addicted and just want to gamble for money, then no. Not everyone is like that. How many people can gamble for a living? 99 out of 100 can't. Recreational gambling isn't a problem, You work in a restaurant 6 days a week, just 1 day off. There's no time to go. Older people, in their 40s, 50s gamble more, less so younger people.

If there are more other recreational activities for Chinese people, do you think they would gamble less?

Yes, like in China. Not many people are addicted. Here, there are really a lot.

They just work in a restaurant with no recreational activities available. We need more other things like stores, buffet, hot pot, Chinese movie theaters, dim sum. People can go eat, shop and have no time to go to casinos. There are places like that in China and Hong Kong.

- Excerpts from transcript of participant 17:

So do you generally go with friends?

Yeah, but I've gone alone by bus before too. Sometimes, there's something bothering me and I don't want to go to work, I've thought about going to the casino. I know it's wrong, but it's hard.

2. At Risk from Exposure to Targeted Casino Marketing and Casino Environment

One of the most common themes in our interviews noted the popularity of casino incentives; namely, free coupons that can be used to gamble or for meals as incentives that were factors making casino gambling attractive. The winning of VIP status, which affords benefits such as free bus rides, was valued to frequent gamblers. A couple interviewees noted that once they enter the casino there are factors in the physical design that make it hard not to gamble a little. There are not seats for relaxing away from the slot machines and the table games have no seats for people to rest away from the game. One interviewee noted that the whole atmosphere was conducive to an intense gambling experience, including something he suspected was “in the air”.

2.1. Incentives: Cash coupons, Meal Coupons

- Excerpts from transcript of participant 6:

Do you often see Chinese people at the casinos?

Yes, a lot, I see a lot of Chinese people. Here, casinos give out cash coupons or buffet coupons that entice people into the casino. They don't offer those coupons in Macau. That's why I often see a lot of the uncles and aunties going to casino. They usually leave for the casino at night.

2.2. VIP Status -- hard to control

- Excerpts from transcript of participant 14:

I have tried not to gamble for a month. I'm already a VIP. With the VIP card, I don't have to pay for the bus, just a \$2 tip. I usually give \$3 or \$5. .. With the \$40 coupon, you can play the slot machines. If you know how to pick the machine,

Do you often see Chinese people at the casinos?

Yes, a lot, I see a lot of Chinese people.

Here, casinos give out cash coupons or buffet coupons that entice people into the casino.

They don't offer those coupons in Macau. That's why I often see a lot of the uncles and aunties going to casino. They usually leave for the casino at night.

Is there anything else you can do there when you go?

No, there's nothing else to do. There's not even a place to sit down. If you want to sit, you sit at the slot machines.

Do you gamble too?

Yes, once you go in, the atmosphere, it's hard not to gamble. You might hang around 1 hour, 2 hours, but by the 3rd hour, you'll gamble.

generally, you can make \$15 daily in average. One time I didn't gamble for a month, and I just played the slots using the free coupons. Sometimes I could win up to \$100, and the lowest at least \$20 worth....However, not everyone has my luck and my skills. You have to control yourself. Even with what I just said, I've actually lost too, but not as much as some people. I've lost all the money that I made from work. That is, about 13 years ago, I lost all my money. I consider it as my patronage to the casino for these past 20 years, but I didn't owe anyone money, not even a penny.

2.3. Ambience Inside Casino, No Seats

- Excerpts from transcript of participant 2:

Is there anything else you can do there when you go?

No, there's nothing else to do. There's not even a place to sit down. If you want to sit, you sit at the slot machines.

Do you gamble too?

Yes, once you go in, the atmosphere, it's hard not to gamble. You might hang around 1 hour, 2 hours, but by the 3rd hour, you'll gamble.

- Quotes from participant 14:

It controls you. There is something particular about the ambience of the casino that once you go inside, it makes you go crazy. It makes you a different person that you lose control of yourself when you are inside, even though once you come out you are back to normal. I suspect that they might put something in the air inside casinos. You wouldn't know it if you have not been in the casino. You would see it once you go inside that everyone just seems to become foolishly insane and cannot escape from it.

It controls you.

There is something particular about the ambience of the casino that once you go inside, it makes you go crazy.

It makes you a different person that you lose control of yourself when you are inside, even though once you come out you are back to normal.

2.4. Risk From Exposure to Targeted Casino Marketing and Casino Environment

One interview participant, participant 19, was married and employed in a private business and had received a college education in China and post graduate education in the U.S. in the field of education. He had immigrated to the U.S about twenty years ago and worked in a restaurant before. He never went to a casino in China.

- Excerpts from transcript of participant 19:

So if you continue to play, you eventually could lose everything. This is a law of gambling. Many people know why there is no winner. 97% of the people here are losing, but why are so many people still going to casinos? It's because the casino will give you a chance to win first, but many people could not control themselves, you could not leave right away and take the

Because in the United States, I didn't know English at the beginning, what kinds of entertainment were there?

There was no entertainment

money home. Eventually you may lose everything. I have heard so many stories like this.

- Quotes from participant 4:

Because in the United States, I didn't know English at the beginning, what kinds of entertainment were there? There was no entertainment.

2.4.1. Proximity of Casino.

- Excerpts from transcript of participant 19:

Would you go to the new casino?

I definitely will go, probably go there several times a week. It will only take me a few minutes to drive from my home to the new casino, and my wife will not be able to control me. She would not even be aware that I went. The only thing that she can do, perhaps set a spending limit on my credit card.

2.4.2. Predatory Lending by Loan Sharks.

- Excerpts from transcript of participant 19:

The bus has a fixed schedule; how would you spend the rest of the time if you lost all the money you had at the beginning?

If I took the evening bus to casino at 12 midnight, and then came back during the day, there are about 4 hours wait time for the next bus, it is possible that I may lose all in the first half an hour, the casino has loan sharks available.

How do loan sharks work? Do casinos in CT have this kind of service?

Yes, they do. You borrow money from them for 3 days with 10% interest rate.

Is there any loan collateral?

No, these loan sharks are operated by Chinese. We all know each other, and they know my home address, I won't run away. For example, if I borrowed \$1,000, I have to return the money in 3 days, plus 10% interest.

Have you used loan shark before?

I used to, not now. What do I do if I lost all my cash in the first half an hour, and reached limit of my credit card? There are loan sharks. If you want to continue to play, you can borrow from them. There are many people who hold fantasies and feel that they can win back the money. I also had similar experience. I borrowed \$1000, spent another half an hour in casino and won back. After I paid back \$1100 to loan shark and I still have some money left. This is the case when you are lucky.

3. Participants' Self-Described Emotional and Psychological Relationship to Gambling

In Sections B.1 and B.2, respectively, we have described participants' description of exposure to social stressors and business practices of the casinos. In this section B.3, we describe themes from our participant's self-described emotions and psychological factors related to their gambling. These included expressions: Imagical thinking, such as belief that one has

special powers to win while minimizing the reality of losing; a belief that gambling can solve problems or make the gambler “alert”; an appreciative feeling that casino staff respect the gambling patron, an attitude not necessarily present in other parts of his/her life; 4) feeling excitement from gambling; the fantasy of being the next big winner when watching another person in the casino win despite very low odds of winning; excitement, and loneliness. Participants also described efforts to self-limit their gambling.

Interestingly, none of our interview participants specifically mentioned belief in numerology or Feng-shui. However, one of our community educators who works with older Chinese immigrants in Chinatown noted that belief in “lucky numbers” is often mentioned in informal conversations about gambling in this sector of the Chinatown population.

3.1. Magical Thinking – Exaggerating Skillfulness in Beating the Casino

- Excerpts from transcript of participant 19:

...To play lottery may cost you about \$20-30, and rarely people will spend \$10,000 to buy lottery tickets. But in casinos you may have someone next to you spending \$10,000 to \$20,000 to play. Besides that, the casino created the illusion that their games were really fair, or that the dealer does not have any advantages, and that I have a better chance of winning. A lot people feel that they are very smart. They can beat casinos. If I know I can't beat you, I definitely will not go there.

- Excerpts from transcript of participant 14:

I bet quite a lot as compared to other women, but I haven't gotten to the point of owing too much money. I'm lucky, and I've got good gambling skills. When I play the game, for example, I would win 9 times out of 10 times. Even just a single loss would be terrible for me because I don't like to lose. I have to continue to play until I win.

3.2. Believe Gambling is a Cure for Problems

- Excerpts from transcript of participant 17:

So do you generally go with friends?

Yeah, but I've gone alone by bus before too. Sometimes, there's something bothering me and I don't want to go to work, I've thought about going to the casino. I know it's wrong, but it's hard. A Chinese saying goes: gambling can cure hundreds of diseases. A lot of people say that. It's like this if you're sick and you gamble, then you become very alert.

3.3. Feeling Respected in the Casino

- Excerpts from transcript of participant 19:

My last question, you have been to many casinos. You also mentioned that you enjoyed the casino. It sounded like that you have to spend some money every month at casinos. Are you going with this attitude, spending some money there for enjoyment?

I enjoyed the casino environment very much; I feel very good in there. The staff there also treat me very well. And still I have the feeling that I am smart, and if I got lucky I may win.

3.4. Fantasy – I Will be the Next Winner

- Excerpts from transcript of participant 19:

The uncertainty of the game is like buying lotteries. Everyone knows that, my kids buy them too. I used to spend \$20-40 a week on lotteries. When Powerball accumulated to a huge number of prizes, the whole country was buying. And then my kids told me not to buy, they told me it's impossible to win, they knew that most of time my \$30, \$40 were wasted. But many people still hold the fantasy thinking they may win one day. The casino gives you the same fantasy. When you go to the casino just for a look, there are always a few people who win. This makes you think that you could be the next winner.

3.5. Excitement

- Excerpts from transcript of participant 16:

Why do you want to go gambling?

Because I sleep very little at home, I can sleep in the car for 3-4 hours. I am happier when I go to the casino. The casino is exciting, and I am more excited.

3.6. Feeling Lonely, or Just Wanting Fun. Cycle of Losing Control

- Excerpts from transcript of participant 14:

Did any of your friends or family tell you to stop?

When you feel lonely and want to go have fun for a bit, but if you lose, even if it is just for fun to begin with, it will become a nonstop cycle.

3.7. Trying to Improve Self-Control

- Excerpts from transcript of participant 14:

But now, we look at it differently. It is just for fun. Whether winning or losing, I stop chasing. That said, I still want to win when I go inside. Not that I want to make money out of the casino, I want to win back my money. People are naturally like that. In a way, it taps into that kind of mentality, and it becomes a cycle. If you don't win in the beginning, it's OK, but once you win, you would become a regular. Now I've learned my lesson. If I lose, I just look at it as a trip. Even now I'm still losing.

- Excerpts from transcript of participant 3:

In the United States, when I have money, I would lend money to not only my wife, but also my friends if they ask. Money alone is not a priority for me. Gambling is not good for most people. There are very few reasonable people, and I'm one of the few reasonable ones, I gamble whenever I want. If I don't feel like going, I don't go, and I go to play chess instead.

What makes you decide to go or not to go?

If I win, I would go every day. If I lose, I would stop going for 2-3 days. If I have been losing for a week, I would stop for two to three day.

Depend on the luck?

Luck is peculiar. Luck is fate, it just doesn't let you win.

Who is him (it)?

I've used all my wisdom, and sometimes I still lose.

- Excerpts from transcript of participant 17:

Some people can control themselves.

Yes, I was almost addicted, but I'm able to control it...You never get sick of gambling. At work, when the boss starts to yell at you, at home, husband and wife argue with each other, your kids don't listen, your job is hard, what can you do to get excitement and stress-relief in life, gambling is first thing that comes to mind.

How do you feel when you lose?

When I lost money? Just a little? Some people can't sleep if they lose because they feel bothered by it. Those people might go borrow money so they can go to gamble, only to lose it all again. When I lose, I also feel bothered, and I would try to think of different strategy to win it back.,,In the past, when I had a chance I just chased it, whenever I had time, whenever I got my pay, I'd go to try to get it back, because I felt defiant about my losing. Nowadays I've changed my attitude/mentality: when I lose, I just treat it as if I was taking a trip. If I go back again, I only bet small amounts; I go with \$500 or \$300. If I lose, I would stop to chase it back. It's less harmful. Based on my calculation, I might break even, but not lose...

3.8. Belief that Efforts to Increase Self-Control Undermined by Paid Ringer

- Excerpts from transcript of participant 14:

You stopped for a few years ...

I have a way to control myself. I go with \$350 cash in one pocket and a bank card that has a withdrawal limit of \$500 in another. If I lose \$300, I take out \$500. If I break even, I stop and leave. At most, I won't lose more than \$800.

4. Effects on Family Members

From Perspective of Gambler:

4.1. Family Strife

- Excerpts from transcript of participant 21:

Do you always go to the casino to gamble?

Now, no, I don't go anymore. I haven't gone in about 10 years. After I got married and had kids, I needed money.

So you lost more than you won?

Of course! I lost so much, I can't stand it.

You haven't gone to the casino for many years, do you feel like you want to go?

Yes, I always want to go, but I'm afraid to go and lose money. Now, I have 2 sons to support. I have to suppress the feelings. Before, when I was younger, friends asked me to go, so I went. We took the bus.

When you want to go to the casino, how do you suppress the feeling?

Of course I want to go, but I'm afraid I'll lose. I have to control myself. I gambled for 10 years. I lost a lot of money. I even lost a house.

So it affected not just you, but your whole family.

Did you borrow money to gamble?

No, I didn't borrow, but I did use my wife's money. Oh, I did borrow from friends and my wife repaid them for me.

Your wife paid off your debts, how did she feel about it?

Of course, she yelled at me. She worked hard for the money and had to use it for my debts. Of course she had something to say about it.

Did people get angry at you or...?

Of course, family was definitely angry. I sneaked off to the casino. People in the family, such as parents, were definitely angry. They would yell at me because I lost so much money.

Why don't you go (to the casino) anymore?

Because of my kids. They're older now.

I want to go, but I have to work and take care of them. Even if you don't eat, they have to eat.

In the past, I didn't like to work, and all I could think was to go there. But then after giving birth to kids, I don't want them to know that I gamble.

I don't want them to follow my path.

4.2. Desire to Protect Children

- Excerpts from transcript of participant 17:

Why don't you go?

Because of my kids. They're older now. I want to go, but I have to work and take care of them. Even if you don't eat, they have to eat. In the past, I didn't like to work, and all I could think was to go there. But then after giving birth to kids, I don't want them to know that I gamble. I don't want them to follow my path. It's not good. I hold it in. You know, you go, and you sit there all day and don't have to work. It's really awesome.

...My gambling habits caused me to owe so much money. I don't want my kids to follow in my footsteps. I'm scared. I don't want them to pick up any vice, such as gambling, drinking, and drugs. Every parent would think the same.

From Perspective of the Spouse of Persons Who Gamble in Casinos:

4.3 Monitoring Spouse's Gambling Problem

- Excerpts from transcript of participant 2:

What do you think about gambling, is it fun?

It's fun while I'm gambling. I don't really want to go, but I have to go with my husband to control him. My friends said that they see him at the bus. There's several buses every day. He stands by the bus and wants to get on. If he goes alone, he loses track of time. For my job, sometimes, I have to stay overnight. That's when he sneaks out to go to the casino. I told him not to go alone, that I'd go with him on the weekend.

And you go every week.

Every Saturday.

Have you ever lost a lot of money?

No, but my husband has. That's why I have to go and watch him.

If you have time and don't go to the casino, do you have other recreational things to do?

Yes, I work hard 5 days, so I can sleep later on Saturday, clean the house, go have dim sum and that's already a day.

What about your husband? He's free every day.

I tried to get him to go to the senior center. It's \$2.00 for lunch, then you can do other things, play ping-pong, ... But after he eats at Hong Luck House, he goes to the bus with his friends. They eat at 11:30 and there's a bus at 12:00, 5 minute walk from Hong Luck House. If the casino is farther away, then he can't go. Twin River is close. They give you a \$40 coupon. My husband stands by the bus and if there's a seat, he goes. To him, to lose \$100, \$200, it's nothing. Too many people gamble, too many Chinese people gamble.

Why do you think it's like that?

There's no recreation. Immigrants don't know English, like my husband. If you tell him to take a bus farther away, he's afraid to.

Why do you think it's like that?

There's no recreation. Immigrants don't know English, like my husband. If you tell him to take a bus farther away, he's afraid to.

What if there are other recreational activities? What kinds?

More movies, Chinese movies.

- Quotes from participant 8:

I don't like it anyway, I don't like him going, but he sometimes wants to go with friends, I don't care and he doesn't tell me.

4.4. Self-limits

- Excerpts from transcript of participant 8:

Some people, anyway, when I am going, some people, when they go to the casino, it seems to be, because they look young, bet big money. I feel like it is very horrifying. They place the bets by dozens and dozens. It seems that they are losing their minds. I don't know. Anyway, I am not going to do the same. just looking. Play very little.

- Excerpts from transcript of participant 2:

When you go with your husband (to the casino), you can control yourself?

Yes, I plan it before I go. I'm still awake when I leave. I have a budget of \$300. If it's gone, then that's it, even if it's not time for the bus yet. I sit and wait.

- Excerpts from transcript of participant 2:

No, If I win, of course I'm happy, but I won't continue to try to win more. I work hard, 10 hours and earn a little more than \$100. You play one round and it's all gone. It's not so easy to earn that money.

No, If I win, of course I'm happy, but I won't continue to try to win more.

I work hard, 10 hours and earn a little more than \$100. You play one round and it's all gone. It's not so easy to earn that money.

- Excerpts from transcript of participant 2:

But your chances of losing are more than winning. The casinos have to make money.

Once you walk in, you can't help it. I'm not addicted, but when I walk in I want to gamble. If I sit at the slot machine, waiting to leave and see someone win, I think maybe I can win at that machine too. You pull out \$20, then another \$20 and before you know it all the money is gone.

4.6. Martial Strife, Evasion, Deception

4.6.1. Loss of home and financial stability.

- Excerpts from transcript of participant 4:

I had no idea when we first met, and it didn't take long before I learned about it. I learned about it when he sold his house. He lost more than one million Renminbi (RMB). I have been in the United States for 11 years. It was about 11-12 years ago when he lost more than one million RMB. It could have scared someone to death, if you think about it, when I heard about it I almost fainted. Someone couldn't even make that much money for their whole life, He borrowed money to a point that he'd lost friends and relatives. After we met, he started to borrow money from me. I didn't think about it much at the time. It scared me when I heard that he owed more than one million RMB, and I thought, better to pay it off. In end, I sold my house.

- Excerpts from transcript of participant 4:
During that time, I became homeless ... I lived in the shelter with my daughter. Gambling has caused me to lose everything...

4.6.2. Hiding gambling from family members.

- Excerpts from transcript of participant 2:
He can go after I leave and come back before I get home and I won't even know he went.

- Excerpts from transcript of participant 13:
The family doctor let him to see a psychiatrist, but that can't help at all. The psychiatrist, just talk to him, useless, ultimately it is about the problem of money.

Short term is money. What about long term?

[We] always fight, want to divorce. Sometimes I didn't know he went to gamble and he said he didn't go. Later on, someone came here and asked me for money, saying if I don't give him the money he owed, he will kill him (her husband). Recently five or six years, we started to go to church and we did not gamble at all. We were at church two times a week.

- Excerpts from transcript of participant 13:
Sometimes we drive ourselves, sometimes go by bus, everyone gambles. I bet on mine he bet his (Bacarat). I was curious at the age of 21, and later someone came to ask for debts. I know that he didn't want me to know because, you know, no marriage anymore -- if I know.

Finally?

He paid back the money ...I'm a little emotional. I saw a psychiatrist, 1-2 times, talking about unhappy things. Emotional, not good...

The family doctor let him to see a psychiatrist, but that can't help at all. The psychiatrist, just talk to him, useless, ultimately it is about the problem of money.

... [We] always fight, want to divorce. Sometimes I didn't know he went to gamble and he said he didn't go.

Later on, someone came here and asked me for money, saying if I don't give him the money he owed, he will kill him (her husband).

Recently five or six years, we started to go to church and we did not gamble at all. We were at church two times a week.

5. Contesting Cultural Stereotypes and Myths

Our interview participants did not volunteer the opinion or express any support for the notion that Chinese as a group are “born to gamble” or even “like to gamble”. Instead, comments on cultural influences suggested a complex mix of cultural influences come into play in shaping popular views on gambling. Games of chance and skill are often played at home as a social past-time not equivalent to gambling in the commercialized casino environment. Some Chinese immigrants adhere to an interpretation of traditional moral values that disapproves of gambling, a viewpoint voice by participant 19. We do not know to what system of values Participant 19

referred in this interview, but it is reported that Confucius (551-479 B.C.) considered gambling “unproductive: and as “violating filial duty” (Wu, 2015). Interestingly, none of our interview participants specifically mentioned belief in numerology or Feng-shui. However, one of our community educators who works with older Chinese immigrants in Chinatown noted that belief in “lucky numbers” is often mentioned in informal conversations about gambling in this sector of the Chinatown population.

5.1. Popularity of social games, such as Mahjong

- Excerpts from transcript of participant 5, 30+ years old, man:

How did you start gambling?

Oh, I was young, a long time ago. You know, Chinese people, for New Year, we get together and play cards. A lot of people get together for New Year, we have some fun, play for a little money.

Are any of the people serious gamblers?

No, not really, we just play for fun. It's not time to eat yet, so we play a couple of rounds.

So you lied to family about going to casino back then?

I still do, because Chinese traditional culture considered gambling is bad.

5.2. Disapproval of gambling in traditional Chinese culture.

- Excerpts from transcript of participant 19:

So you lied to family about going to casino back then?

I still do, because Chinese traditional culture considered gambling is bad. When it comes about going to the casino, it's not a very good sign for most Chinese.

They said that gambling is in our blood.

Most of the people in casino are Chinese, Vietnamese, Korean, but rarely Japanese, Japanese are not interested in casinos.

5.3. Chinese not born as gamblers.

- Excerpts from transcript of participant 8:

Why do you think this is the case? You just said that white people are able to control themselves on gambling but, Chinese people could not? Based on your personal experience, why is that?

They said that gambling is in our blood I do not think that we are born as gamblers. I feel like I enjoy being in the casino when I go there. It is a very comfortable environment, the dealer who are working there are very nice and respectful to me. I knew I was losing money, while we are engaging conversations and laughing. We know that 97% of the people are losing money, and maybe three people are winning. Once you got there, things seem to be changed. it's like smoking marijuana and doing drugs. It is very difficult to get rid of them. I think gambling is a bit similar as drug addiction. Your central nervous system is being numbed in here.

I do not think that we are born as gamblers.

6. Thoughts on Opening of New Casino in Everett

In response to our question about seeking their viewpoint about advantages and disadvantages of opening a new casino close to Chinatown, several of our interviewees readily offered their opinions. A common theme: the new casinos are good because they provide jobs and tax income, but are bad for people who are addicted or problem gamblers. The likely negative impact of increasing risk for problem or addicted gamblers is acute, some individuals remarked, because the casino was going to be so close to where they lived. It would be easy to take public transportation, rather than take a longer bus ride to Connecticut. Opinions varied on whether the disadvantages outweighed the advantages.

Is it good or bad to have casinos?

Casinos are good for people to have jobs, but there's more bad than good.

People lose their hard-earned money and have nothing. People who don't gamble can save money to buy a house, buy cars for their kids.

- Excerpts from transcript of participant 22 (who was introduced to gambling in China through illegal gambling, and gambled in the U.S after friends took him):

I gambled a lot. I've lost about \$80,000 over 20 years. My wife yells at me, tells me to stop, my friends tell me to stop too.

Do you know about the new casino opening in Everett next year?

Yes, but I'm afraid to go. I have no more money. I've lost it all. I've borrowed money and lost it, then I have to ask friends to let me work for them a few days so I can repay what I borrowed because I'm retired,

Is it good or bad to have casinos?

Casinos are good for people to have jobs, but there's more bad than good. People lose their hard-earned money and have nothing. People who don't gamble can save money to buy a house, buy cars for their kids.

- Excerpts from transcript of participant 10:

Do you think the new casino opening in Everett next year will affect the Chinese people?

I think it's ridiculous. It's too close. If there are advantages, then there are disadvantages. They open the casino to make money, they won't open a losing business. That's their advantage. Of course it'll affect us. You have to have control and not go every day and become addicted.

Are the disadvantages more than the advantages?

Mmm, I don't know. If people become addicted, that's a disadvantage, but there is an advantage for me. It's a place where I can go to relax, then it'll be easier for me to do my job. It's doesn't matter to me, individually, if they open a few more because I won't go every day. I don't go to make money, just to relax. I work for my money. My boss makes money and can pay me, I'm happy.

Do you think some Chinese people will want to work there?

Yes, then everyone will have a job.

- Excerpts from transcript of participant 7:

Next year, a new casino will open in Everett....

Oh, when they open, I'll go take a look, walk around. No way I'll become like I was again.

Do you think more people will go from Chinatown?

I think so, but let's see if they offer any benefits. People don't have to go so far. Twin River is an hour away. Foxwood, Mohegan Sun are 2 hours away. This one is only a little more than 10 minutes away. They save a lot of time.

Will more people become addicted?

Oh, that's hard to say. If they offer more benefits, people will go more often.

Are there any Advantages?

Advantage? There's advantages for the government. For the people, there's no advantage. For those addicted, they can just come back and get more money and go back again. It so close. It's a disadvantage. Foxwood, Mohegan Sun, they can't just come back to get more money.

What if there are no Casinos?

Then the government won't have income. Other sources don't bring in as much money. The government gets a lot of taxes from them. They've thought it through. They thought about residential safely and a lot of things. That's why they have to have a vote before it can open. People who don't gamble oppose it. Residential safely is affected in a big way.

- Excerpts from transcript of participant 15:

Will you go to Everett when the new casino opens there?

Yes, I will go gamble even more, it's so close, my friends will too.

Is it good to have more casinos?

No, it's not good to open more casinos. It's for the boss and good to get taxes. People can get jobs to work there, but you have to know English, but if you work there, you want to gamble too. But if you work there, you can't gamble there. You have to go to another casino to gamble.

- Excerpts from transcript of participant 4:

In response to a question about the impact of her husband's gambling on her daughter, part of her response included a comment about opening of the casino very near her home:

Even if it is built, one of the advantages is that there are more job opportunities. If you don't build it, everyone will go to Connecticut. The money from gambling flows out, and from an economic point of view, it's an advantage. If the casino isn't built, is it possible to limit how often people visit the casino? In fact, I personally think that it is most useful to encourage people to not get so deep into gambling that they become lost in it. It is not useful to discuss whether or not to build the casino, but to talk about the effects it will have, and to remind everyone that you are going to gamble. You are going there for entertainment. It's the most important thing to not let your family get hurt by playing. When the family is hurt, really, many things can't be salvaged.

7. Participant Recommendations for Prevention

Our interview protocol did not use specific language referring to “protective factors” when asking participants to reflect on how they started gambling, what may have helped them gain control once at risk for gambling problems, or what “can be done” to improve the situation where too many community residents become addicted to gambling. From their responses on these topics, we extract several themes:

7.1. Family-based Support Systems

- Excerpts from transcript of participant 3:
Have your husband and son told you not to gamble?
Yes, it helped me. I was addicted before, but not now.

Research indicates that the involvement of family members in addiction treatment may be much more important in Asian American addicts than others (Zhu et al., 2002); it would stand to reason then that whole family engagement would make prevention efforts more effective as well. Approximately 10% of respondents to our research study were the spouse of a problem gambler, rather than a gambler themselves.

Research indicates that the involvement of family members in addiction treatment may be much more important in Asian American addicts than others (Zhu et al., 2002); it would stand to reason then that whole family engagement would make prevention efforts more effective as well.

- Excerpts from transcript of participant 17:
Why don't you go?
Because of my kids. They're older now. I want to go, but I have to work and take care of them. Even if you don't eat, they have to eat.

Researchers also consider that in Asian cultures, the concept of doing it for the benefit of one's family may be more powerful than the common American concept of the strong-willed individual overcoming their challenges alone. To address the issues of addiction among the Asian American Pacific Islander (AAPI), Fong and Tsuang (2007) have suggested “working with the families...will also help to identify and reduce enabling and codependency behaviors that can be difficult for AAPI families to break because family harmony and acting as one are more familiar concepts than direct confrontation.”

7.2. Community Education

- Excerpts from transcript of participant 4:
Then what do you think can be done to educate more people about self-control, gambling only for entertainment, but not become addicted to gambling?
I think it could be like the method done by the church. The church gives out flyers. Or it could be made into a pamphlet, and sent to everyone, or it can be posted/left at a place for people to read, or something like that. I think the effect may be bigger through the format of advertisement. There is no way to stop people from gambling. Everyone is an adult...

- Excerpts from transcript of participant 2:

Few Chinese people will help, but like where I work, the Americans and Hispanics will participate. Put it on the internet, pass out leaflets in Chinatown for people who don't use computers. There must be a way. You people are smart. There must be a way. Do your best.

Even widespread addiction can be impacted by a coordinated and well-planned public education campaign, as shown by success of widespread education on smoking. While numerous factors have likely contributed to a decrease in smoking rates in this country over the last 50 years, a remaking of the public image of smoking has also played a role. Regarding the significance of the public education campaign, Cummings (2016) has argued: “The shift in public perceptions is important because perception and the social pressure that comes along with it have been the driving force behind the decline of smoking over the last half century. Once consider a rite of passage into adulthood, the majority of teenagers today have never smoked and don't intend to.”

A robust marketing campaign about the dangers of gambling addiction could be an important component of preventing increases in rates of problem gambling in the future. Moreover, a linguistically-appropriate and culturally-competent campaign directed at Chinese and other Asian communities would be a necessary part of this strategy, as the motivations for gambling are quite different, as we have shown in this report.

You people with power have to do something, not like us, who have no money, no power.

You elect someone, they should do something. You educated people should do something. Get people's kids to help. They are the real victims.

7.3. Facilitate Civic Engagement

- Excerpts from transcript of participant 2:

You people with power have to do something, not like us, who have no money, no power. You elect someone, they should do something. You educated people should do something. Get people's kids to help. They are the real victims.

- Excerpts from transcript of participant 19:

What do you think the government is going do? Perhaps to provide some counseling on gambling issues?

How do you counsel? I don't know how the government could help. The government has brought the casino here. How can they counsel their residents and advise them not to go? This is contradictory in itself. If no one is going to casinos, that will hurt the government revenue. If the government encourage you to go, it may bring many social problems. I can predict the crime rate will increase after the Boston casino opens next year. Because gamblers may lost their money, I am expecting larceny and theft may occur more often, The government allowed the casino open through legislation, and then it asked everyone not to gamble? This makes no sense?

A common theme in the answers of some participants was that powerful people want a casino in the region for the benefits to society – such as jobs, increased tax revenue, appeal to tourists – but that poor people would bear the brunt of the negative outcomes. A greater sense of empowerment for the Asian immigrant community would help some of these community members feel more in-control of the impact of the casino on themselves and their community. Some of this work can be led by community-based organizations, and other parts of this could be achieved with more articulated transparency from bodies such as the Mass Gaming Commission.

Many respondents are very aware of the potential harm that comes from addiction, but feel powerless to even begin to address it. Working on developing a sense of responsibility and power over the problem could help communities develop more resilience.

7.4. More Recreational Options

Several people pointed to the lack of recreational opportunities in Chinatown, as noted earlier in our discussion of Risk Factors. These comments suggest that availability of adequate recreational opportunities in people’s own neighborhoods, near their home or workplace would give them an alternative to gambling or seeking socializing outlets in casinos; thus, making recreational alternatives available in communities would act as a protective factor.

- As participant 19 commented, excerpts from transcript: Most of time, Chinese do not know how to plan their life, when you are in China, you may have other hobbies, such as watching ball games, or playing Go. There is no such thing in the United States. It’s hard to find anyone to hang out with you. Besides, people are very busy here, and everyone's schedule is different. You could get very bored and depressed here, nothing to do on your off days.

Most of time, Chinese do not know how to plan their life, when you are in China, you may have other hobbies, such as watching ball games, or playing Go.

There is no such thing in the United States. It’s hard to find anyone to hang out with you. Besides, people are very busy here, and everyone's schedule is different.

You could get very bored and depressed here, nothing to do on your off days.

Section IV: Discussion of Findings and Conclusion

It is widely acknowledged among public health professionals that culturally relevant mental health services for gambling problems in low-income Asian American communities are critically needed but hard to find. The importance of funding research and services is largely underestimated or neglected because of the social marginalization of these immigrant communities. Our interviews confirmed the existence of a serious service-treatment gap.

However, community participants went much further to talk about deeper roots of gambling problems, not focusing on supposed Chinese cultural preferences to gamble or not gamble, but rather pointing to social determinants that shape gambling behavior: the desire to relieve stress of low-wage jobs, the dream of winning “easy” money in the hope of escaping

poverty, the lack of other recreational options in Chinatown, and factors such as the proximity of casinos, low cost and frequent bus rides, and inducements in the form of coupons and opportunities for Chinese meals and shopping. The factors that contribute to problem gambling in this community are numerous, and the community-based infrastructure to counter them is not yet well-developed. These comments and opinions of our research participants about why they take part in casino gambling clearly point to a critical need: it will be important to devote public health and community mitigation resources from casino revenues to prevention as well as treatment.

Recommendations

Effective problem gambling prevention and treatment require development and careful evaluation of evidence-based practices that are closely attuned to risk factors affecting individuals, families and communities. For residents and workers in Chinatown, effective preventive and treatment interventions require cultural tailoring to the complex mix of risk factors affecting individuals, families and communities. Our research indicates that in low-income Chinese immigrant communities with concentrations of at-risk members, prevention and treatment need to address social stressors arising from work conditions, low-pay, social-linguistic isolation, and cultural influences that make people unwilling to seek help outside families for mental health problems. From the earliest stages of designing and pilot testing interventions to later stages of implementation and evaluation, it is necessary to build and sustain close collaborations between health professionals, educators, and community organizations. These partnerships will leverage diverse expertise and efforts to devise novel and effective methods of prevention, screening, referral systems, and treatment sensitive to social context and cultural factors. The factors include economic disadvantage, family dynamics, concepts of “face”, gender, acculturation in multi- and inter-generational communities, age differences, styles of recreation, and culturally-influenced concepts of healthful living.

Concurrent development of prevention and services: To be effective, the provision of culturally appropriate gambling counseling services needs to occur **concurrently** with the culturally tailored public health campaign. In general, individuals will not become more open to seeking services without culturally appropriate education and assurance that help is available. But if individuals are persuaded to initially explore counseling or other forms of help and no bilingual and culturally proficient counselors are available, individuals will be discouraged from seeking help in the future and the credibility of community-wide prevention and treatment efforts will likely be harmed.

Development and delivery of culturally appropriate interventions will be successful only if **community-based organizations** can develop the necessary **institutional capacity** at a pace commensurate with heightened exposure to risk in vulnerable neighborhoods, especially those near or easily accessible by public transportation to new casino businesses.

We recommend a **multi-pronged** program of action.

Culturally Appropriate Prevention and Services

1. **Public Health Campaign:** Support for culturally appropriate public health campaigns on problem gambling. The messages should be tailored to for different youth and adult age groups. Scholars and family counselors in Chinatown frequently note that clients are very reluctant to seek gambling counseling. Even if clients do attend an initial counseling interview it is hard to sustain participation. A major barrier is a cultural norm that discourages talking about mental health problems and any family problems outside the family for fear of losing “face”. Thus, there is an urgent need to develop innovative ways

to gradually open up conversation in both private and more public settings about gambling problems, explaining differences between benign recreational and problematic gambling. A first step will be to disseminate the knowledge gained from this project, *Talking About Casino Gambling: Community Voices from Boston Chinatown*, to everyday Chinatown residents and gather community comments in a series of workshops. These conversations will inform a second step, which entails development of a series of age-appropriate educational pamphlets and videos. The third step is to develop and implement strategies to use the educational pamphlets in existing social service settings and a series of workshops in diverse community settings.

2. **Support for Provision of Culturally Appropriate Services:** There are virtually **no culturally appropriate gambling counseling services available** for Chinese immigrants, including in Chinatown or outside of Chinatown. A critical first step will be to integrate vastly expanded services into existing family counseling and youth programs in agencies and clinics. Training alone of existing staff in standard screening and treatment approaches has not yielded satisfactory levels and quality of services in the past. Rather, there is a need to expand service capacity and develop tools for the staff to conduct culturally appropriate education, screening and counseling models for the Chinese low-income population. Provision of more counseling focused solely on gambling issues alone will not be effective. Gambling addiction typically leads to multiple negative consequences, both emotional and material. When individuals are affected they need not just counseling to control gambling problems and address related problems, but also social assistance to manage daily living, stabilize families, and stabilize finances disrupted by gambling problems.
3. **Preventive Education and Services for Casino Workers:** Development of a prevention campaign and culturally appropriate services for Asian American casino employees. A large proportion of casino employees at the Encore Boston Harbor casino are Asian American. Since it is known that casino employees are at heightened risk for gambling problem, targeted prevention and treatment services are required for this population.
4. **State-supported Reimbursement** for community-based treatment program in health clinics and social agencies is vitally needed. Even limited services for treating gambling problems in community clinics that are not at this time culturally tailored do not receive such support.
5. **Professional Training.** The local pool of culturally trained counselors needs to be greatly expanded. With heightened concern about gambling problems in Chinatown, there is an urgent need for development of a professional certification program on cultural competence in problem gambling counseling for Asian Americans.

Participatory Deliberation in Regulatory Process

6. **Regulatory Goal Setting:** Engagement of community-based organizations and professionals knowledgeable about Asian American communities in **goal-setting for reducing the negative impact of legalized gaming** on the low-income Asian population. The purpose is to ensure **representation of stakeholders in** communication among representatives of the gaming industry, community organizations, and professionals working to counter the harm caused by the casino industry itself
7. **Community Engagement in Public Policy:** Work with leaders in the Asian community to **engage community-members in public presentations** about the public uses of casino revenue, and how their communities can be further engaged in influencing those decisions;
8. **Ethics Review of Targeted Ethnic Advertising and Marketing Practices:** Establish an advisory committee to review the **ethics of targeted advertising and other marketing practices** aimed at vulnerable populations, including low-income, immigrant, and racial-ethnic minority communities. Advertising includes promotional communication in varied formats, including web-based marketing, signage, social media, and printed formats. The advisory committee will include community leaders and public health professionals with necessary linguistic and ethnic-cultural expertise.

Expanded Scope of Collaboration and Services

9. **Regional Resource Sharing and Learning:** Support for a **co-learning and mutual support pan-Asian coalition** of community-based organizations that provide family support and wellness programs for immigrant and refugee communities in the region.
10. **Healthy Recreational Alternatives:** Support community-based efforts to provide **healthy and culturally appropriate recreational alternatives** to casino gambling in local neighborhoods. To be effective, prevention cannot be limited to educational campaigns and interventions alone but must also address resource inequities that limit alternative entertainment options in Chinatown and in other low-income Asian American communities.

Research Agenda—Support for a five-year **research** agenda to develop:

11. **Increased understanding of the impact of legalized casino gaming on diverse Asian Americans communities**, including Cambodian, Korean, Vietnamese, and South Asian ethnic groups. This pilot study focused on a sample of residents and workers in Chinatown who are casino customers. A larger study of more broadly representative ethnic Asian American populations is needed.

12. **Culturally appropriate prevention and treatment interventions** require tailoring for **both youth and adults, understanding of intergenerational community and family dynamics**. It is critical to integrate understanding of the effects of migration and immigrant transitions, war and refugee experiences in homelands, cultural perspectives on mental health and wellbeing in prevention messages and counseling or alternative therapy approaches.

13. **Methods to obtain representative samples for hard to reach Asian American populations**. Our research experience underscores the important role of community organizations in aiding researchers construct sampling lists of prospective survey or interview respondents from their membership or client base. In a small community with dense social ties, it is vital to take careful measures to preserve confidentiality, not making it known who participated in a research project by inadvertent exposure of identities.

14. **Expansion of Research to Multiple Asian American communities**. We began this research with the expectation that Chinatown would be an important starting point for studying gambling among members of other Asian American communities. We recommend placing priority for next steps on study of gambling problems, prevention, and treatment for low-income Vietnamese and Cambodians residing in Dorchester, Quincy, Lowell, Malden, and Worcester, where communities are at risk for problem gambling because of social stressors arising from the refugee experience, low-income, social and linguistic isolation, and a lack of problem gambling services.

References

- Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., ... Alegría M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. *American Journal of Public Health, 97*(1), 91-98. <https://doi.org/10.2105/AJPH.2006.098541>
- Asian Americans Advancing Justice. (2013). *A Community of Contrasts: Asian Americans, Native Hawaiians, and Pacific Islanders in the Northeast*. Washington, D.C.: Asian American Advancing Justice. Retrieved from https://www.advancingjustice-la.org/sites/default/files/CommunityofContrasts_Northeast2013.pdf
- Boston Public Health Commission. (2013). *Health of Boston 2012-2013: A neighborhood focus*. Boston, MA: Boston Public Health Commission. Retrieved from http://www.bphc.org/healthdata/health-of-boston-report/Documents/HOB-2012-2013/HOB12-13_FullReport.pdf
- Chóliz, M. (2018). Ethical gambling: A necessary new point of view of gambling in public health policies. *Frontiers in Public Health, 6*:12. <https://doi.org/10.3389/fpubh.2018.00012>
- Community Assessment of Freeway Exposure and Health. (2017). *Improving health in communities near highways: A study of the Reggie Wong Park in Chinatown*. Boston, MA: Community Assessment of Freeway Exposure and Health, Tufts University. Retrieved from <https://sites.tufts.edu/cafeh/files/2011/10/Reggie-Wong-Park-report-2.pdf>
- Department of Public Health & Massachusetts Gaming Commission. (2016). *Strategic Plan: Services to Mitigate the Harms Associated with Gambling In Massachusetts*. Boston, MA: Department of Public Health, and the Massachusetts Gaming Commission.
- Fong, T.W. (2005). The vulnerable faces of pathological gambling. *Psychiatry (Edgmont), 2*(4): 34-42.
- Griffiths, M. D. (2015, November 19). Gambling advertising and marketing: Can gambling advertising and marketing be more socially responsible? *Psychology Today*. Retrieved from <https://www.psychologytoday.com/us/blog/in-excess/201511/gambling-advertising-and-marketing>
- Hancock, L., Schellinck, T, & Schrans, T. (2008). Gambling and corporate social responsibility (CSR): Re-defining industry and state roles on duty of care, host responsibility and risk management. *Policy and Society, 27*(1), 55-68. <https://doi.org/10.1016/j.polsoc.2008.07.005>
- Islam, N. S., Khan, S., Kwon, S., Jang, D., Ro, M., & Trinh-Shevrin, C. (2010). Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: historical challenges and potential solutions. *Journal of Health Care for the Poor and Underserved, 21*(4), 1354-1381. <http://dx.doi.org/10.1353/hpu.2010.0939>
- Kim, W. (2012). Acculturation and gambling in Asian Americans: when culture meets availability. *International Gambling Studies, 12*(1), 69-88. <https://dx.doi.org/10.1080/14459795.2011.616908>

- Kim, W. (2019). Healthy mahjong, little mahjong: social gambling among older Chinese immigrants in the U.S. *International Gambling Studies*.
<https://doi.org/10.1080/14459795.2019.1672767>
- Kong, G., Tsai, J., Pilver, C. E., Tan, H. S., Hoff, R. A., Cavallo, D. A., ... Potenza, M. N. (2013). Differences in gambling problem severity and gambling and health/functioning characteristics among Asian-American and Caucasian high-school students. *Psychiatry Research*, 210(3), 1071-1078. <https://doi.org/10.1016/j.psychres.2013.10.005>
- Lee, B. K. (2015). Towards a relational framework for pathological gambling (Part II): Congruence. *Journal of Family Therapy*, 37(1):103–118. <https://doi.org/10.1111/j.1467-6427.2012.00591.x>
- Lee, B. K. & Awosoga, O. (2015). Congruence couple therapy for pathological gambling: a pilot randomized controlled trial. *Journal of Gambling Studies*, 31(3):1047-1068. <https://doi.org/10.1007/s10899-014-9464-3>.
- Lee, B. K., Kellett, P., Seghal, K., & Van den Berg, C. (2018). Breaking the silence of racism injuries: a community-driven study. *International Journal of Migration, Health and Social Care*, 14(1):1-14. <https://doi.org/10.1108/IJMHS-01-2016-0003>
- Lee, K. W. (2018). Critical reflections on the “Myth of the Chinese Gambler”. In Lee, K. W. and Echeverri, N. (eds), *Macau and the Casino Complex*. Reno and Las Vegas, NV: University of Nevada Press.
- Lesieur, H. R., Cross, J., Frank, M., Welch, M., White, C. M., Rubenstein, G., ... Mark, M. (1991). Gambling and pathological gambling among university students. *Addictive Behaviors*, 16(6), 517-527. [https://doi.org/10.1016/0308-4603\(91\)90059-Q](https://doi.org/10.1016/0308-4603(91)90059-Q)
- Loo, J. M. Y., Raylu, N., & Oei, T. P. S. (2008). Gambling among the Chinese: a comprehensive review. *Clinical Psychology Review*, 28(7), 1152-1166. <https://doi.org/10.1016/j.cpr.2008.04.001>
- Marotta, J. (n.d.). Advertising and marketing practice. Boston, MA: Massachusetts Gaming Commission. Retrieved from <http://massgaming.com/wp-content/uploads/5-Advertising-and-Marketing-Practices.pdf>
- Marshall, G. N., Elliott, M. N., & Schell, T. L. (2009). Prevalence and correlates of lifetime disordered gambling in Cambodian refugees residing in Long Beach, CA. *Journal of Immigrant and Minority Health*, 11(1), 35–40. <https://doi.org/10.1007/s10903-007-9082-6>
- McComb, J. L., Lee, B. K., & Sprenkle, D. H. (2009). Conceptualizing and treating problem gambling as a family issue. *Journal of Marital and Family Therapy*, 35(4):415-431. <https://doi.org/10.1111/j.1752-0606.2009.00146.x>
- Oei, T. P. S., Raylu, N., & Loo, J. M. Y. (2019). Role of culture in gambling and gambling disorder. In A. Heinz, N. Romanczuk-Seiferth, & M. N., Potenza (Eds). *Gambling Disorder*. Cham, Switzerland: Springer.
- Papineau, E. (2013). The expansion of electronic gambling machines in China through anthropological and public health lenses. *Asian Journal of Gambling Issues and Public Health*, 3:3. <https://doi.org/10.1186/2195-3007-3-3>
- Peters, M. (2007, August 11). An Asian niche at Mohegan Sun. *Hartford Courant*. Retrieved from <https://www.courant.com/news/connecticut/hc-xpm-2007-08-11-0708110266-story.html>

- Petry, N. M., Armentano, C., Kuoch, T., Norinth, T., & Smith, L. (2003). Gambling participation and problems among South East Asian refugees to the United States. *Psychiatric Services*, 54(8), 1142–1148. <https://doi.org/10.1176/appi.ps.54.8>
- Raylu, N., & Oei, T. P. (2004). Role of culture in gambling and problem gambling. *Clinical Psychology Review*, 23(8), 1087-1114. <https://dx.doi.org/10.1016/j.cpr.2003.09.005>
- Reichel, D. & Morales, L. (2017). Surveying immigrants without sampling frames – evaluating the success of alternative field methods. *Comparative Migration Studies*, 5(1):1-22. <https://doi.org/10.1186/s40878-016-0044-9>
- Rinker, D. V., Rodriguez, L. M., Krieger, H., Tackett, J. L., & Neighbors C. (2016). Racial and ethnic differences in problem gambling among college students. *Journal of Gambling Studies*, 32(2), 581-90. <https://dx.doi.org/10.1007/s10899-015-9563-9>
- Simpson, D. (2006, August 1). US casino companies bet big on Asia and Asians. *Leisure Tourism*. Retrieved from <https://www.cabi.org/leisuretourism/news/15919>
- Smith, C. (2018, May 29). Ontario, Canada gaming campaign lures Chinese gamblers, despite indications of high risks for addiction. *Casino.org*. Retrieved from <https://www.casino.org/news/chinese-gamblers-targeted-in-new-ad-campaign-despite-public-health-warnings>
- Volberg, R. A., Nysse-Carris, K. L., & Gerstein, D. R. (2006). 2006 California problem gambling prevalence survey. Sacramento, CA: California Department of Alcohol and Drug Programs, Office of Problem and Pathological Gambling. Retrieved from https://www.standupca.org/reports/CA_Problem_Gambling_Prevalence_Survey-Final_Report.pdf
- Volberg, R. A., Munick, I. M., & Petry, N. M. (2011). A quick and simple screening method for pathological and problem gamblers in addiction programs and practices. *The American Journal on Addictions/American Academy of Psychiatrists in Alcoholism and Addictions*, 20(3),220-27. <https://doi.org/10.1111/j.1521-0391.2011.00118.x>
- Volberg, R. A., Williams, R. J., Stanek, E. J., Houpt, K. A., Zorn, M., & Rodriguez-Monguio, R. (2015). *Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey*. Amherst, MA: School of Public Health and Health Science, University of Massachusetts Amherst; 2015. Retrieved from www.umass.edu/seigma/sites/default/files/SEIGMA%20Baseline%20Survey%20Report_Final.pdf
- Walters, A. (2013, July 15). From China to U.S., the game of mahjong shaped modern America, says Stanford scholar: PhD candidate Annelise Heinz tracks the intersection of race and gender in 20th-century American culture through a study of the game of mahjong. *Stanford News*. Retrieved from <https://news.stanford.edu/news/2013/july/humanities-mahjong-history-071513.html>
- Welte, J. W., Barnes, G. M., Tidwell, M. C. O., & Hoffman, J. H. (2011). Gambling and problem gambling across the lifespan. *Journal of Gambling Studies*, 27(1), 49–61. <https://doi.org/10.1007/s10899-010-9195-z>.
- Welte, J. W., Barnes, G. M., Wiczorek, W.F., Tidwell, M. C., & Parker, J. C. (2004). Risk factors for pathological gambling. *Addictive Behaviors*, 29(2), 323–335. <https://doi.org/10.1016/j.addbeh.2003.08.007>
- Wong, C., Hosotani, H., & Her, J. (2012). *Information on Small Populations with Significant Health Disparities: A Report on Data Collected on the Health of Asian Americans in*

- Massachusetts. Boston, M.A.: Institute of Asian American Studies, University of Massachusetts Boston. Retrieved from http://scholarworks.umb.edu/iaas_pubs/33
- Wong, C., & Wu, H. C. (2019). Gambling behavior of ethnic Chinese and Vietnamese college students in the United States. *International Gambling Studies*.
<https://doi.org/10.1080/14459795.2019.1646779>
- Wu A., & Lau J.T. (2015). Gambling in China: socio-historical evolution and current challenges. *Addiction* 110:210–6.
- Ying, Y. W., & Miller, L.S. (1992). Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, 20(4), 549-56.
- United States Chamber of Commerce Foundation. (2019). Corporate social responsibility in the gaming industry. Washington, DC: United States Chamber of Commerce Foundation & American Gaming Association. Retrieved from
https://www.uschamberfoundation.org/sites/default/files/CSR_Gaming_Industry_Report.pdf

Appendix: Interview Questions

Interview Question for Persons Who Gambles

- 1) When did you start (a. to gamble b. going to the casino?)
- 2) How often do you go to the casino?
- 3) When you don't go to the casino, where else do you do for fun?
- 4) How do you know this information about the casino?
- 5) What do you think about gambling? What does it do to you?
- 6) Does your family know about this? How do they feel about it?

Family Members

- 1) How did you find out about the gambling of your family member?
- 2) What are the signs that make you aware that your family is gambling?
- 3) Have you tried to stop him/her from gambling? If not, why? If yes, what did you do?
- 4) What do you think why he/she goes to gamble? (the purpose of gambling)

Additional questions for All Participants

1. When the new casino opens, will you go check it out?
2. When the casino is opened close to Boston, do you think it will affect a lot of Chinese people?
3. Are there advantages or disadvantages of opening the new casino? Which is greater, the advantages or disadvantages?
4. For people who indicated they have trouble controlling their gambling: Do you know about people or programs who help you quit? If you want to see a counselor, can we help you find one ?
5. Do you have anything you would like to add?

Treatment Services Gap Analysis: Gambling Treatment Capability Gaps

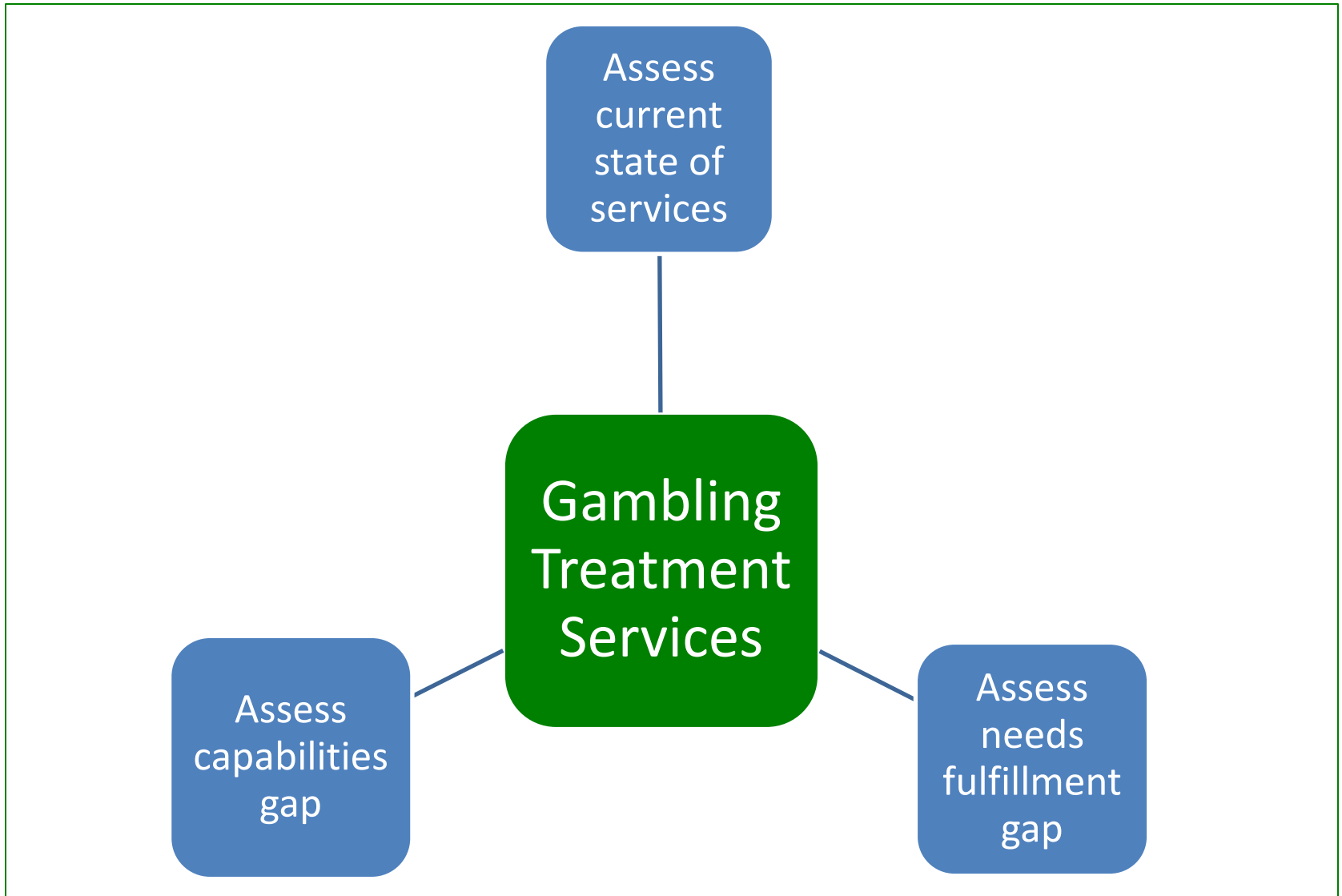
*Division on Addiction, Cambridge Health Alliance
Harvard Medical School*

*Presentation at the PHTF Executive Committee Meeting
November 18, 2019*

Rationale for the Gap Analysis



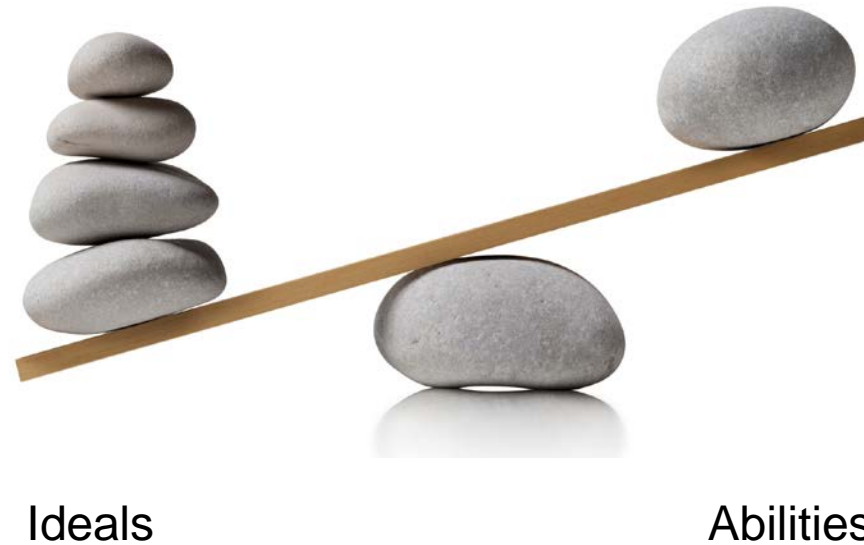
Framework for the Gap Analysis



Ideal versus Actual Abilities

TREATMENT CAPABILITY GAP ANALYSIS

Purpose & Goal of the Capabilities Gap Assessment



Identifying the Domains of Interest

- Goal: To work with OPGS to determine key areas of interest for understanding gap
- Participatory research process via electronic interview
 - Modified version of the *Index of Training Needs* (Hall et al., 1997)
 - OPGS reported level of interest for all possible capability domains
 - No interest, Very little interest, Moderate interest, Considerable interest, Maximum interest

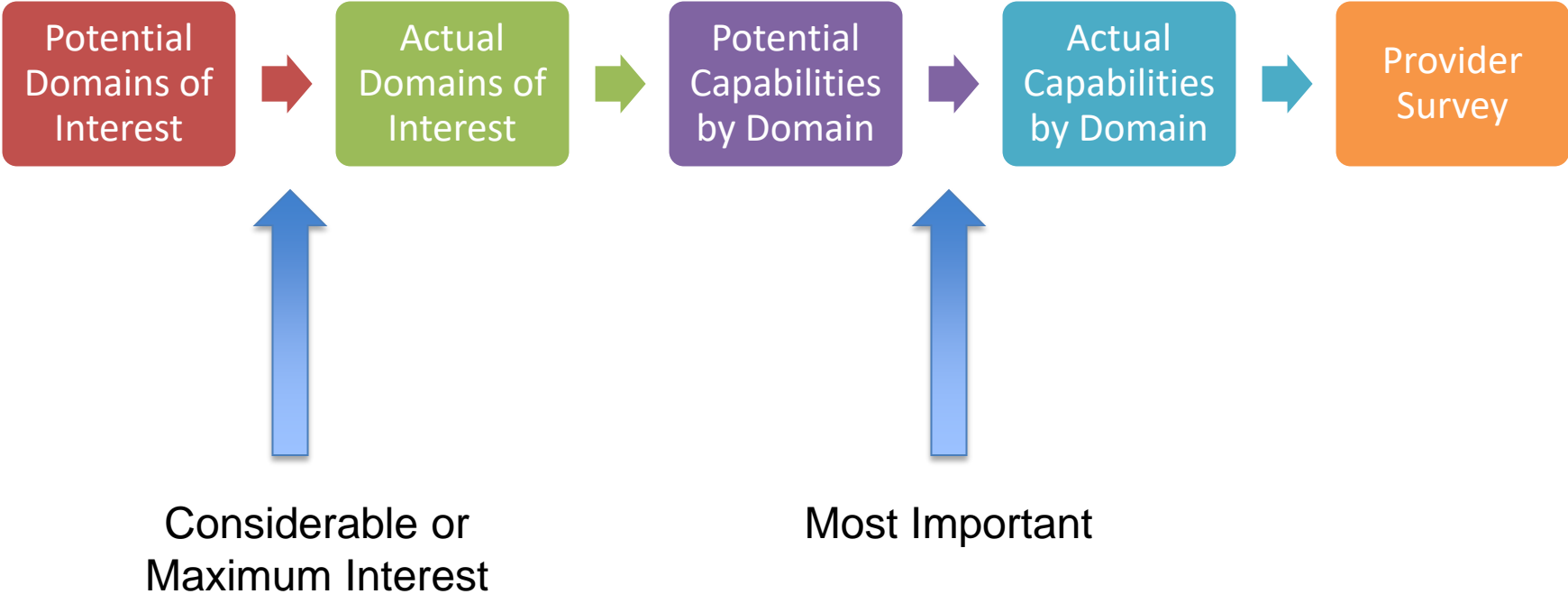
Domains of Interest

- Providers' understanding of the relationship between gambling and other mental health problems
- Screening for gambling
- Assessment for gambling
- Diagnosis for gambling
- Providers interest in treatment gambling-related problems
- Treatment process skills
- Therapy organization and movement skills
- Intervention skills
- Providers' understanding of: (1) addiction to gambling, (b) theoretical models of Gambling Disorder, and (c) signs and symptoms of Gambling Disorder
- Treatment techniques
- Ability to make referrals for gambling
- Interpersonal process skills
- Perceived BSAS support for addressing gambling
- Perceived DPH support for addressing gambling
- Special populations
- Treatment administration skills
- Current training history for gambling
- Anticipated training for gambling
- Perceived organizational support for addressing gambling
- Massachusetts Problem Gambling Specialist certification
- Other gambling-related certification

Identifying Capabilities of Interest

- Goal: To work with OPGS to determine what clinical capabilities it expects of providers for the key domains of interest
- Participatory research process via electronic interview
 - For “All BSAS Providers” and “BSAS Providers who Treat Gambling” OPGS indicated the level of importance of specific capabilities
 - Not important, Important, Most Important

Survey Development Process Summary



Survey Procedure Summary

- BSAS helped identify a convenience sample of 226 providers from 27 organizations contracted to provide gambling treatment services for DPH
- Two-waves of data collection (i.e., summer 2018 & fall 2018) yielded our sample
 - 161 (71%) opened e-survey
 - 153 (68%) consented
 - 135 (60%) completed more than 1-2 questions

Respondent Characteristics

- Worked as BSAS-affiliated provider 8.2 (SD=7.7) years
- Worked in current position 5.5 (SD=5.5) years
- 84.4% reported highest level of education was Master's Degree

Description (N=135)	n	%
MA-PGS certified	32	23.7%
ICGC certified	2	1.5%
CAS w/ gambling specialization	2	1.5%
Have treated a client for gambling at current job	69	51.1%
Client with gambling problems might be assigned to me	42	31.1%
Have treated a client for gambling in private practice	9	6.7%
None of the above	42	31.1%

Screening for Gambling

BSAS Providers Who Treat Gambling

Providers should be able to identify specific brief screens for gambling-related problems from a list	51.2% ✓
Providers should be able to generate a list of specific screens for gambling-related problems	23.4% ✓
Providers should be able to identify specific screens for gambling-related problems from a list	59.7% ✓
Providers should consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening	90.9%

Note. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

Providers should be able to list at least one specific brief screen for gambling-related problems	24.6% ✓
	3.0% ✓
Providers should report that they at least occasionally screen their clients for gambling-related problems	65.0%
	63.7%
Providers should report that they always screen their clients for gambling-related problems	48.1%
	27.3%

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

Assessment for Gambling

BSAS Providers Who Treat Gambling

Providers should consistently complete an assessment of those clients who screen positive for gambling-related problems	58.5%
Providers should consistently screen clients for other disorders if they screen positive for gambling-related problems	74.1%
Providers should consistently assess clients who screen positive for gambling-related problems for readiness to change	67.6%
Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery	72.8%

Note. Percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

- None specified

Diagnosis for Gambling

BSAS Providers Who Treat Gambling

Providers should use gambling history information as part of diagnostic decision-making related to gambling	81.9%
Providers should screen for current physiological and mental state of clients, in conjunction with the DSM-5 as part of diagnostic decision-making related to gambling	83.2%

Note. Percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making related to gambling	67.6%
	39.4%

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Percentages indicate percent who agree or strongly agree with a statement.

Treatment Process Skills

BSAS Providers Who Treat Gambling

- None specified

All BSAS Providers

Providers should be aware of cultural factors that could influence the gambling treatment process	(1) Coping styles; (2) Tendency toward help-seeking; (3) Purpose and understanding of gambling
	(1) Purpose and understanding of gambling; (2) Tendency toward help-seeking; (3) coping styles
Providers should adapt their treatment for cultural factors that could influence the gambling treatment process	(1) Considered the client's psychosocial environment; (2) Actively monitored own biases and stigma; (3) Examined how social status might impact clinical relationship
	(1) Considered the clients' psychosocial environment; (2) Actively monitored own biases and stigma; (3) Inquired about cultural identity to inform diagnosis; (4) Examined how social status might impact clinical relationship

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Listed items are most endorsed items for each group.

Intervention Skills

BSAS Providers Who Treat Gambling

Providers should understand that Gambling Disorder is associated with experiences of self-harm	58.4% ✓
--	----------------

Note. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

Providers should know when and how to intervene in life crisis situations	(1) Determine whether client has a history of self-harm; (2) Determine whether the client has a plan; (3) Determine whether the client has access to a means for self-harm
	(1) Determine the nature and persistence of the harmful thoughts; (2) Determine whether the client has a plan; (3) Determine whether the client has access to a means for self-harm; (4) Determine whether the client has a history of self-harm; (5) Set up a follow-up plan if not at imminent risk

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Listed items are most endorsed items for each group.

Treatment Techniques

BSAS Providers Who Treat Gambling

- None specified

All BSAS Providers

Providers should be aware of the DPH Treatment Guidelines manual	---
	15.1%
Providers should be able to list evidence-based practices for treating Gambling Disorder	66.0% ✓
	57.6% ✓

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

Ability to Make Referrals for Gambling

BSAS Providers Who Treat Gambling

- None specified

All BSAS Providers

Providers should be able to refer clients to the Gambling Helpline	67.6%
	39.4%
Providers should know who in their organization (if anyone) is a gambling specialist	67.5%
	39.4%

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Percentages indicate percent who agree or strongly agree with a statement.

Special Populations

BSAS Providers Who Treat Gambling

Providers should be able to report that race and ethnicity is associated with risk for gambling-related problems	68.8%
Providers should report that they take race and ethnicity into account for gambling-related treatment planning	49.4%

Note. Percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

Providers should be able to report that Intimate Partner Violence (IPV) perpetrators are at increased risk for gambling-related problems	41.6%
	27.3%
Providers should report that they take IPV into account for gambling-related treatment planning	48.1%
	27.3%
Providers should report that they take Veteran status into account for gambling-related treatment planning	37.7%
	24.3%

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Percentages indicate percent who agree or strongly agree with a statement.

Treatment Administration Skills

BSAS Providers Who Treat Gambling

- None specified

All BSAS Providers

Providers should keep records, as required	98.7% ✓
	81.3% ✓
Providers should protect the privacy of patients, as required	(1) Implemented privacy policies and procedures; (2) Developed privacy policies and procedures; (3) Implemented workforce training related to client privacy
	(1) Developed privacy policies and procedures; (2) Implemented privacy policies and procedures; (3) Implemented workforce training related to client privacy
Providers should understand HIPAA, such that patients are protected accordingly	42.5% * ✓
	57.6% * ✓

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

** = also endorsed wrong responses at a high rate.*

Current Training History for Gambling

BSAS Providers Who Treat Gambling

Providers should have a history of attending at least one gambling training	66.2% ✓
---	---------

Note. Check marks indicate percentages who completed a given action. Other percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

- None specified

Perceived Organizational Support for Addressing Gambling

BSAS Providers Who Treat Gambling

Providers should indicate that their organization reimburses for participation in gambling-related training	49.4%
---	--------------

Note. Percentages indicate percent who agree or strongly agree with a statement.

All BSAS Providers

Providers should indicate that their organization provides them time to participate in gambling-related training	75.0%
	48.5%
Providers should indicate that their organization provides time to complete gambling-related screening	53.3%
	34.0%
Providers should indicate that their organization provides time to treat clients' gambling-related problems	68.9%
	60.6%

Note. Light cells are responses from providers who treat gambling; dark cells are responses from providers who do not treat gambling. Percentages indicate percent who agree or strongly agree with a statement.

Self-perceived Capabilities

Capabilities	% Endorsing BSAS Providers who Treat Gambling	% Endorsing All Other BSAS Providers
I am prepared to handle such situations right away *	50.6	3.0
I feel most comfortable referring clients with such issues to someone else *	24.7	48.5
I have too many other things to consider adding gambling-related problems into the mix *	1.3	12.1
I need more training about screening for gambling *	41.6	78.8
I need more training about evidence-based practices for gambling *	49.4	69.7
I am concerned that I will see more gambling-related problems among my patients because of gambling expansion	32.5	21.2
Gambling-related problems are rare, so I don't expect to have this be a common issue	3.9	3.0

* = statistically significant difference between groups; $p < .05$.

Exploratory Comparisons: MA-PGS Status

- MA-PGS were more likely than others to:
 - Report that one can list a brief gambling screen
 - Always screen for gambling-related problems
 - Always use DSM-5 Gambling Disorder as part of diagnostic decision-making
 - Report they know who to refer to the helpline
 - Know a gambling specialist in their organization
 - Report their organization would support screening, treatment, and training for gambling

Cross-analysis Perspectives and Considerations

COMBINED GAP ANALYSIS RECOMMENDATIONS

State of Services
Recommendations

**Overlapping
Recommendation Domains**

Screening & Assessment
Practice Guidelines & Training
Vulnerable Populations
Data & Infrastructure
Helpline & MA-PGS

Capabilities
Recommendations

Treatment Need
Recommendations

State of Services Recommendations

- Target gambling treatment expansion to southeastern MA, Cape Cod, and Worcester
- Provide information about validated gambling assessments to all BSAS-affiliated substance use programs
- Continue to update and publicize the BSAS Practice Guidelines for gambling treatment
- Provide information through the Helpline on full range of gambling treatment services in client's area
- Have the Helpline adopt a warm handoff approach to treatment
- Incorporate a single validated gambling screening tool in all BSAS-affiliated substance use programs
- Collect comprehensive information about gambling screening, referral, and treatment from all BSAS-affiliated programs
- Create and maintain a database of gambling treatment services and MA-PGS certified providers
- Implement a data system for the Helpline to collect information from gambling providers about fulfillment of referrals

Screening & Assessment Recommendations

- Apply the adjusted treatment need algorithm to assess treatment need in MA once data are available
- Add questions to the planned SEIGMA follow-up surveys to measure variables related to treatment need
- Adopt a universal non-pejorative labeling system for individuals' gambling-related problems by severity
- Implement studies of at-risk populations with potential unique treatment need experiences
- Convene a meeting of researchers with experience studying gambling in MA to discuss state of currently available data and possible approaches to assessing treatment need

Treatment Capacity Recommendations

- Provide gambling screening education to specialists and non-specialists
- Integrate gambling screening into BSAS-affiliated treatment protocols
- Provide training to advance from gambling screening to assessment
- Provide feedback to increase knowledge and use of robust diagnostic decision-making practices
- Evaluate the prevalence and nature of cultural and individual differences among BSAS clients
- Deliver training related to culturally informed gambling treatment
- Support a gambling and suicide initiative
- Update and expand the BSAS Practice Guidelines
- Promote the Helpline and other immediately available resources
- Encourage BSAS-affiliated programs to maintain a gambling specialist on staff
- Develop a training agenda to better understand at-risk groups and begin outreach to groups that serve these populations
- Reinforce good treatment administration practice
- Conduct interviews with BSAS-affiliated program representatives to identify barriers to supporting gambling-related training
- Provide participation incentives for gambling-related training to providers and organizations
- Conduct clinical trainings related to gambling screening and evidence-based treatment
- Conduct interviews with BSAS-affiliated providers to assess training interest and need
- Engage in provider awareness campaign about similarities in substance use disorder and gambling disorder assessment, treatment, and resources
- Promote MA-PGS certification

State of Services Recommendations

- Target gambling treatment expansion to southeastern MA, Cape Cod, and Worcester
- Provide information about validated gambling assessments to all BSAS-affiliated substance use programs
- Continue to update and publicize the BSAS Practice Guidelines for gambling treatment
- Provide information through the Helpline on full range of gambling services in a client's area
- Have the Helpline adopt a warm handoff approach to treatment
- Incorporate a single validated gambling screening instrument in all BSAS-affiliated substance use programs
- Collect comprehensive information about gambling screening, referral, and treatment from all BSAS-affiliated programs
- Create and maintain a database of gambling treatment services and MA-PGS certified providers
- Implement a data system for the Helpline to collect information from gambling treatment services and providers about fulfillment of referrals

Practice Guidelines & Needs Assessment Recommendations

- Apply the adjusted treatment need algorithm to assess treatment need in MA once data are available
- Add questions to the planned SEIGMA follow-up surveys to measure variables related to treatment need
- Adopt a universal non-pejorative labeling system for individuals' gambling-related problems by severity
- Implement studies of at-risk populations with potential unique treatment need experiences
- Convene a meeting of researchers with experience studying gambling in MA to discuss state of currently available data and possible approaches to assessing treatment need

Treatment Capacity Recommendations

- Provide gambling screening education to specialists and non-specialists
- Integrate gambling screening into BSAS-affiliated treatment protocols
- Provide training to advance from gambling screening to assessment
- Provide feedback to increase knowledge and use of robust diagnostic decision-making practices
- Evaluate the prevalence and nature of cultural and individual differences among BSAS clients
- Deliver training related to culturally informed gambling treatment
- Support a gambling and suicide initiative
- Update and expand the BSAS Practice Guidelines
- Promote the Helpline and other immediately available resources
- Encourage BSAS-affiliated programs to maintain a gambling specialist on staff
- Develop a training agenda to better understand at-risk groups and begin outreach to groups that serve these populations
- Reinforce good treatment administration practice
- Conduct interviews with BSAS-affiliated program representatives to identify barriers to supporting gambling-related training
- Provide participation incentives for gambling-related training to providers and organizations
- Conduct clinical trainings related to gambling screening and evidence-based treatment
- Conduct interviews with BSAS-affiliated providers to assess training interest and need
- Engage in provider awareness campaign about similarities in substance use disorder and gambling disorder assessment, treatment, and resources
- Promote MA-PGS certification

State of Services Recommendations

- Target gambling treatment expansion to southeastern MA, Cape Cod, and Worcester
- Provide information about validated gambling assessments to all BSAS-affiliated substance use programs
- Continue to update and publicize the BSAS Practice Guidelines for gambling treatment
- Provide information through the Helpline on full range of gambling services in a client's area
- Have the Helpline adopt a warm handoff approach to treatment
- Incorporate a single validated gambling screening instrument in all BSAS-affiliated substance use programs
- Collect comprehensive information about gambling screening, referral, and treatment from all BSAS-affiliated programs
- Create and maintain a database of gambling treatment services and MA-PGS certified providers
- Implement a data system for the Helpline to collect information from gambling treatment services and providers about fulfillment of Helpline Services

Vulnerable Populations Recommendations

- Apply the adjusted treatment need algorithm to assess treatment need in MA once data are available
- Add questions to the planned SEIGMA follow-up surveys to measure variables related to treatment need
- Adopt a universal non-pejorative labeling system for individuals' gambling-related problems by severity
- Implement studies of at-risk populations with potential unique treatment need experiences
- Convene a meeting of researchers with experience studying gambling in MA to discuss state of currently available data and possible approaches to assessing treatment need

Treatment Capacity Recommendations

- Provide gambling screening education to specialists and non-specialists
- Integrate gambling screening into BSAS-affiliated treatment protocols
- Provide training to advance from gambling screening to assessment
- Provide feedback to increase knowledge and use of robust diagnostic decision-making practices
- Evaluate the prevalence and nature of cultural and individual differences among BSAS clients
- Deliver training related to culturally informed gambling treatment
- Support a gambling and suicide initiative
- Update and expand the BSAS Practice Guidelines
- Promote the Helpline and other immediately available resources
- Encourage BSAS-affiliated programs to maintain a gambling specialist on staff
- Develop a training agenda to better understand at-risk groups and begin outreach to groups that serve these populations
- Reinforce good treatment administration practice
- Conduct interviews with BSAS-affiliated program representatives to identify barriers to supporting gambling-related training
- Provide participation incentives for gambling-related training to providers and organizations
- Conduct clinical trainings related to gambling screening and evidence-based treatment
- Conduct interviews with BSAS-affiliated providers to assess training interest and need
- Engage in provider awareness campaign about similarities in substance use disorder and gambling disorder assessment, treatment, and resources
- Promote MA-PGS certification

State of Services Recommendations

- Target gambling treatment expansion to southeastern MA, Cape Cod, and Worcester
- Provide information about validated gambling assessments to all BSAS-affiliated substance use programs
- Continue to update and publicize the BSAS Practice Guidelines for gambling treatment
- Provide information through the Helpline on full range of gambling services in a client's area
- Have the Helpline adopt a warm handoff approach to treatment
- Incorporate a single validated gambling screening instrument in all BSAS-affiliated substance use programs
- Collect comprehensive information about gambling screening, referral, and treatment from all BSAS-affiliated programs
- Create and maintain a database of gambling treatment services and MA-PGS certified providers
- Implement a data system for the Helpline to collect information from gambling treatment services and providers about fulfillment of Helpline Services

Data & Assessment Needs & Recommendations

- Apply the adjusted treatment need algorithm to assess treatment need in MA once data are available
- Add questions to the planned SEIGMA follow-up surveys to measure variables related to treatment need
- Adopt a universal non-pejorative labeling system for individuals' gambling-related problems by severity
- Implement studies of at-risk populations with potential unique treatment need experiences
- Convene a meeting of researchers with experience studying gambling in MA to discuss state of currently available data and possible approaches to assessing treatment need

Treatment Capacity Recommendations

- Provide gambling screening education to specialists and non-specialists
- Integrate gambling screening into BSAS-affiliated treatment protocols
- Provide training to advance from gambling screening to assessment
- Provide feedback to increase knowledge and use of robust diagnostic decision-making practices
- Evaluate the prevalence and nature of cultural and individual differences among BSAS clients
- Deliver training related to culturally informed gambling treatment
- Support a gambling and suicide initiative
- Update and expand the BSAS Practice Guidelines
- Promote the Helpline and other immediately available resources
- Encourage BSAS-affiliated programs to maintain a gambling specialist on staff
- Develop a training agenda to better understand at-risk groups and begin outreach to groups that serve these populations
- Reinforce good treatment administration practice
- Conduct interviews with BSAS-affiliated program representatives to identify barriers to supporting gambling-related training
- Provide participation incentives for gambling-related training to providers and organizations
- Conduct clinical trainings related to gambling screening and evidence-based treatment
- Conduct interviews with BSAS-affiliated providers to assess training interest and need
- Engage in provider awareness campaign about similarities in substance use disorder and gambling disorder assessment, treatment, and resources
- Promote MA-PGS certification

State of Services Recommendations

- Target gambling treatment expansion to southeastern MA, Cape Cod, and Worcester
- Provide information about validated gambling assessments to all BSAS-affiliated substance use programs
- Continue to update and publicize the BSAS Practice Guidelines for gambling treatment
- Provide information through the Helpline on full range of gambling services in a client's area
- Have the Helpline adopt a warm handoff approach to treatment
- Incorporate a single validated gambling screening instrument in all BSAS-affiliated substance use programs
- Collect comprehensive information about gambling screening, referral, and treatment from all BSAS-affiliated programs
- Create and maintain a database of gambling treatment services and MA-PGS certified providers
- Implement a data system for the Helpline to collect information from gambling treatment services and providers about fulfillment of Helpline Services

Helpline & MA-PGS Recommendations

- Apply the adjusted treatment need algorithm to assess treatment need in MA once data are available
- Add questions to the planned SEIGMA follow-up surveys to measure variables related to treatment need
- Adopt a universal non-pejorative labeling system for individuals' gambling-related problems by severity
- Implement studies of at-risk populations with potential unique treatment need experiences
- Convene a meeting of researchers with experience studying gambling in MA to discuss state of currently available data and possible approaches to assessing treatment need

Treatment Capacity Recommendations

- Provide gambling screening education to specialists and non-specialists
- Integrate gambling screening into BSAS-affiliated treatment protocols
- Provide training to advance from gambling screening to assessment
- Provide feedback to increase knowledge and use of robust diagnostic decision-making practices
- Evaluate the prevalence and nature of cultural and individual differences among BSAS clients
- Deliver training related to culturally informed gambling treatment
- Support a gambling and suicide initiative
- Update and expand the BSAS Practice Guidelines
- Promote the Helpline and other immediately available resources
- Encourage BSAS-affiliated programs to maintain a gambling specialist on staff
- Develop a training agenda to better understand at-risk groups and begin outreach to groups that serve these populations
- Reinforce good treatment administration practice
- Conduct interviews with BSAS-affiliated program representatives to identify barriers to supporting gambling-related training
- Provide participation incentives for gambling-related training to providers and organizations
- Conduct clinical trainings related to gambling screening and evidence-based treatment
- Conduct interviews with BSAS-affiliated providers to assess training interest and need
- Engage in provider awareness campaign about similarities in substance use disorder and gambling disorder assessment, treatment, and resources
- Promote MA-PGS certification

Summary of Combined Recommendations

➤ Screening & Assessment

- Increase training about gambling screening and assessment, and implement a single validated gambling screening instrument to be used across all BSAS-affiliated programs.

➤ Practice Guidelines & Training

- Build provider awareness of the potential for clinical skill transfer for gambling treatment by offering clinical training opportunities that highlight available resources, reflect up-to-date practice and screening guidelines, and proactively address both potential barriers to engagement and provider interests and needs.

Summary of Combined Recommendations

➤ Vulnerable Populations

- Target research, professional development, and treatment expansion to people who might be vulnerable to gambling problems on the basis of their age, cultural background, mental health, or geography.

➤ Data & Infrastructure

- Collect comprehensive, statewide information about treatment need and current services to inform future decisions; create a data infrastructure to link gambling providers, programs, and the Helpline and track referrals and intakes.

Summary of Combined Recommendations

- Helpline & MA-PGS
 - Promote Helpline and MA-PGS certification to all BSAS-affiliated programs; work toward wider sharing of potential resources and referrals and more direct referrals through the Helpline.

Thank You

Debi LaPlante
Sarah Nelson
Heather Gray

<http://www.divisiononaddiction.org/>

MADPH Problem Gambling Performance Snapshot

August 21st, 2019

Report #3 of 3 - Final

thinkargus

work that matters.

Strategy Recap

Parameters

Objectives:

- Promote problem gambling awareness.
- Drive traffic to mass.gov landing page for more information.

Target Audience:

- Primary: Men 35-55, African American & Latino
- English and Spanish language version ads

Geography:

- Massachusetts
- Fall River/New Bedford
- Springfield

Flight Dates:

- June 24-August 18, 2019

Media:

- Digital: Pre-Roll, YouTube & Facebook
- Transit: Bus Kings & ICCs

Overall Campaign Snapshot

Digital Delivery Snapshot: Overview

The Problem Gambling digital campaign delivered 4,231,307 million impressions across all tactics.

- 13,728 clicks delivered an overall Click-Through-Rate of .32%
- Strong deliveries across all tactics.

Tactic	Line Item	Impressions	Clicks	CTR
YouTube	English	1,177,731	1008	0.09%
	Spanish	370,722	351	0.09%
PreRoll	English	1,038,180	2132	0.21%
	Spanish	218,441	274	0.13%
Facebook	English	770,282	5174	0.67%
	Spanish	655,951	4789	0.73%
		4,231,307	13,728	0.32%

Digital Snapshot: Pre-Roll

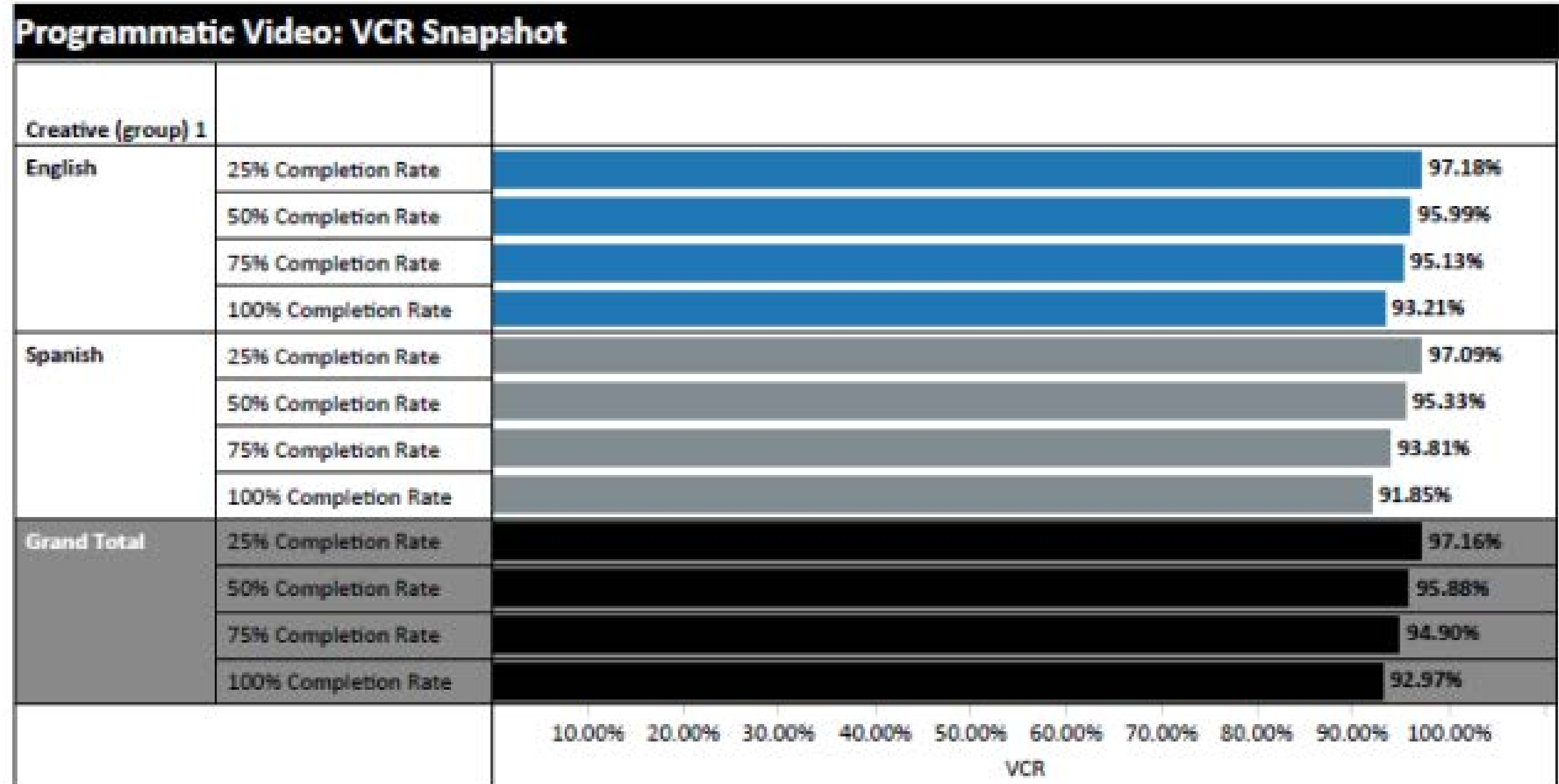
The Problem Gambling campaign delivered 1,256,621 pre-roll impressions.

- 92.97% viewed the video to 100%.
- CTR of .19%.
- Pre-roll consistently delivered strong video completion rates and CTR throughout the duration of the campaign.

* VCR = Video Completion Rate

Programmatic Overview Snapshot						
IO Tactic - Placement	Impressions	Clicks	CTR	Video Plays	Video Complete Plays	100% Completion Rate
Added Value - Video Make Good	365,472	573	0.16%	364,485	340,579	93.44%
Video	891,149	1,833	0.21%	890,015	825,772	92.78%
Grand Total	1,256,621	2,406	0.19%	1,254,500	1,166,351	92.97%

Programmatic Creative Snapshot						
Creative (group)	Impressions	Clicks	CTR	Video Plays	Video Complete Plays	100% Completion Rate
English	1,038,180	2,132	0.21%	1,036,444	966,069	93.21%
Spanish	218,441	274	0.13%	218,056	200,282	91.85%
Grand Total	1,256,621	2,406	0.19%	1,254,500	1,166,351	92.97%



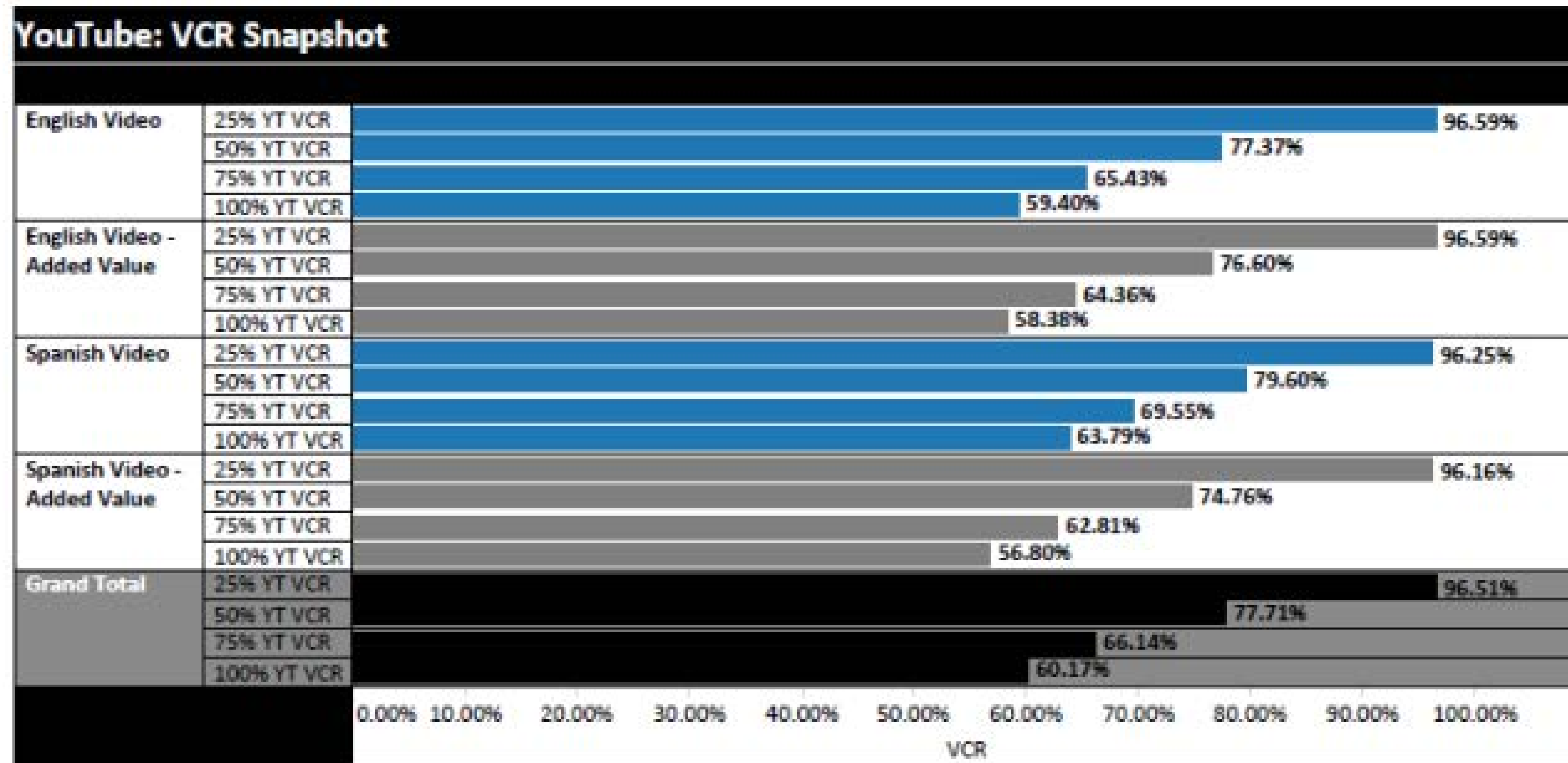
Digital Snapshot: YouTube

The Problem Gambling campaign has delivered 1,548,453 YouTube impressions.

- 60.17% viewed the video to 100%.
 - 59.40% viewed English language video to 100%.
 - 63.79% viewed Spanish language video to 100%.
 - Campaign held steady with an overall CTR of .09.

* VCR = Video Completion Rate

YouTube Overview Snapshot										
Line Item	Impressions	Clicks	CTR	TrueView: Views	View Rate	Earned Likes	Earned Playlist Additions	Earned Shares	Earned Subscribers	Earned Views
English Video	1,062,078	914	0.09%	643,340	60.57%	0	0	0	0	0
English Video - Added Value	115,653	94	0.08%	68,865	59.54%	0	0	0	0	0
Spanish Video	325,903	309	0.09%	210,052	64.45%	0	0	0	0	0
Spanish Video - Added Value	44,819	42	0.09%	25,645	57.22%	0	0	0	0	0
Grand Total	1,548,453	1,359	0.09%	947,902	61.22%	0	0	0	0	0



Digital Snapshot: Facebook

Campaign Name	Impressions	Clicks (All)	Link Clicks	CTR	Post Comments	Post Reactions	Post Shares	Page Likes
MA DPH Problem Gambling Q3 2019 - SPA	655,951	7,678	4,789	0.73	17	276	110	
MA DPH Problem Gambling Q3 2019 - ENG	770,282	7,899	5,174	0.67	22	248	81	
Totals	1,426,233	15,577	9,963	0.70	39	524	191	

Campaign Name	3-Second Video Views	10-Second Video Views	Video Watches at 25%	Video Watches at 50%	Video Watches at 75%	Video Watches at 95%	Video Watches at 100%
MA DPH Problem Gambling Q3 2019 - SPA	104,800	30,035	55,301	26,557	16,400	12,023	11,439
MA DPH Problem Gambling Q3 2019 - ENG	99,986	27,095	54,380	25,500	16,080	12,791	12,169
Totals	204,786	57,130	109,681	52,057	32,480	24,814	23,608

The Problem Gambling campaign delivered 1,426,233 Facebook impressions with CTR delivering at 0.70%.

Google Analytics Snapshot

3

GA Placement Overview

Video	Placement	Total Sessions	% New Sessions	Avg. Session Duration	Total Users	New Users	% New Users	Page Views	Unique Page Views	Avg. Time Spent on Page
English	Preroll :15	2,031	74.69%	0:06	1,571	1,515	96.44%	2,411	2,031	0:34
	Social :15	1,300	81.23%	0:37	1,219	1,056	86.63%	1,490	1,327	4:15
	Social :30	1,625	80.00%	0:03	1,463	1,300	88.86%	1,733	1,652	0:48
	YouTube :15	650	79.23%	0:15	623	515	82.66%	975	840	0:30
Spanish	Preroll :15	352	38.55%	0:39	271	135	49.82%	596	515	0:56
	Social :15	1,408	96.16%	0:05	1,354	1,354	100.00%	1,544	1,436	0:56
	Social :30	1,761	76.89%	0:02	1,598	1,354	84.73%	1,842	1,788	0:47
	YouTube :15	244	88.93%	0:00	217	217	100.00%	244	244	0:00
Totals		9,371	79.48%	0:11	8,316	7,446	93.55%	10,835	9,833	1:09

The Problem Gambling campaign delivered 9,371 total sessions to the landing page.

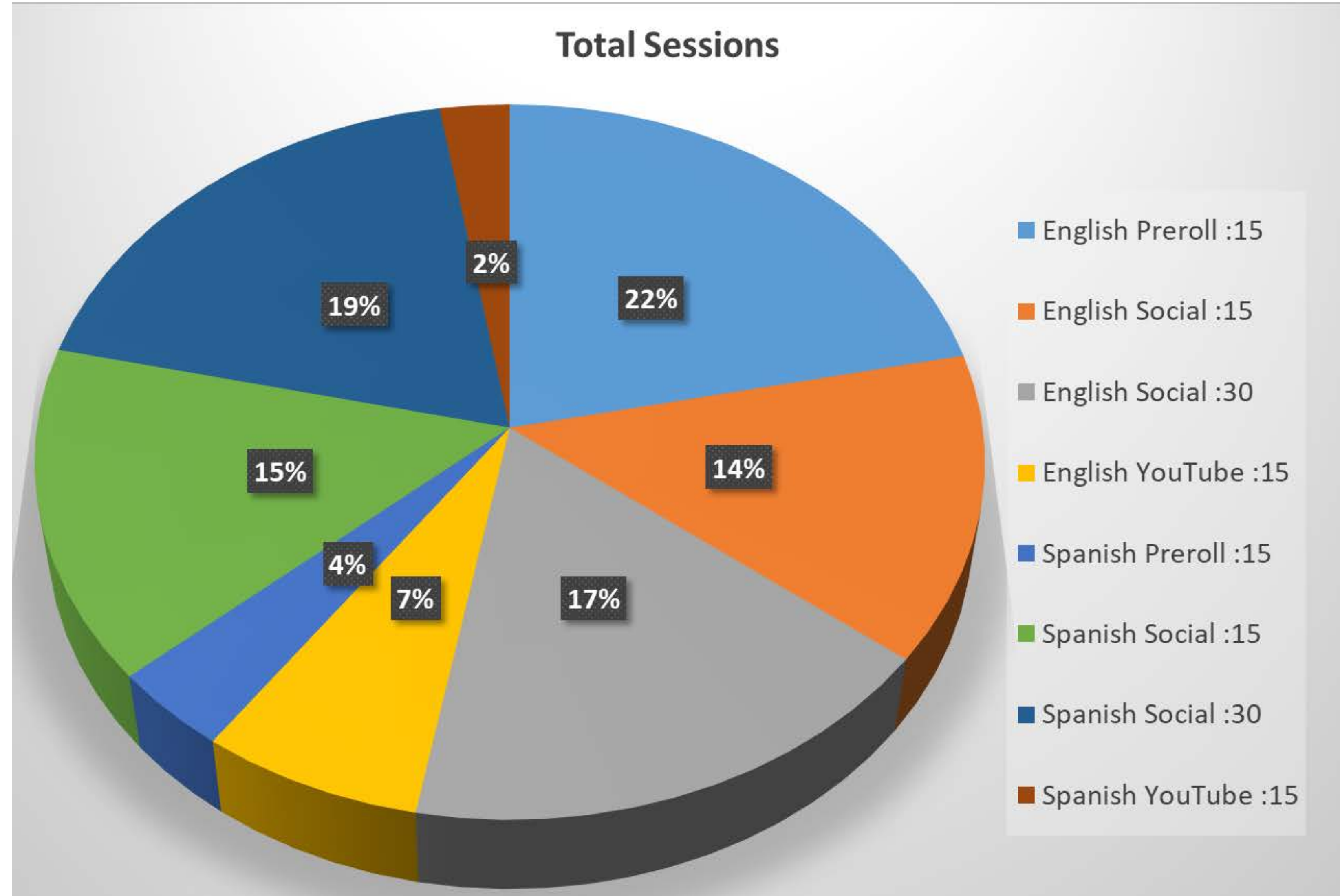
- 7,446 of sessions were new sessions, with 93.55% of new users attributable to the Problem Gambling Campaign.
 - Our agency standard for new sessions is 70% - 80% range for both Video and Social tactics.
- Time spent on page was 1:09, which showed an uptick from previous reporting period.

GA Overview: Traffic Source

Language	Placement	Total Sessions	% New Sessions
English	Preroll :15	2,031	74.69%
	Social :15	1,300	81.23%
	Social :30	1,625	80.00%
	YouTube :15	650	79.23%
Spanish	Preroll :15	352	38.55%
	Social :15	1,408	96.16%
	Social :30	1,761	76.89%
	YouTube :15	244	88.93%
Totals		9,371	85.90%

Social placements attributed to the largest number of sessions.

- 3,169 sessions were attributable to Spanish language ads on Facebook.
- 2,925 sessions were attributable to English language ads on Facebook.

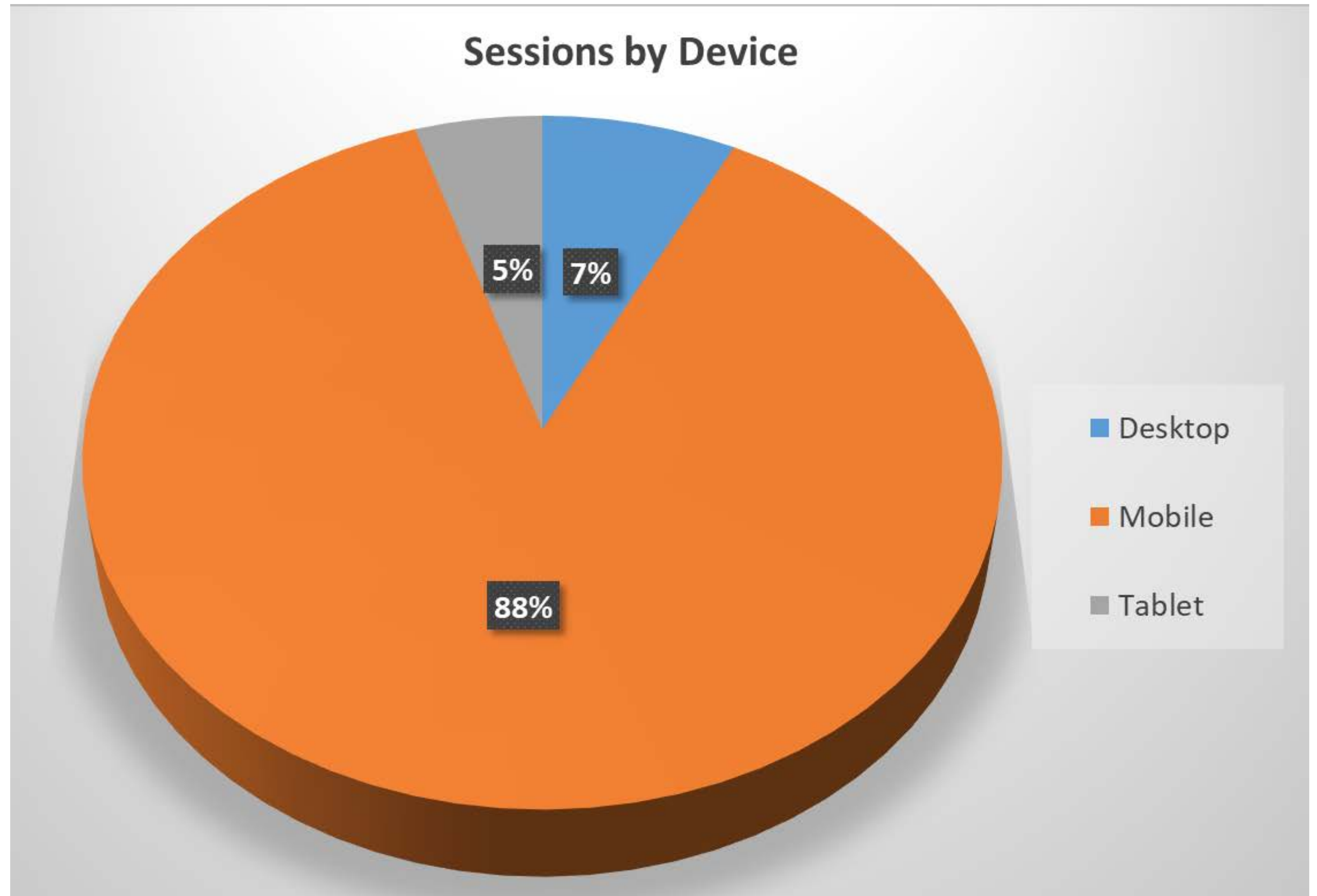


GA Overview: Session Device Usage

	Sessions
Desktop	704
Mobile	8207
Tablet	460

Mobile drove 88% of sessions to the Problem Gambling campaign.

- 7% were desktop sessions.
- 5% were tablet sessions.

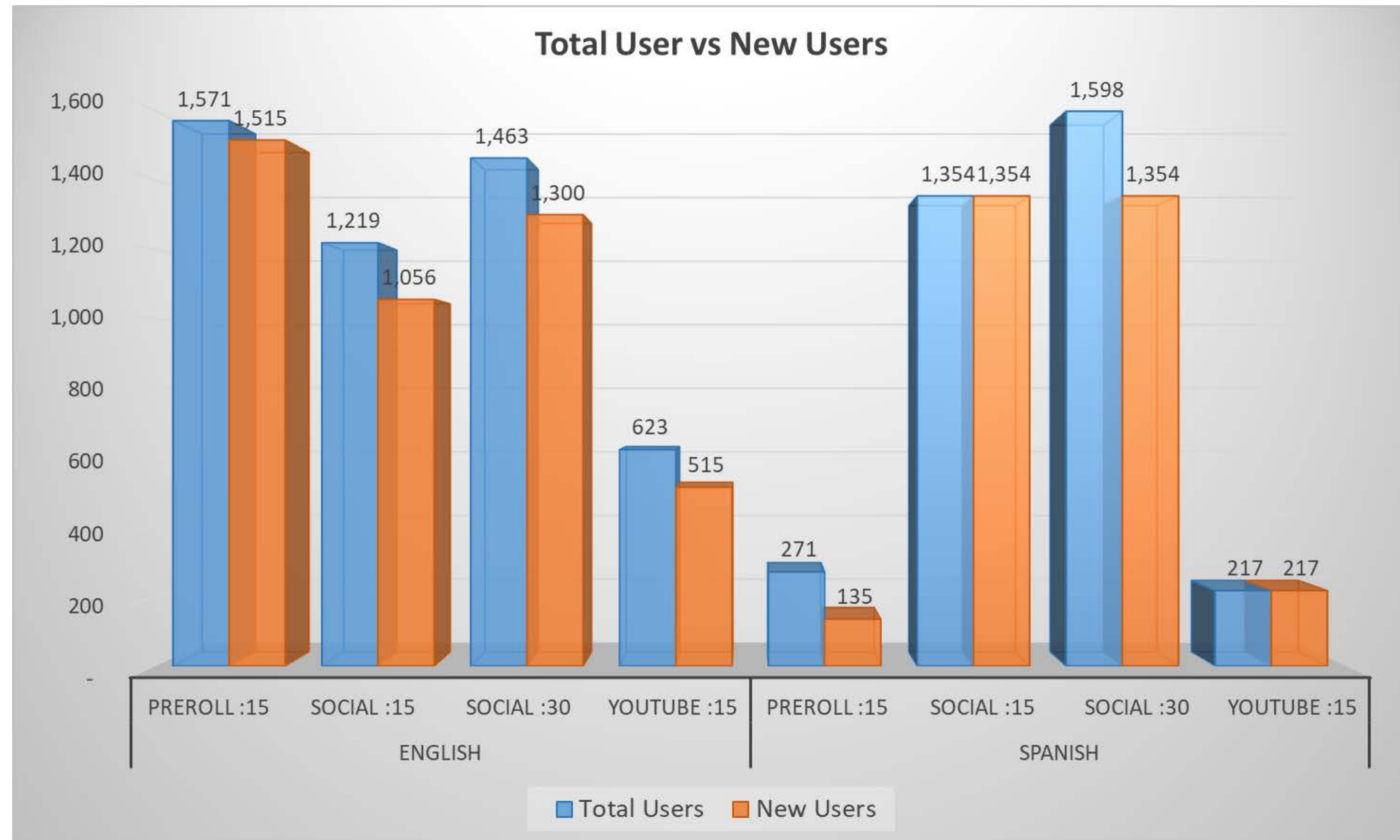


GA Overview: Unique Users

Language	Placement	Total Users	New Users
English	Preroll :15	1,571	1,515
	Social :15	1,219	1,056
	Social :30	1,463	1,300
	YouTube :15	623	515
Spanish	Preroll :15	271	135
	Social :15	1,354	1,354
	Social :30	1,598	1,354
	YouTube :15	217	217
Totals		8,316	7,446

The Problem Gambling campaign delivered 7,446 unique users to the site.

- The social tactic drove 5,064 new users to the site.



Campaign Notes and Recommendations

The campaign was strong out of the gate and maintained high levels of performance in CTR/VCR and impressions during the campaign.

Digital Screenshots

YouTube English

The screenshot shows a YouTube video player with the following elements:

- Header:** YouTube logo, search bar, and navigation icons.
- Video:** A man with glasses and a white sweater is speaking. Text overlay reads: "Vernel Problem Gambling Ambassador".
- Video Title:** "Gambling Addiction & Me - The Real Hustler (Full Documentary) - Real Stories".
- Views:** 459,109 views.
- Engagement:** 2.1K likes, 197 comments, and share/save options.
- Channel:** Real Stories.
- Right Sidebar:**
 - Advertisement:** "Help St. Jude" with a "DONATE" button.
 - Up next:** "Las Vegas sucker bets" (553K views), "Breaking Vegas Documentary: The True Story of The MIT..." (2.3M views), "Casanova Conman | How Hamish McLaren swindled ove..." (1M views), "Downward Spiral - Inside The Case Against Aaron Hernandez" (2.1M views), "TOP 4 MOST ICONIC POKER FIGHTS OF ALL TIME!" (3.1M views), and "Gambling on Addiction : How Governments Rely on Problem..." (235K views).

YouTube Spanish

YouTube

Search

Up next

AUTOPLAY

Extra en Español Ep 02 Sam va de compras
Spanish Thailand
1M views
24:28

Extra en Español Ep 03 Sam aprende a ligar
Spanish Thailand
753K views
24:23

Extra en Español Ep 04 Sam busca un trabajo
Spanish Thailand
790K views
24:28

Learning a language? Speak it like you're playing a video gam...
TEDx Talks
3.6M views
15:31

HOW TO BE ITALIAN • 20 Rules Italians never break
Marco in a BOX
2.6M views
7:54

Aprender español: Los alimentos (nivel básico)
Tu escuela de español
1.6M views
6:26

Extra, todos los capitulos
Spanish Thailand
13

Family Time "Work Wife, Unhappy Life" (S6,E9)

Samuel
Problem Gambling Ambassador

Extra en Español Ep 01 La llegada de Sam
2,301,865 views

14K 599 SHARE SAVE

Spanish Thailand

SUBSCRIBE 34K

Pre-Roll English




YAHOO! SPORTS Search Players and Teams Search Sign in Mail

Publishers Clearing House PCH House WIN \$5,000.00 A WEEK FOR LIFE! DO YOU WANT A CHANCE TO WIN? ACT NOW! Winner to be Announced 8/30 on NBC!

Mixed Martial Arts

Daniel Cormier apologizes to family, coaches and fans for 'let down' loss at UFC 241

Chris Cwik, Yahoo Sports



DRUGS. ALCOHOL. GAMBLING. Different stories. Same problem. mass.gov/ProblemGambling

25 Daniel Cormier feels like he let down his family, coaches and fans [after losing to Stipe Miocic at UFC 241](#). Two days after the fight, Cormier apologized to all those groups in a post on Instagram.

Wendy Anderson, wife of Arkansas State coach Blake Anderson, dies after bout with cancer

Pre-Roll Spanish

EL MUNDO

TV

ACTUALIDAD DEPORTES OCIO TELEVISIÓN VIRALES CIENCIA PAPEL YODONA ZEN VIAJES LOC

Google ha cerrado el anuncio
Dejar de ver anuncio ¿Por qué este anuncio? ▶

Siguiente >



Mensaje del Departamento de Salud Pública de Massachusetts

DROGAS. ALCOHOL. JUEGOS DE APUESTAS.
Diferentes historias. Mismo problema.
mass.gov/ProblemGambling

La reina Letizia, protagonista de un documental alemán

EUROPA PRESS El sábado 24 de agosto se estrena un documental protagonizado por la reina Letizia en el que la periodista Julia Melchior la ha acompañado durante un año, tanto dentro como fuera de España. El documental alemán "Die Königin" se estrenará el próximo 24 de agosto en el canal alemán ARD.

Trintellix
vortioxetine
5mg-10mg-20mg tablets

Take the first step.
Talk to your healthcare professional.

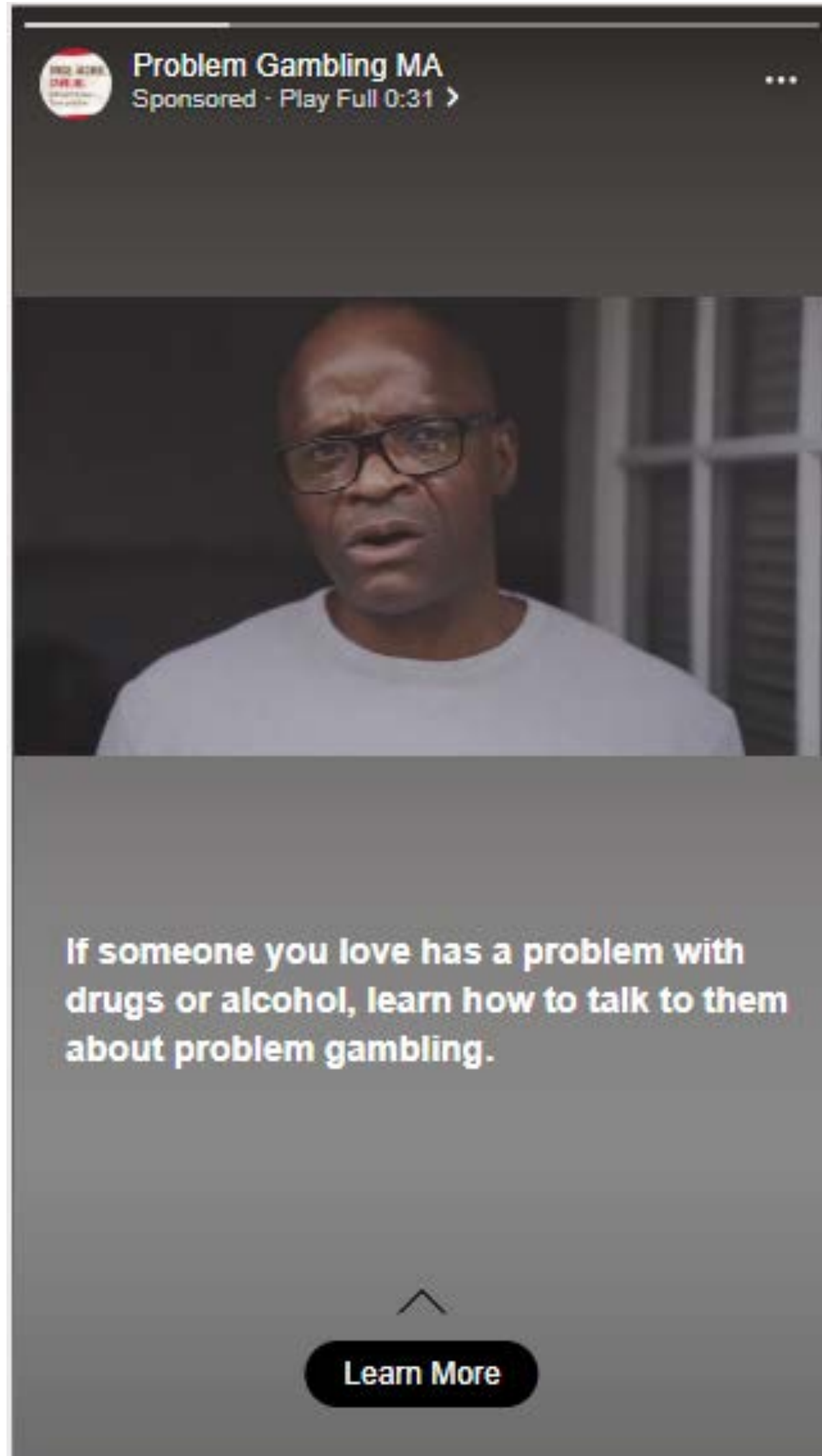
Find Out How ▶

TRINTELLIX is a prescription medicine used to treat Major Depressive Disorder (MDD) in adults.

Important Safety Information [+]

Suicidal Thoughts and Actions and Antidepressant Drugs
Antidepressants may increase suicidal thoughts or actions in some children, teens or young adults within the first few months of treatment or when the dose is changed. Depression or other serious mental illnesses are the most important causes of suicidal thoughts or actions. People who have (or have a family history of) bipolar illness, or suicidal thoughts or actions may have a particularly high risk. Pay close attention to any changes, especially sudden changes in mood, behavior, thoughts or feelings. Call your healthcare provider right away if symptoms such as anxiety, irritability, impulsivity, trouble sleeping, aggressive behavior or suicidal thoughts are new, worse or worry you. TRINTELLIX has not been evaluated for use in patients under 18.

Facebook English



Facebook Spanish



The screenshot shows the Facebook News Feed interface in Spanish. On the left is a navigation menu with options like News Feed, Messenger, Watch, Marketplace, and Shortcuts. The main content area features a sponsored post from 'Problem Gambling MA' with a video of a man speaking. Below the video is a post from 'MASS.GOV' with the text 'Los juegos de apuestas son adictivos. Proteja a sus seres queridos.' and a 'Learn More' button. To the right, there are group recommendations for 'Anderson .Paak's Fan Club' and 'Friends of the Nashua Dog Park'. At the bottom, there are 'Friend Requests' and a language selection menu.

Problem Gambling MA
Sponsored · 🌐
Si sus seres queridos tienen problemas con las drogas o el alcohol, hableles sobre los problemas con los juegos de apuestas.
See Translation

Anderson .Paak's Fan Club
915 members + Join Group

Friends of the Nashua Dog Park
489 members + Join Group

Friend Requests See All
4 mutual friends
Confirm Delete

English (US) · Español · Português (Brasil) · Français (France) · Deutsch +

Search Marketplace

Problem Gamblin...

Si sus seres queridos tienen problemas con las drogas o el alcohol, hableles sobre los problemas con los juegos de apuestas.



Los juegos de apuestas son adictivos.

Proteja a sus seres queridos.

mass.gov

Learn More >

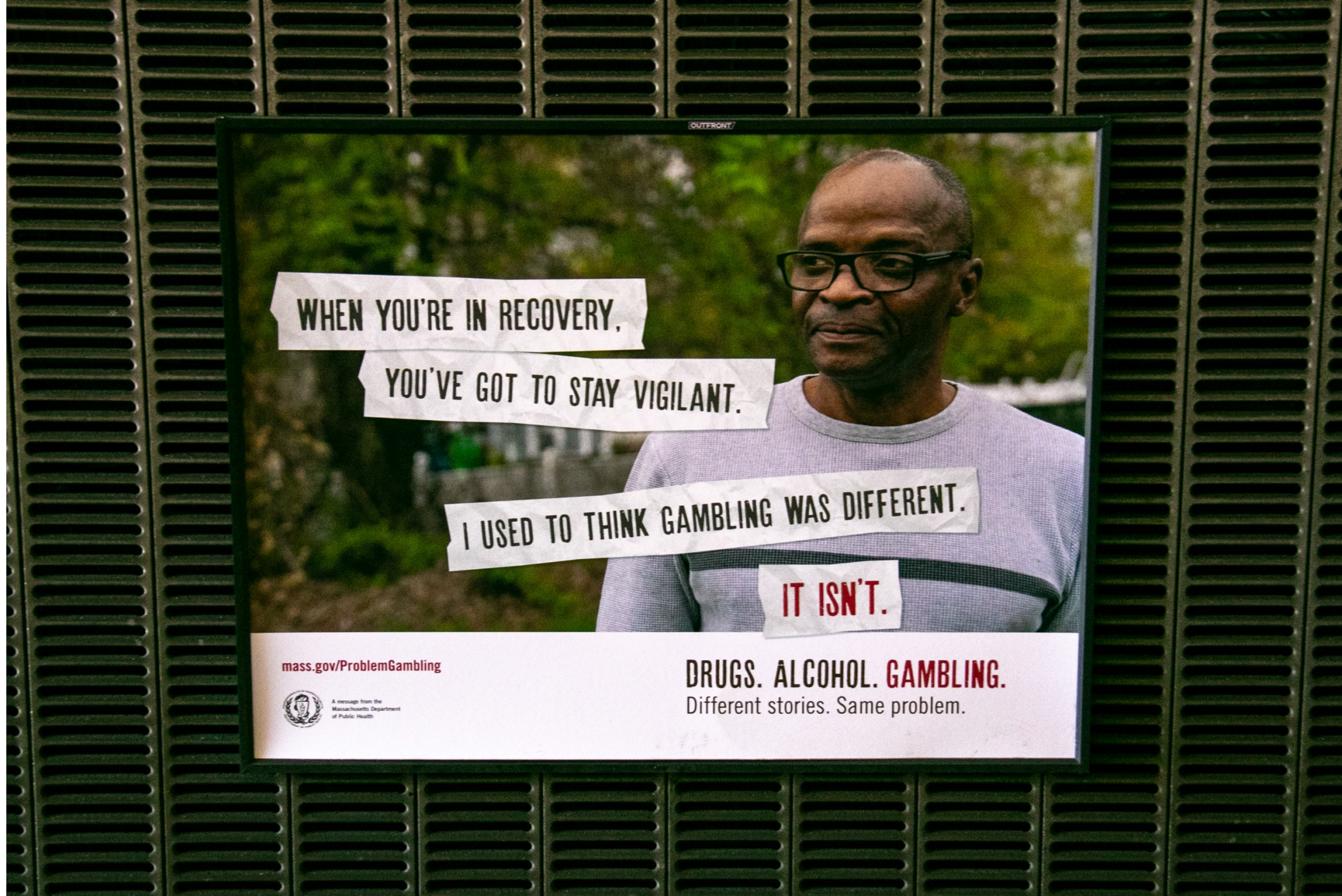
Brand New in Electronics



Transit/OOH

5

Subway Two-Sheet: MBTA



Bus Kings: MBTA



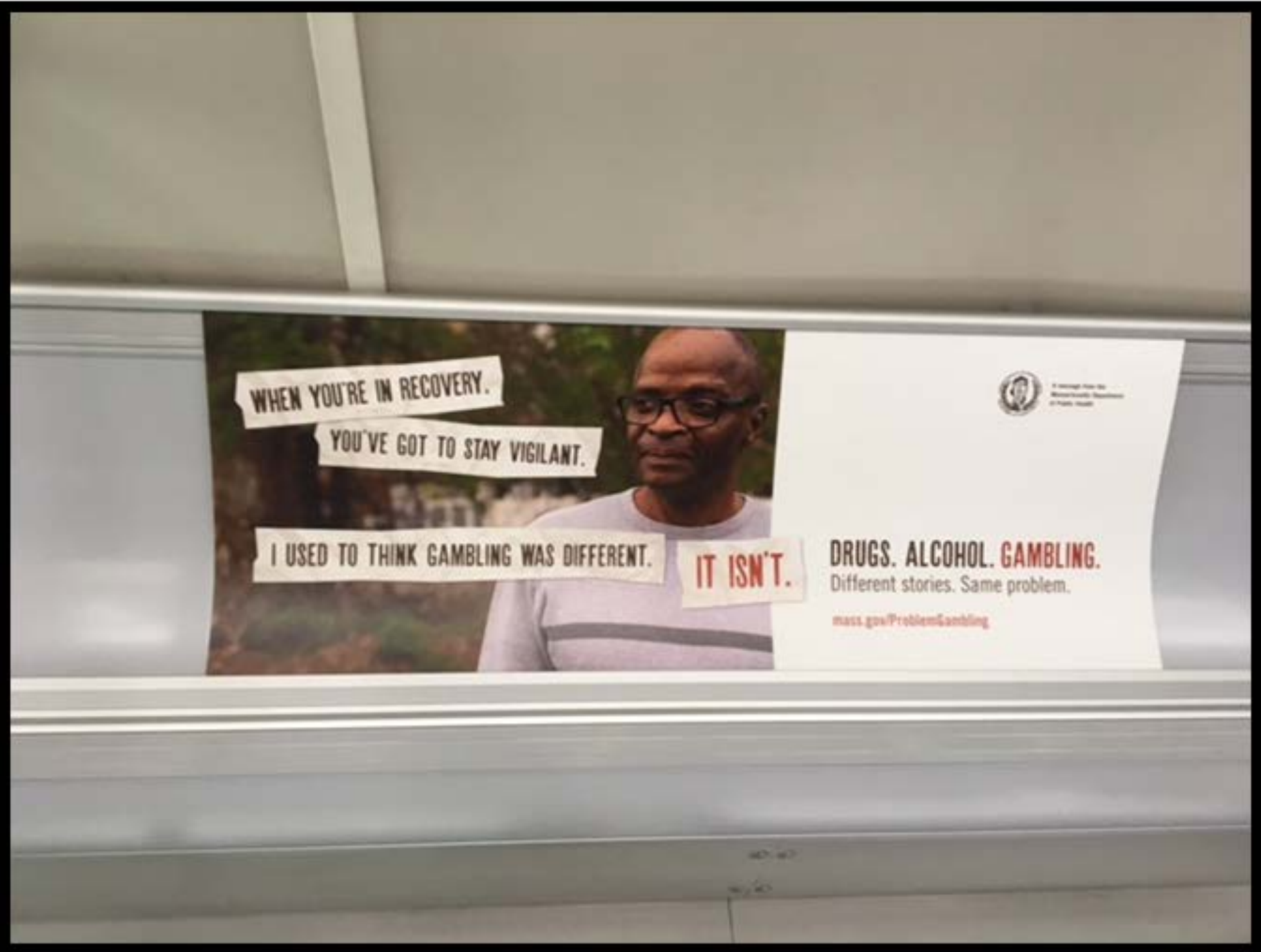
Subway 11 x 28: MBTA



Bus Kings: New Bedford/Fall River



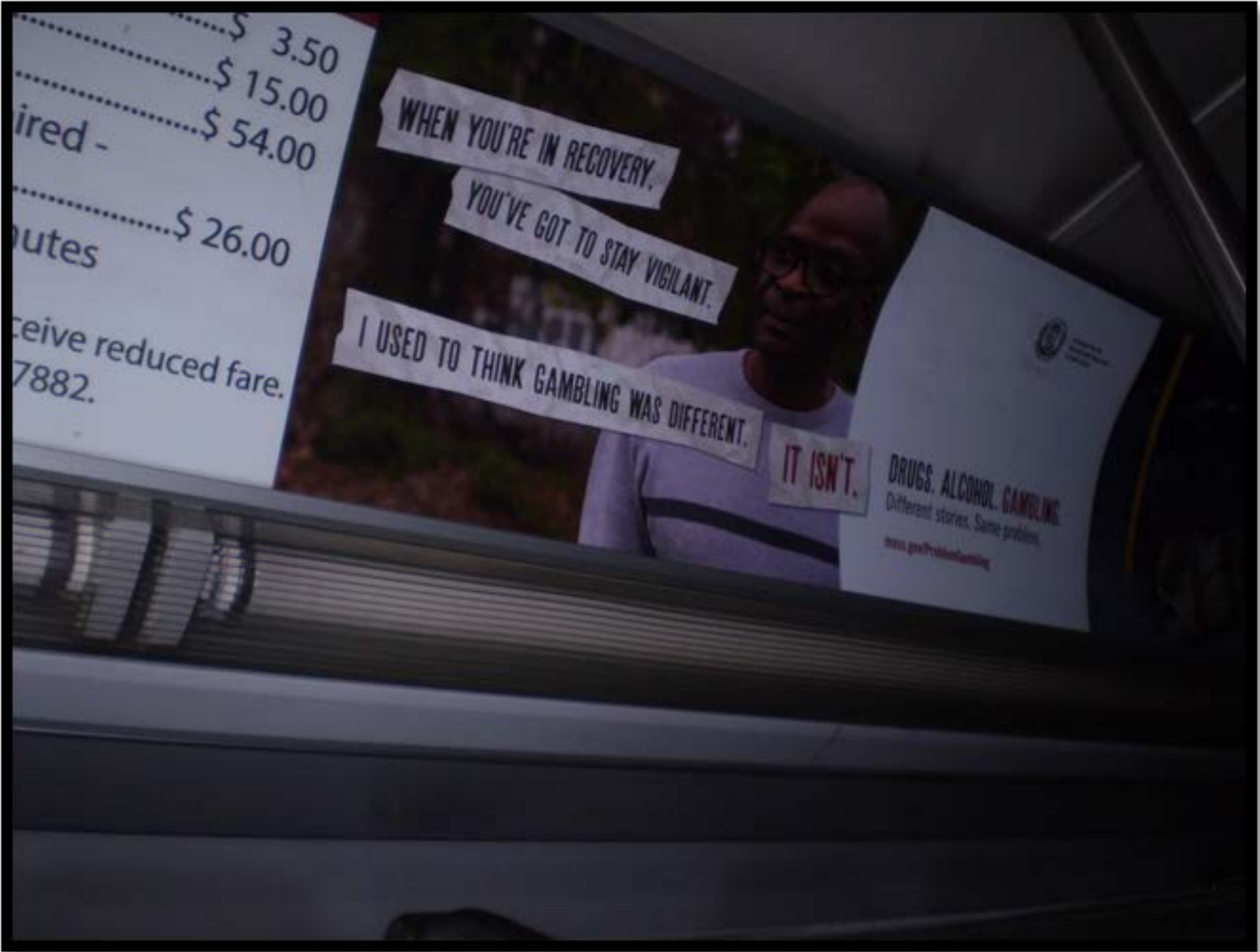
ICC 11 x 28: New Bedford/Fall River



Bus Kings: Springfield



ICC 11 x 28: Springfield



Bus Kings: Taunton/Attleboro



ICC 11 x 28: Taunton/Attleboro



Bus Kings: Brockton/Stoughton



ICC 11 x 28: Brockton/Stoughton



Convenience Store Posters



Massachusetts Department of Public Health
 Massachusetts Gaming Commission
 Public Health Trust Fund
 November 18, 2019

	FY19 Projection	FY19 Actuals	FY20 Original Projection	FY20 Projection
Revenues	8,000,000	7,764,509	15,118,830	14,897,718
PHTF - Category 1 Region B	3,000,000	2,905,302	3,344,508	3,123,396
PHTF - Category 1 Region A (6/20-6/31) *	0	209,874	6,774,322	6,774,322
FY19 MGC Assessment **	5,000,000	4,649,333	5,000,000	5,000,000

* Initial Projection did not assume revenues from Region A

** Unspent assessment (\$350,667) is offset from future assessment (does not carry forward)

Expenditures/Commitments	FY19 Approved	FY19 Actuals	Difference	FY20	Expended (as of Oct 31)
A. Personnel	874,448	655,018	219,430	1,531,713	231,061
MGC (inclusive of all expenses except indirect)	311,981	297,906	14,075	399,000	83,752
MDPH (inclusive of all costs, including indirect)	562,467	357,112	205,355	1,132,713	147,309
B. Prevention and Health Promotion	2,478,552	2,263,426	215,126	4,097,000	1,016,781
MGC Initiatives	1,748,552	1,684,107	64,445	2,907,000	938,871
MDPH Initiatives	730,000	579,319	150,681	1,190,000	77,910
C. Infrastructure, Development and Capacity Building	1,408,000	344,476	1,063,524	1,731,000	20,130
MGC Initiatives	0	0	0	103,000	0
MDPH Initiatives	1,408,000	344,476	1,063,524	1,628,000	20,130
D. Research	2,609,000	2,286,578	322,422	2,610,000	277,948
MGC Initiatives	2,549,000	2,185,667	363,333	2,505,000	267,189
MDPH Initiatives	60,000	100,911	(40,911)	105,000	10,759
E. Marketing and Communication	600,000	964,059	(364,059)	820,000	84,606
MGC Initiatives	200,000	265,989	(65,989)	220,000	84,606
MDPH Initiatives	400,000	698,070	(298,070)	600,000	0
F. Strategic Planning	30,000	41,645	(11,645)	0	0
MGC Gaming Research Strategic Planning	30,000	41,645	(11,645)	0	0
G. Indirect Costs				489,106	83,402
MGC Indirect Costs (10% of allowable costs)				410,100	83,402
DPH Indirect Costs (13.31% of allowable costs)				79,006	0
MGC Initiatives	4,839,533	4,475,314	364,219	6,544,100	1,457,820
DPH Initiatives	3,160,467	2,079,888	1,080,579	4,734,719	256,108
Total	8,000,000	6,555,202	1,444,798	11,278,819	1,713,928

Actual Revenues End of FY19 (June 30, 2019)	7,764,509 *
Actual Expenditures End of FY19	(6,555,202)
Balance End of FY19	1,209,307
Projected Revenues End of FY20 (June 30, 2020) **	14,897,718 **
Additional Revenues Encore Fine	1,775,000
Proposed Budget FY20	(11,278,819)
Projected Balance End of FY20	6,603,206

* Actual Revenues did not reflect Encore Fine

** Projection includes both Category 1 (MGM & Encore) plus MGC assessment. Projection averages recent monthly GGR * remaining months plus monthly actuals

Massachusetts Department of Public Health Massachusetts Gaming Commission Public Health Trust Fund					
	FY19 Approved	Adjustments	Adjusted Budget	Committed / Expended	Actual end FY19
A. Personnel					
MGC (inclusive of all expenses except indirect)	311,981	(1,981)	310,000	314,126	297,906
MDPH (inclusive of all costs, including indirect)	562,467	(60,112)	502,355	356,061	357,112
Staff Augmentation			0	-	-
SUB-TOTAL	874,448	(62,093)	812,355	670,187	655,018
B. Prevention and Health Promotion					
MGC Initiatives					
GameSense Program at MGM and Region B	891,000		891,000	891,000	891,000
GameSense Program at Wynn and Region A	185,552		185,552	125,552	125,552
GameSense Program at Plainridge Park Casino and Region C	664,000		664,000	664,000	664,000
PlayMyWay enrollment incentive	8,000		8,000	3,555	3,555
MDPH Initiatives					
Photovoice Project Region C	60,000	3,000	63,000	61,978	61,978
Ambassador Project Region C	100,000	(10,000)	90,000	84,828	84,828
Pilot (4) Prevention Initiatives (TBD) targeting Youth and Parents i	120,000	(105,000)	15,000	11,295	11,295
Pilot (2) Prevention Initiatives (TBD) targeting At-Risk Populations	100,000	(25,000)	75,000	75,000	75,000
Technical Assistance (TA) of Prevention Services	350,000		350,000	346,218	346,218
SUB-TOTAL	2,478,552	(137,000)	2,341,552	2,263,426	2,263,426
C. Infrastructure, Development and Capacity Building					
MDPH Initiatives					
Suicide and Gambling Community-based activities	58,000		58,000	52,794	52,794
Suicide and Problem Gambling training for Suicide Prevention wo	25,000	15,000	40,000	40,000	40,000
MassMen and Gambling Project	50,000	(6,000)	44,000	29,217	29,217
CHW and Gambling Needs Assessment: Region A	25,000		25,000	24,979	24,979
CHW and Gambling Training: Plainville/Region C	75,000	25,249	100,249	93,531	93,531
CHW and Gambling Training: Region B	75,000	(75,000)	0	-	-
Pilot of CHW and Problem Gambling Project - Region B	450,000	(450,000)	0	-	-
Pilot IPAEP and Gambling Programmatic Services	150,000	(150,000)	0	-	-
Helpline Evaluation/TGA Phase II/Trainings	90,000		90,000	89,891	89,891
Distribution of Your First Step to Change / Clearinghouse Materia	10,000		10,000	9,064	9,064
Gambling Treatment Enhancements and Initiatives	200,000	(200,000)	0	-	-
Community Level Health Project	200,000	(195,000)	5,000	5,000	5,000
SUB-TOTAL	1,408,000	(1,035,751)	372,249	344,476	344,476

Massachusetts Department of Public Health Massachusetts Gaming Commission Public Health Trust Fund						
		FY19 Approved	Adjustments	Adjusted Budget	Committed / Expended	Actual end FY19
D. Research						
MGC Initiatives						
Social and Economic Impacts of Gambling in Massachusetts	1,180,000			1,180,000	1,154,553	1,154,553
PlayMyWay program evaluation	150,000	(75,000)	75,000	-	-	
Massachusetts Gaming Impact Cohort	815,000		815,000	810,956	810,956	
Public Safety and Crime	30,000		30,000	29,891	29,891	
Targeted At-Risk Community / Community Driven Research	200,000	(9,219)	190,781	41,727	41,727	
Research Peer Review	45,000		45,000	34,982	34,982	
Research Consultant	79,000	35,000	114,000	113,558	113,558	
Data, Transfer, Storage and Access Project	50,000	(50,000)	0	-	-	
MDPH Initiatives						
Community Engagement Listening Session (Rudy Vega)		40,911	40,911	40,911	40,911	
Evaluation of all Prevention Pilots	60,000	0	60,000	60,000	60,000	
SUB-TOTAL	2,609,000	(58,308)	2,550,692	2,286,578	2,286,578	
E. Marketing and Communication						
MGC Initiatives						
GameSense Communications/ KHJ	200,000	66,000	266,000	265,989	265,989	
DPH Initiatives						
Men of Color with History of Substance Misuse	200,000	316,246	516,246	513,916	513,916	
Communication Campaign: Research, planning, and development: Youth and Parents	100,000	(7,923)	92,077	92,077	92,077	
Communication Campaign Research, planning, and development of additional target audience (TBD)	100,000	(7,923)	92,077	92,077	92,077	
SUB-TOTAL	600,000	366,400	966,400	964,059	964,059	
F. Strategic Planning						
MGC Gaming Research Strategic Planning	30,000	15,000	45,000	41,645	41,645	
Subtotals						
MGC Initiatives	4,839,533	(20,200)	4,819,333	4,491,534	4,475,314	
DPH Initiatives	3,160,467	(891,552)	2,268,915	2,078,837	2,079,888	
Total	8,000,000	(911,752)	7,088,248	6,570,371	6,555,202	

Massachusetts Department of Public Health				
Massachusetts Gaming Commission				
Public Health Trust Fund				
Expenditures as of October 31, 2019	FY20 Approved	Adjustments	Adjusted Budget	Committed / Expended
A. Personnel				
MGC (inclusive of all expenses except indirect)	399,000		399,000	83,752
MDPH (inclusive of all costs, including indirect)	1,211,719		1,211,719	147,309
Staff Augmentation			0	
SUB-TOTAL	1,610,719	0	1,610,719	231,061
B. Prevention and Health Promotion				
MGC Initiatives				
GameSense Program at MGM and Region B	601,000		601,000	196,333
GameSense Program at Wynn and Region A	1,200,000		1,200,000	381,023
GameSense Program at Plainridge Park Casino and Region C	515,000		515,000	168,667
GameSense Support and Indirect	568,000		568,000	186,333
VSE Resource Liason	15,000		15,000	3,750
PlayMyWay enrollment incentive	8,000		8,000	2,765
MDPH Initiatives				
Photovoice Project Region C	100,000		100,000	9,630
Ambassador Project Region C	130,000		130,000	910
Photovoice Region A/B	150,000		150,000	6,882
Ambassador Project Region A/B	260,000		260,000	7,939
Technical Assistance (TA) of Prevention Services	500,000		500,000	47,549
Stakeholder Listening Session	50,000		50,000	5,000
	MGC SUB-TOTAL	0	2,907,000	938,871
	DPH SUB-TOTAL	0	1,190,000	77,910
PREVENTION AND HEALTH PROMOTION SUB-TOTAL	4,097,000	0	4,097,000	1,016,781
C. Infrastructure, Development and Capacity Building				
MGC Initiatives				
Regional RG Conference	65,000		65,000	-
Regional Voluntary Self Exclusion Software	3,000		3,000	-
Veterans Services Technical Assistance	35,000		35,000	-
MDPH Initiatives				
Suicide and Gambling Community-based activities	58,000		58,000	7,691
Suicide and Problem Gambling training for Suicide Prevention workforce	60,000		60,000	
MassMen and Gambling Project	50,000		50,000	
CHW and Gambling Training- Plainville Region C	75,000		75,000	
CHW and Gambling Training: Region B	75,000		75,000	
CHW and Gambling Community Project: An Evaluation of the Pilot	150,000		150,000	
Programmatic Assessment for IPAEP, Domestic Violence, Sexual Assault and Gambling	50,000		50,000	5,844
Gambling Treatment Enhancements and Initiatives	200,000		200,000	
Massachusetts Health Promotion Clearinghouse	10,000		10,000	
Community Level Health Project	200,000		200,000	6,595
Community-based initiatives	700,000		700,000	

Massachusetts Department of Public Health					
Massachusetts Gaming Commission					
Public Health Trust Fund					
Expenditures as of October 31, 2019	FY20 Approved	Adjustments	Adjusted Budget	Committed / Expended	
MGC SUB-TOTAL	103,000		103,000		
DPH SUB-TOTAL	1,628,000		1,628,000		20,130
INFRASTRUCTURE, DEVELOPMENT AND CAPACITY BUILDING SUB-TOTAL	1,731,000	0	1,731,000		20,130
D. Research					
MGC Initiatives					
Social and Economic Impacts of Gambling in Massachusetts	825,000		825,000		126,227
SEIGMA (1/1/20 to 6/30/20)	300,000		300,000		-
Massachusetts Gaming Impact Cohort	915,000		915,000		78,992
Public Safety and Crime	60,000		60,000		9,727
Community Driven Research	200,000		200,000		8,693
Research Peer Review	50,000		50,000		8,550
Research Consultant	105,000		105,000		35,000
Data, Transfer, Storage and Access Project	50,000		50,000		-
MDPH Initiatives					
Evaluation of all Prevention Pilots	105,000		105,000		10,759
MGC SUB-TOTAL	2,505,000	0	2,505,000		267,189
DPH SUB-TOTAL	105,000	0	105,000		10,759
SUB-TOTAL	2,610,000	0	2,610,000		277,948
E. Marketing and Communication					
MGC Initiatives					
GameSense Communications/ KHJ	220,000		220,000		84,606
DPH Initiatives					
Communication Campaign: Research, planning, and development: Youth and Parents	300,000		300,000		-
Communication Campaign Implementation: At-risk population (TBD, Elders, Asian Americans)	300,000		300,000		-
MGC SUB-TOTAL	220,000	0	220,000		84,606
DPH SUB-TOTAL	600,000	0	600,000		0
MARKETING AND COMMUNICATIONS SUB-TOTAL	820,000	0	820,000		84,606
F. Indirect					
MGC Indirect (10% of allowable costs)	410,100		410,100		83,402
DPH Indirect (13.31% of allowable costs) - \$79k included in staff costs					
Subtotals					
MGC Initiatives	6,544,100		6,544,100		1,457,820
DPH Initiatives	4,734,719		4,734,719		256,108
Total	11,278,819	0	11,278,819		1,713,928



TO: Public Health Trust Fund Executive Committee

FROM: Mark Vander Linden, Director of Research and Responsible Gaming

DATE: November 18, 2019

RE: Building capacity for Knowledge Translation and Exchange

Last May, the document, *Research Strategy for Gaming in Massachusetts* (strategy), was adopted. Section 5 of the strategy calls for the development of strategic knowledge translation to fully exploit the substantial knowledge generated through the research program

Lead author of the strategy, Judith Glynn, noted that a key finding from stakeholder consultations was the lack of understanding of the comprehensiveness of the current research. This was true even of highly engaged stakeholders, suggesting that the perception is fairly entrenched and requires explicit communication efforts on the comprehensiveness and potential value of the research to a range of community stakeholders.

Knowledge translation: the process of putting research findings to practical use. More specifically, this process refers to the steps needed to ensure that new research findings are made known to the right people and used to inform relevant policies, programs and services

The specific need to develop a capacity for knowledge translation described above is further illuminated by the recent release of several reports. Since the last Public Health Trust Fund meeting in July, ten reports or publications and two fact sheets have been released. The value of this work is only realized when it reaches the audience that can activate it through policy and practice. The strategy refers to this as Knowledge Pathways. Knowledge pathways are parallel paths of research and development of policy and programs, and how the research findings reach the right audience. This includes:

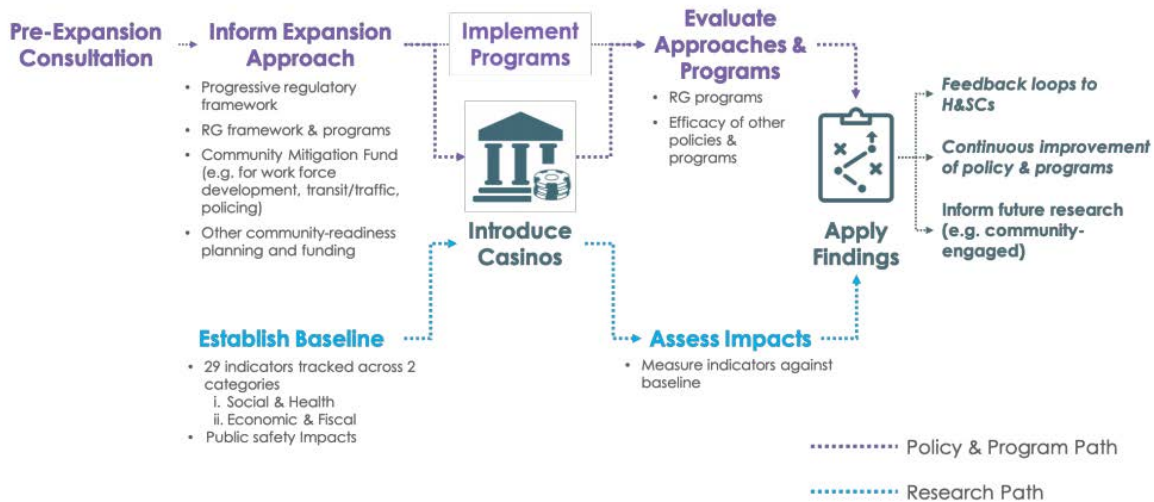
- **Host and surrounding communities** – Research knowledge should be communicated for a number of purposes, such as to demonstrate the impact of readiness efforts; to provide monitoring and early alerts to changes in their communities; and to inform future work to sustain and build on positive impacts and reduce negative ones.
- **Policy and programs** – This includes internally for the MGC and DPH to advance the regulatory and programmatic approaches and to ensure the quality and effectiveness of the public health services. Externally almost every organization providing health and social services in host communities could benefit from the research findings. The same is true of economic stakeholders, especially those representing local business and economic development.



Massachusetts Gaming Commission

- **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.

Knowledge Pathways



Possible Structure

The leadership for the knowledge translation function is envisioned as part of the role of a Research Strategy Manager. This individual should understand the potential of the research knowledge, the range of knowledge users who would benefit from the findings, and the implications for future research. From there, I see a few options to implement this capability.

- MGC to hire a Knowledge Broker. This person would be a staff of the MGC and responsible for the implementation of the knowledge translation strategy, collaborate with key stakeholders to develop knowledge products, and work with both internal MGC staff and external organizations to drive knowledge into practice.
- MGC to leverage the expertise of external vendor. Develop a single or multi-year plan to build a knowledge translation strategy and develop sustained in-house capacity to carry out this work. During this interim period, the vendor would launch efforts, developing KT products and materials.

Timeline

Given the hurdles to hire or procure a vendor, I expect this to launch in early FY2021.

I welcome feedback from the PHTF Executive Committee as the MGC seeks to implement this component of the strategy.



Massachusetts Gaming Commission

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: June 28, 2019

RE: Assessing Advantages and Disadvantages of Connecting Addiction-related Helplines

Purpose: Our FY19 scope of services required the Division on Addiction (Division) to commence a helpline analysis with the aim of supporting of the Commonwealth of Massachusetts's [Strategic Plan](#)'s Screening and Referral strategy, *Evaluate and explore potential enhancements to the current statewide gambling helpline*. The Strategic Plan indicates that three activities compose Phase I of this strategy: (1) Explore potential advantages, disadvantages, and mechanisms for connecting the statewide gambling Helpline to the Massachusetts Substance Abuse Helpline [sic]; (2) Since waiting time can increase attrition, explore the benefits, potential harms, and possibilities of connecting treatment providers directly with the gambling Helpline or with Helpline data, so that treatment providers can actively reach out to those in need (Linnet & Pederson, 2014); and (3) Explore mechanisms for increasing the number of languages in which the gambling Helpline can be operated. As requested, the Division's current efforts concern the Phase I activity, *"Explore potential advantages, disadvantages, and mechanisms for connecting the statewide gambling Helpline to the Massachusetts Substance Abuse Helpline [sic]."*

Deliverables: Assess available helpline literature to determine if it supports the superiority of one helpline model over another; Engage in a state by state review to establish whether proof of concept for combined services is available; Analyze caller surveys to determine overlap of substance use and gambling-related issues among callers, as well as call volume and timing; Complete a comparative evaluation of helpline characteristics and activities for the current helpline services.

Recommendations: Based on our review and evaluation, we provide 7 recommendations:

- (1) Maintain separate helplines, at least temporarily, and revisit the possibility of combining helplines in the future, including the completion of helpline caller surveys with respect to this issue.
- (2) Require helplines maintain minimum standards certification by 3rd party such as Contact USA.
- (3) Develop a cooperative training agenda to advance helplines' capabilities for addressing mental health, gambling, and substance use problems, as needed.
- (4) Create a shared resource database that informs referrals for both helplines.
- (5) Require helplines to develop and implement plans for addressing mental health, gambling, and substance use problems, as needed.
- (6) Engage with a business consultant to better understand and align helpline costs that currently appear to be disproportionate to services.
- (7) Commence an initiative to explore the development and implementation of innovative bridges between the gambling and substance use helplines.

Assessing Advantages and Disadvantages of Connecting Addiction-related Helplines

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

by the Division on Addiction

June 28, 2019

Assessing Advantages and Disadvantages of Connecting Addiction-related Helplines

The Commonwealth of Massachusetts Department of Public Health (DPH) currently supports services for dedicated gambling and substance use helplines, among other public health initiatives. Since 1987, the Massachusetts Council on Compulsive Gambling (MCCG) has managed 1-800-426-1234, the gambling helpline. Since 1997, Health Resources in Actions (HRiA) has managed 1-800-327-5050, the substance use helpline. Following gambling expansion in the Commonwealth, and the creation of the Office of Problem Gambling Services, it is imperative to review these available services and determine whether any revisions might benefit the public's health.

The scientific literature and the Addiction Syndrome model of addiction (Shaffer et al., 2004; Shaffer, LaPlante, & Nelson, 2012) suggest that different expressions of addiction share risk factors and consequences, and often co-occur. This implies that segregated treatment practices might be inefficient. Nonetheless, as the Addiction Syndrome model suggests, different expressions of addiction also yield unique consequences. Therefore, maintaining dedicated services might be beneficial. It follows that although consolidation of addiction-related helplines is in line with some aspects of such contemporary perspectives of addiction, the unique experiences and consequences of these conditions also suggest that retaining a segregated structure might hold some benefits. Consequently, an evidence-based exploration of the pros and cons of helpline consolidation is warranted.

To provide guidance for the future of addiction-related helpline support in the Commonwealth, this report includes the following sections: (1) a helpline scientific literature review; (2) a state-by-state survey of US helplines; (3) an examination of caller characteristics for MA-based substance use and gambling helplines; and (4) a comparative analysis of the MA-based substance use and gambling helpline service characteristics. The first three components shed light upon the pros and cons of combining helplines versus maintaining separate helplines, and the fourth component informs our understanding of the helpline providers' readiness to support any suggested changes.

1. Helpline Literature Review

We conducted a literature review to identify research concerning helplines that address multiple health issues, with particular interest in identifying helpline models that handle both substance use and gambling-related problems. We did this to understand whether there is available evidence related to the efficacy of combined or segregated helpline services.

As shown in Figure 1, we searched the online PubMed and PsycINFO databases for peer-reviewed literature using the following Boolean search phrases: 1) (gambling AND substance use) AND (helpline OR hotline OR telephone); and 2) (gambling OR substance use) AND (helpline OR hotline OR telephone). We used a best match algorithm for the PubMed search, and did not set any date restrictions. The first search phrase returned 23 articles from PsycINFO and 24 articles from PubMed. The second phrase returned 948 articles from PsycINFO and 805 articles from PubMed. In total, our database search returned 1,800 articles published through April 2019. After removing duplicates and non-journal articles, 1,277 unique articles remained in our sample.

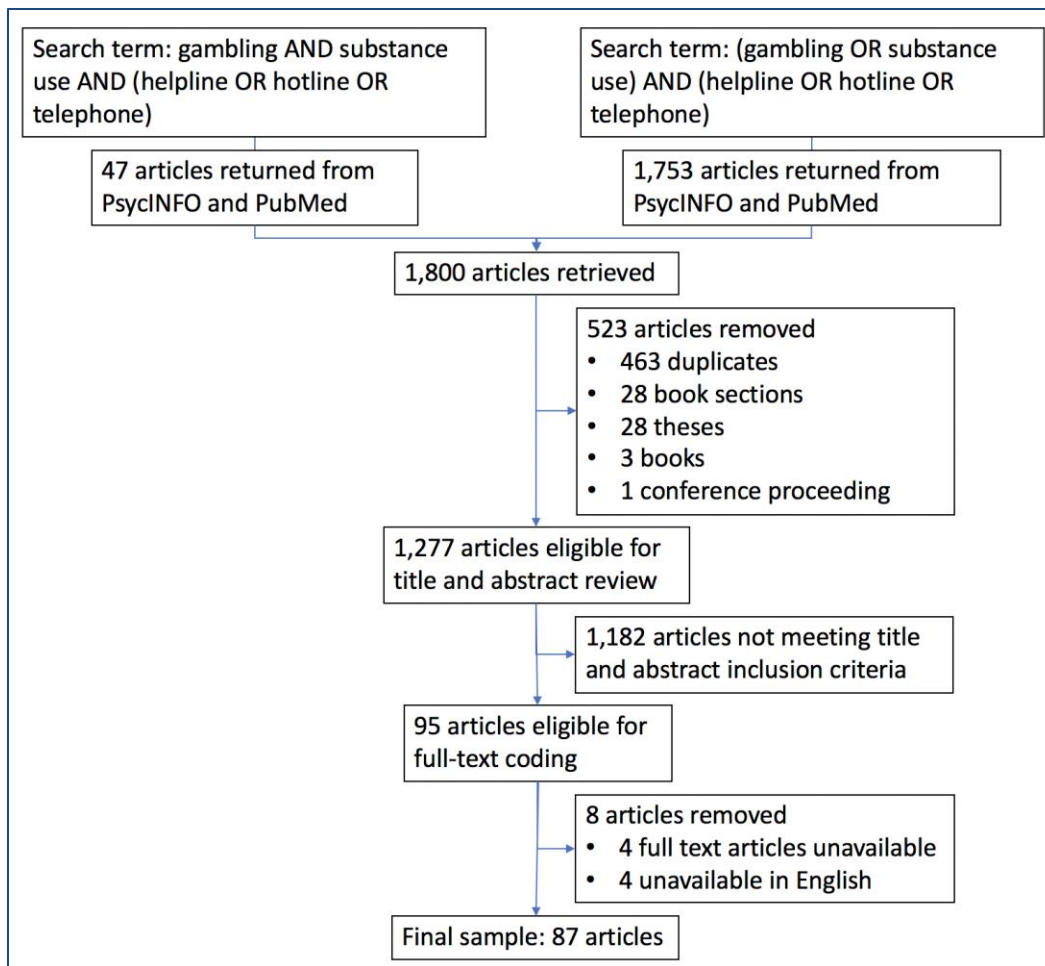


Figure 1. Helpline Literature Review CONSORT Diagram

We then conducted a title and abstract review using the following inclusion criteria: 1) the study must relate to helplines or hotlines, 2) the study must be relevant to gambling, substance use, or addiction, and 3) the study must be an empirical journal article. Three coders first established reliability by coding the same sample of 10 studies, achieving 100% agreement. The coders then divided the remaining studies and coded their titles and abstracts using the inclusion criteria. This process yielded a sample of 95 articles meeting title and abstract inclusion criteria.

We were able to retrieve 91 of these 95 articles for full-text evaluation. For these, we completed full-text coding according to the following research questions:

- 1) *Helpline Type*: Is the study about a gambling helpline, a substance use (other than smoking) helpline, both, smoking, or other?
- 2) *Article Focus*: Does the study do anything to look at helpline outcomes or best practices, or is it simply descriptive (e.g., what are the characteristics of people who call helplines)?
- 3) *Helpline Combination*: Does the study address combined substance use and gambling-related helplines?
- 4) *Helpline Comparison*: Does the study compare helplines addressing multiple health issues to helplines specializing in a single health problem?

During this process, we discovered that four articles were not available in English. We excluded these articles from further consideration, leaving us with a review sample of 87 articles. The results of this full-text coding are presented in Table 1. Following this, we provide a narrative description of pertinent studies by research question.

Table 1: Characteristics of Full-Text Articles

Full-Text Coding Factor	Number of Studies
Helpline Type ^a	
Gambling-specific	39
Substance use-specific (not smoking)	13
Smoking-specific	26
Other	11
Article Focus	
Outcomes	29
Best Practices	2
Descriptives	38
Other	18
Helpline Combination	
Yes	0
No	87
Helpline Comparison	
Yes	0
No	87

^a One article systematically reviewed gambling only, substance use only, and smoking only helplines but did not compare them. This study was coded into all three categories, yielding 89 total entries in this section, instead of 87.

Helpline Combination and Helpline Comparison

We did not find any literature specifically addressing combined substance use and gambling-related helplines, or any studies that compared helplines addressing multiple health issues to helplines specializing in a single health problem. The absence of such literature precludes confidently forming literature-based recommendations related to combining or maintaining separate addiction-related helplines. Nonetheless, we examined the other coded literature to determine whether it might provide some guidance. In the sections that follow, we briefly describe the (1) best practices research literature and (2) outcomes research literature, as well as a secondary exploratory literature search we conducted on crisis hotlines.

Best Practices Research

We identified two studies that related to helpline best practices. Both of the studies focusing on best practices investigated a pre-recorded smoking cessation support line. The first study offered guidance regarding the best types of pre-recorded messages to implement (Shapiro, Ossip-Klein, Gerrity, & Stiggins, 1985), whereas the second article addressed the most cost-effective ways to promote such a support line (Ossip-Klein, Shapiro, & Stiggins, 1984). These studies do not offer guidance related to combining or maintaining separate addiction-related helplines.

Outcomes Research

The twenty-nine studies that examined outcomes addressed helplines that offer telephone-based therapeutic interventions and helplines that offer information and treatment referral only (see Appendix A for a table of these studies). Among these twenty-nine studies, eight evaluated gambling-related helplines, six evaluated substance use-related helplines, thirteen evaluated smoking-related helplines, and two were classified as “other.” One of the studies classified as “other” evaluated the impact of a homework helpline on student substance use outcomes (Amuedo-Dorantes, Mach, & Clapp, 2004). The second study that we classified as “other” reviewed studies evaluating gambling-, alcohol-, and smoking-specific helplines (Danielsson, Eriksson, & Allebeck, 2014).

Overall, the studies suggested mixed evidence for the impact of addiction-related helplines on clinically relevant outcomes. One systematic review (Gates, 2015) identified preliminary support for the effectiveness of helplines for reducing general illicit drug use and alcohol related harms. However, a systematic review of addiction-related self-help-based helplines found that the available evidence only supported the efficacy of smoking cessation helplines, but not other types of addiction-related helplines (Danielsson et al., 2014). One study in our sample reported that among substance use treatment seekers, those who utilized substance use helplines utilized outpatient treatment services less (Mosavel, 2004). Helplines providing therapeutic interventions based on motivational interviewing and cognitive behavioral therapy were found to be effective in two studies (Gates, Norberg, Copeland, & Digiusto, 2012; Heinemans, Toftgard, Damstrom-Thakker, & Galanti, 2014).

Our sample included primarily outcome studies addressing gambling- or smoking-specific helplines.

Gambling Helpline Studies

Four studies of gambling helplines observed high caller satisfaction, reduced gambling behavior, and a high level of post-call treatment seeking among helpline callers (Abbott et al., 2018; Ferland et al., 2013; Rodda, Hing, & Lubman, 2014; Shandley & Moore, 2008). Bischof and colleagues (2014) reported that self-help, addiction counseling, and general practitioner counseling were the most common types of help seeking among a gambling hotline sample. Among gambling helpline callers receiving treatment referral, Weinstock and colleagues (2011) observed that being offered a first appointment within 72 hours positively predicted subsequent treatment attendance. Another study found that callers’ reasons for contacting a gambling helpline predicted later treatment attendance (Valdivia-Salas, Blanchard, Lombas, & Wulfert, 2014). One study indicated that among a variety of problem gambling services assessed, awareness of the availability of the service was highest for gambling helpline services (Gainsbury, Hing, & Suhonen, 2014).

Tobacco Helpline Studies

Three studies supported the effectiveness of offering tobacco quitlines in a variety of contexts and languages (Cummins et al., 2015; Shiffman, 1982; Wong et al., 2011). One study provided mixed support for a tobacco quitline in comparison to an intensive outpatient counseling intervention for reducing tobacco use behaviors (Ni, Wang, Link, & Sherman, Online First). Another study suggested that smokers assigned to use a tobacco quitline were less likely to use nicotine

replacement therapy compared to those assigned to receive other self-help materials (Buller et al., 2014). Some research also indicates that uptake of a tobacco quitline compared to other interventions is poor (Glasgow, Hollis, McRae, Lando, & LaChance, 1991).

Other Helpline Studies

Many of the remaining outcome-related studies in our sample related only tangentially to the use of quitlines. For example, there were other tobacco helpline studies that included these services in conjunction with medication interventions (Biazzo et al., 2010; Bush et al., 2008; Docherty, Lewis, McEwen, Bauld, & Coleman, 2014; Tworek, Haskins, & Woods, 2009). Other studies also were less relevant to understanding the general efficacy of helplines. For example, one study focused upon barriers for helpline support of concerned others of smokers (Brockman, Patten, & Lukowski, 2018) and another on the use of technology to facilitate quitline referral acceptance (Brown et al., 2017). Other weakly related studies examined helplines in terms of how they might be used for other purposes. For instance, one study assessed quitline caller status with respect to completion of a financial counseling research study (Courtney et al., 2017) and another used helpline data as a social indicator to estimate numbers of people who might attend face-to-face treatment (Clemens & Ritter, 2008). Another study observed that substance use helpline responders in four states were not trained to respond to questions about marijuana use (Carlini & Garrett, 2018).

Crisis Hotline Extension

Acknowledging that crisis hotlines, more generally, offer services addressing a variety of mental health issues in addition to suicidality and other psychosocial concerns, we conducted a second more limited literature search using the Boolean search phrase “crisis AND telephone AND hotline.” We identified three publications discussing multi-issue helpline models. Rosenbaum and Calhoun (1977) note that telephone hotlines were created in response to the observation that 78% of calls to suicide prevention centers were for non-suicidal crises. This indicated the heterogeneity of needs among those seeking assistance from telephone-based crisis services. Corroborating these findings, two more recent publications evaluating a national crisis and referral hotline identified the most common reasons for calls to the hotline (Ingram et al., 2008; Teare, Garrett, Coughlin, & Daly, 1995). Teare and colleagues (1995) found that of calls made by adolescents to the Boys Town National Hotline, a crisis counseling hotline for adolescents and parents, the most common reasons for calling included relationship issues, sexuality, addiction, and abuse or violence. Over a decade later, Ingram and colleagues (2008) found that among all callers to the Boys Town National Hotline, the most common topics included parenting, youth concerns, and mental health, including addiction. Thus, addiction-related problems are a prominent concern for people who call crisis hotlines, yet assessments actually evaluating best practices for implementing addiction-specific helpline services appear lacking.

Summary

Helpline efficacy outcome studies, in general, are limited and slightly more prevalent for gambling helplines than substance use helplines. These outcomes studies report somewhat favorable results; however, the results are more mixed for substance use helplines than for gambling helplines. For instance, some efficacy outcomes studies for substance use indicated limited impact on substance use disorder symptoms. This might suggest favoring the maintenance of separate helplines; however, it might also simply reflect the small number of studies in this area. Unfortunately, the complete absence of literature related to combined outcomes or comparing single issue versus multi-issue outcomes prevents us from generating definitive literature-based recommendations related to combining services in Massachusetts.

2. State-by-State Survey of US Helplines

To understand gambling and substance use helpline services available in the US, we conducted limited internet searches to identify (1) local state public health agencies and/or (2) National Council on Problem Gambling (NCPG) affiliate websites in each state. We considered websites to be local state agencies if they were hosted on a “.gov” web address and self-identified as the state of interest (e.g., Washington State). We categorized websites as NCPG affiliates if they self-identified as such. All identified websites are available for review in Appendix B.¹ The primary purpose of this activity was simply to determine if there was “proof of concept” for offering combined helpline services in the US. We did not intend to provide a comprehensive listing of all such helpline services.

For each identified website, we collected information about gambling and/or substance use helpline services. We only collected information about helplines that a local state agency or NCPG affiliate specifically featured on its website.² Using information from the website, or from listed contacts we called or emailed directly when a website did not have the available information, we recorded the following:

- existence of gambling, substance use, or combined gambling and substance use helpline;
- contact information;
- operating organization;
- hours of operation;
- additional modes of contact (e.g., text, live chat);
- affiliated organizations and links to their websites; and
- qualitative notes about each service.

Observations

Figure 2 illustrates the number of states featuring specific substance use and/or gambling helpline services. We identified 46 states featuring gambling helpline services; however, 10 of these states direct callers experiencing gambling-related problems to call the National Council on Problem Gambling (NCPG) national helpline. We identified 37 states featuring substance use helpline services; however, 4 of these states direct callers experiencing substance use problems to call the national Substance Abuse and Mental Health Services Administration (SAMHSA) substance use helpline. All other states that offer helpline services appear to direct callers to independent helplines. Combined gambling and substance use helplines were available in five states: Alabama³, Maine, New York, Oklahoma, and Tennessee. We review the services provided by these states in the following sections. The full details of identified helpline services available in all 50 states are available in Appendix B.

¹ A more advanced review with different or more comprehensive search terms might yield a different set of websites. When possible, we cross-referenced our findings with the *2016 Survey of Problem Gambling Services in the United States* (Marotta et al., 2017).

² We did not include a review of so-called helplines for addiction treatment intake centers. This approach is consistent with the NCPG’s review of gambling services in the U.S. (Marotta et al., 2017). See report here: <https://bit.ly/2v14HPU>.

³ Alabama, Maine, and Oklahoma utilize 211 numbers for their combined gambling and substance use helpline services; 211 numbers are available in all states and provide a variety of services, though service offerings vary by state.

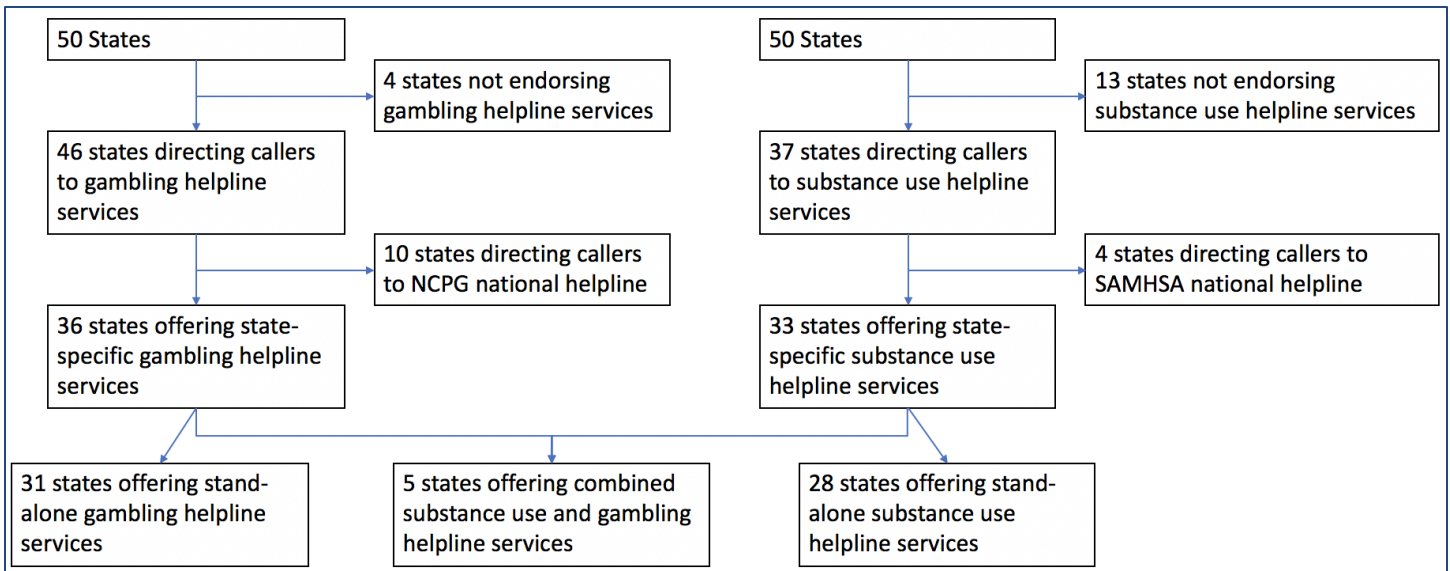


Figure 2. State Helpline CONSORT Diagram

For the 4 states that did not feature information on any specific gambling helpline services and the 13 states that did not feature information for any specific substance use helpline services, national helplines (i.e., the NCPG national hotline and the SAMHSA national hotline) and 211 hotlines are still available to residents. Though all 50 states provide 211 service in some form, we did not systematically assess whether each state’s 211 services aided with gambling disorder (GD) and substance use disorder (SUD) issues. We only gathered information on 211 services in instances when the local state website or local NCPG affiliate proactively featured a 211 number as a gambling or substance use helpline. As noted earlier, below we provide information about the 5 states that offer combined substance use and gambling helpline services.

New York⁴

New York state hosts the [HOPEline](#), a 24/7, toll-free, confidential hotline providing referrals to gambling and substance use services. The HOPEline is advertised on the [New York State Office of Alcoholism and Substance Abuse Services \(OASAS\)](#) website and is operated by [Vibrant Emotional Health](#), formerly known as the Mental Health Association of New York City. Individuals seeking help may contact the HOPEline via call, text message, or live chat. The HOPEline is staffed by master’s level clinicians trained in motivational interviewing (Miller & Rollnick, 1991) and can provide crisis intervention. HOPEline staff have access to a referral database of over 1,500 prevention services and treatment providers. Upon request, staff will provide callers with additional informational materials and follow-up with a return call within 48 hours of initial contact. HOPEline services are available in many languages, and informational flyers can be downloaded in English, Russian, Spanish, Italian, Haitian-Creole, Korean, and Traditional Chinese.

Tennessee

Tennessee hosts the [Tennessee REDLINE](#), a 24/7 hotline providing referrals to gambling and substance use services. The Tennessee REDLINE is operated by the [Tennessee Association of Alcohol, Drug, and other Addiction Services \(TAADAS\)](#) and is supported by grant funding from the State of Tennessee [Department of Mental Health and Substance Abuse](#)

⁴ The following information is derived from the websites of the New York State Office of Alcoholism and Substance Abuse Services and Vibrant Emotional Health. We were unable to get in touch with either of these organizations for follow-up information after sending multiple emails to both organizations and making several phone contact attempts with subsequent voicemails to the supervisor at the HOPEline. We did not make informational calls to the HOPEline service itself to reduce the burden on the crisis service.

[Services](#). REDLINE staff are not trained to perform crisis intervention, counselling, or therapy services, but can provide psychoeducation related to addiction and referrals to care services in line with the caller’s stated needs, as well as utilize warm handoff (i.e., directly connecting callers to the referred agency while remaining on the line) procedures for most referrals. The service is available in any language, and several staff are multilingual. For all languages not spoken by staff, the Tennessee REDLINE contracts an external, real time, over-the-phone translation service. The Tennessee REDLINE helpline staff comprise a mix of paid staff and volunteers who have at minimum a high school diploma or GED. Prior call center experience and qualification as a Certified Peer Recovery Specialist is preferred, but not necessary, for initial employment. In addition to gambling and substance use services, the REDLINE provides information and referral services regarding other concerns, such as HIV/AIDS, housing insecurity, obtaining federal health insurance, domestic violence, and other mental health issues. Free informational materials are available in hard copy format delivered by mail from the Tennessee REDLINE. These informational materials are available in multiple non-English languages, including Spanish and French. The TAADAS website also hosts a free video lending library for resources related to addiction and a bookstore with recovery-related items for purchase.

*Alabama*⁵

Alabama utilizes 211, a 24/7, toll-free hotline that provides referrals to gambling and substance use services. The 211 phone service is listed on the [Alabama Council on Compulsive Gambling](#) website and is operated by [United Ways of Alabama](#). The 211 service can refer callers to gambling and substance use services, in addition to services for employment, housing, family support, and other concerns. The service is available in over 150 languages through an externally contracted translation service, and many of the 211 staff are bilingual. Additionally, the state of Alabama hosts a separate 24/7 substance use services hotline. This service is run by the Alabama Department of Mental Health and Recovery Organization of Support Specialists (ROSS).

Maine

Maine utilizes 211, a 24/7 hotline that provides gambling and substance use helpline services. 211 is listed on the [State of Maine Department of Health and Human Services](#) website and is operated by the [United Ways of Maine](#). Services are also available by text or email. Callers can receive information and referrals to prevention, treatment, support, and continuing care. Specialists are available for those who call with concerns relating to opioid use disorders. The helpline also offers follow-up call services within 72 hours of first contact to ask if individuals received the services they were referred to, such as suboxone treatment or housing for people experiencing homelessness. The program is funded mostly by United Way.⁶ Some funding comes from the [Department of Social and Health Services](#), the [Office of Substance Abuse and Mental Health Services \(SAMHS\)](#), and other organizations. 211 Maine also is the main contact for the state regarding substance use services. Program staff can receive training and certification as “Certified Administration Specialists” with the appropriate experience and education. Specialists are not certified in crisis intervention, though some crisis intervention skills are touched upon during staff training. 211 staff are trained to de-escalate callers in order to direct them towards the services they need. Staff are not trained in any brief screening or brief interventions. 211 staff are provided with a hard script for most phone calls, but they are allowed to alter and use a loose script for callers seeking assistance with opioid use. Some 211 staff are bilingual in Arabic and Spanish; 211 contracts with “Optimal” for translation services in other languages. Most referrals by 211 are conducted as “cold handoffs,” though staff do provide follow-up calls and warm transfers to connect

⁵ The following information is derived from the websites of the Alabama Council on Compulsive Gambling and the United Ways of Alabama. We were unable to contact the operators responsible for the Alabama 211 service by phone or email despite repeated attempts.

⁶ Most 211 services across the United States are funded this way.

people experiencing homelessness to organizations providing shelter, or for anyone else who needs immediate resources. 211 staff do not ask callers about gambling or substance use unprompted; they only address the issues that the callers themselves mention.

Oklahoma

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and the Oklahoma Association on Problem and Compulsive Gambling (OAPCG) websites both direct visitors to the NCPG helpline. Calls to the NCPG helpline originating from anywhere in Oklahoma are automatically redirected to Heartline, the 211 operator for Western Oklahoma. The regular 211 service for Eastern Oklahoma is operated by Tulsa 211, but Tulsa 211 does not provide services for gambling-related issues; therefore, all calls to NCPG from throughout the state are redirected to Heartline. Heartline is contracted and funded by the OAPCG and is operated out of Oklahoma City. The ODMHSAS website primarily advertises the Heartline and Tulsa 211 for substance use helpline services, but also advertises a separate “Reachout Hotline” for mental health and substance addiction services. This “Reachout Hotline” is also answered by Heartline. All Heartline-operated services offer 24-hour mental health and substance addiction services. The Heartline is operated by both paid and volunteer workers. Heartline staff offer both cold and warm hand-offs. Services are provided by English-Spanish bilingual staff. Translation for other languages is available through a contracted external interpreter service. Heartline staff conduct screening assessments for substance use disorders and gambling disorder, and evaluate other related circumstances that callers might be experiencing, including psychiatric comorbidity, suicidality, insurance coverage, healthcare access, and psychosocial factors. Heartline mails information packets containing mental health resources to callers by request.

Summary

Although states are more likely to have standalone gambling helplines than combined helplines, the existence of combined helplines in 5 states indicates that such services are a viable solution. Beyond proof of concept, however, it is also important to establish that combining services will not result in service avoidance (i.e., a tendency to avoid using a specific service due to characteristics of that service). Therefore, future work that involves surveys or interviews with helpline callers regarding their helpline experiences and preferences is important.

3. Caller Characteristics for MA-based Substance Use and Gambling Helplines

To determine overlap of substance use and gambling-related issues among callers to Commonwealth gambling and substance use helplines, as well as assess the demographic overlap of callers to these helplines, we completed (1) a helpline records-review and (2) a caller survey. To accomplish this, we coordinated⁷ with the MCCG and HRiA to access their helpline data records and engage in four months of supplemental data collection. For our records review, both helplines made available information available such as call date, first time caller status, caller location, age, gender, referral source, and treatments experienced. Uniquely, HRiA provided information related to primary and secondary drugs of use and MCCG provide details related to gambling game engagement. For the supplemental data collection, we requested that both helplines integrate a set of supplemental data items into their standard helpline data protocols from January 1, 2019 through April 30, 2019, asking these questions of all callers during that time period.

⁷ Coordination with these organizations included several rounds of protocol and item development activities and a two-week pilot data collection period during December 2019.

Gambling Helpline Supplemental Data Items

- 1) Have you (Has your loved one) ever had a substance use problem?
 - a. (If yes) Have you (Has your loved one) ever called the substance use helpline?
 - b. (If yes) Have you (Has your loved one) ever received treatment for a substance use problem?
- 2) Have you (Has your loved one) ever had a mental health problem other than substance use or gambling problems⁸, such as depression or anxiety?
 - a. (If yes) Have you (Has your loved one) ever sought help for a mental health problem other than substance use or gambling problems, such as depression or anxiety?⁹
- 3) Have you (Has your loved one) ever received treatment for a gambling problem?

Substance Use Helpline Supplemental Data Items

- 1) Have you (Has your loved one) ever had a gambling problem?
 - a. (If yes) Have you (Has your loved one) ever called the gambling helpline?
 - b. (If yes) Have you (Has your loved one) ever received treatment for a gambling problem?
- 2) Have you (Has your loved one) ever had a mental health problem, such as depression or anxiety?
 - a. (If yes) Have you (Has your loved one) ever sought help for a mental health problem such as depression or anxiety?
- 3) Have you (Has your loved one) ever received treatment for a substance use problem?¹⁰

Analytic Plan

We provide basic descriptive statistics for the aforementioned Supplemental Data Items and three caller characteristic variables from the helpline data records: gender, age, and DPH region of residence. To inform the DPH decision about whether to combine the helplines, we also report key comparisons with general population estimates and between helplines, as described in the following sections. We completed our analyses for the full sample, as well as separately for first time callers and repeat callers.

Decision Points

Prior to analyzing the data, we considered how we might use the above information to inform DPH’s decision-making related to its helpline services. We considered two primary decision points to inform our approach. First, we considered information that would support transitioning to a combined helpline. Specifically, we suggested that (1) high levels of mental health comorbidity on both helplines, and (2) high levels of co-occurring gambling and substance use problems on both helplines both are suggestive of the need for a combined service. Second, we considered information that would support maintaining separate helpline services. Specifically, we suggested that (1) high repeat caller rates might indicate service preferences and therapeutic alliance, and (2) distinct demographic patterns between helplines both might indicate

⁸ Originally, this question was drafted as written here. However, as can be seen in the substance use helpline supplemental data items, the substance use helpline simplified the question to not include “other than substance use or gambling problems”.

⁹ Though this was the drafted question, upon implementation, the gambling helpline instead asked “Have you (Has your loved one) ever called a mental health helpline?”

¹⁰ The substance use helpline informed us they already collected this information, so did not ask this question separately, instead relying on information obtained from a separate question about number of treatment attempts their callers had made.

independent caller populations that require specialized helpline services. In addition to these variables, we also report upon key treatment seeking patterns for gambling, substance use, and mental health by describing proportions of caller groups that have engaged in such activities.

Analyzing Evidence for Combined Helplines

To identify “high” levels of psychiatric comorbidity among gambling helpline callers and among substance use helpline callers, we identified rates of mood disorder and anxiety disorder comorbidity among people with gambling disorder and substance use disorders in the general population. We operationalized “high” as a rate that exceeds the lower range of the confidence interval for the highest psychiatric comorbidity estimate. According to the National Epidemiological Survey on Alcohol & Related Conditions (NESARC), among those with gambling disorder, 49.62% (95% CI = 40.49%, 58.75%) had a lifetime mood disorder and 41.30% (95% CI 32.38%, 50.22%) had a lifetime anxiety disorder (Petry, Stinson, & Grant, 2005). With respect to those with substance use disorder, NESARC indicated that 19.67% (95% CI = 18.14%, 21.99%) had a past 12-month¹¹ mood disorder and 17.71% (95% CI = 16.12%, 19.30%) had a past 12-month anxiety disorder (Grant et al., 2004). Therefore, we considered mental health disorder rates to be high if they were 40.5% or more among gambling helpline callers. Likewise, we considered mental health disorder rates to be high if they were 18.1% or more among substance use helpline callers.

To identify “high” levels of substance use disorder comorbidity among groups of helpline callers we identified rates of substance use disorder, alcohol use disorder, and gambling disorder comorbidity among people with gambling disorders and substance use disorders in the general population. We operationalized “high” as a rate that exceeds the lower range of the confidence interval for the highest comorbidity estimate. With respect to gambling, according to the NESARC, among people with gambling disorder, 38.10% (95% CI = 28.87%, 47.33%) had a drug use disorder and 73.22% (95% CI = 71.00%, 75.24%) had an alcohol use disorder (Petry et al., 2005). Therefore, we considered substance use disorder rates to be high if they were 71.0% or more among gambling helpline callers. With respect to substance use disorders, according to the NESARC, among people with substance use disorder, 1.56% (95% CI = 1.11%, 2.01%) had a gambling disorder and among people with alcohol use disorder, 1.03% (95% CI = 0.81%, 1.25%) had a gambling disorder (Petry et al., 2005). Therefore, we considered gambling disorder rates to be high if they were 1.1% or more among substance use helpline callers.

Analyzing Evidence for Separated Helplines

There is no reliable published information in the peer reviewed literature related to typical repeat caller rates to gambling helplines or substance use helplines. Therefore, in the absence of guiding information prior to analyzing the data we selected an arbitrary benchmark of 20%. Therefore, for both helplines we considered repeat caller rates to be high if they exceeded 20% of all callers.

Finally, we used the helpline caller records to examine the demographic characteristics of callers to each helpline. Recall that we specifically were interested in understanding the degree of demographic similarity for these helplines. Similarity would indicate evidence that supports combining services. To assess this, we completed chi square comparisons and t-tests, as necessary. Comparisons included age, gender, and DPH region of residence. As noted above, we did this for the full sample, and separately for first-time callers and repeat callers.

¹¹ Whereas existing publications that use the NESARC data reported lifetime rates for gambling disorder comorbidity with other disorders, they reported past 12-month rates for substance use disorder comorbidity with mood and anxiety disorders.

Observations

During the supplemental data collection period (i.e., January 2019 through April 2019), in all there were 3,276 callers to the substance use helpline and 130 callers to the gambling helpline.

Evidence for Combined Helplines

As Table 2 shows, we observed that the overall rate of substance use problems among gambling helpline callers did not exceed our threshold to be considered “high” (39.8% actual versus 71.0% cut-point). This was the case for first-time callers and repeat callers, as well. The rate for repeat callers was just under our predetermined threshold. However, the overall rate of mental health problems did exceed our threshold (44.7% actual versus 40.5% cut-point). Although this was the case for repeat callers, first-time callers did not exceed our predetermined threshold. Therefore, the evidence from the gambling helpline in support of combining the helplines was mixed but leaned somewhat against combination.

Table 2: Evidence for Combined Helplines: Characteristics of Gambling Helpline Callers (N=130 calls)

	Overall %	% of first-time callers	% of repeat callers
Ever experienced a substance use problem ^a	39.8%	28.8%	69.0%
Ever had a mental health problem other than substance use or gambling problems, such as depression or anxiety ^b	44.7%	37.7%	66.7%

^a This question was not asked of 20 of the callers; a value of “unknown” was entered for 2 callers; 5 callers refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (103 total; 73 first-time callers; 29 repeat callers; 1 caller whose repeat status was unknown).

^b This question was not asked of 26 of the callers; a value of “unknown” was entered for 2 callers; 8 callers refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (94 total; 69 first-time callers; 24 repeat callers; 1 caller whose repeat status was unknown).

As Table 3 shows, our examination of substance use helpline caller rates of gambling-related problems suggested that the overall prevalence was higher than our predetermined threshold (2.3% actual versus 1.0% cut-point), and likewise, overall rates of mental health problems also exceeded our threshold to be considered “high” (50.7% actual versus 18.1% cut-point). Although this pattern held for first-time callers, it only held partially for repeat callers. More specifically, the rate of gambling-related problems among repeat substance use helpline callers did not exceed our threshold; however, the rate of mental health problems among repeat callers did do so. Largely, these findings support the notion of working toward the development of a combined helpline.

Table 3: Evidence for Combined Helplines - Characteristics of Substance Use Helpline Callers (N=3,276 calls)

	Overall %	% of first-time callers	% of repeat callers
Ever experienced a gambling problem	2.3% (w/ additional 6.5% indicating “not sure”)	2.4% (w/ additional 6.4% indicating “not sure”)	0.0% (w/ additional 8.8% indicating “not sure”)
Ever had a mental health problem, such as depression or anxiety	50.7% (w/ additional 7.1% indicating “not sure”)	50.4% (w/ additional 7.0% indicating “not sure”)	58.9% (w/ additional 10.5% indicating “not sure”)

^a This question was not asked of 67 of the callers. The percentages provided are out of the respondents who answered the question either “yes”, “no” or “not sure” (3209 total; 3084 first-time callers; 125 repeat callers).

^b This question was not asked of 64 of the callers. The percentages provided are out of the respondents who answered the question either “yes” or “no” or “not sure” (3212 total; 3088 first-time callers; 124 repeat callers). The phrasing of the question differed slightly from that asked of Gambling Helpline callers.

Evidence for Separated Helplines

We identified 129 (3.9%) substance use helpline callers as repeat callers and 42 (32.6%)¹² gambling helpline callers as repeat callers. Recall that we suggested that we would consider a repeat caller rate greater than 20% to indicate support for maintaining separate helplines. Whereas the substance use helpline repeat caller rate does not meet this threshold, the gambling helpline repeat caller rate indicates that its caller population has a meaningful number of repeat callers and exceeds this threshold. It is possible that these callers have built a rapport with the gambling helpline staff. In such a case, it might be beneficial to maintain gambling helpline access as usual.¹³

We also examined the helplines in terms of three demographic characteristics (i.e., Age, Gender, and DPH Region). We suggested that evidence of extensive demographic differences between the two helplines indicates different caller populations that might be better served by separate helplines. Our observations related to demographic characteristics, presented in Table 4, were mixed. Whereas Age, Gender, and DPH Region evidenced significant differences overall, these differences appear to be driven by the characteristics of repeat callers and with the exception of age, were not reflected among first-time callers. Therefore, the evidence in support of separating the helplines was mixed, but leaned somewhat against combination.

Generally speaking, callers to the gambling helpline are older and less likely to be female. They also appeared to have a distinct DPH Region profile: notably, for the gambling helpline, rates in the Central region appeared elevated and rates in the Metro West and Boston regions appeared depressed. These patterns of findings held for repeat callers, but among first-time callers, we only observed a significant difference for age: first-time gambling helpline callers were older than first-time substance use disorders callers. Again, these observations provide mixed support for the maintenance of separate helplines.

¹² This excludes one individual who had missing data for whether they were a repeat caller or not.

¹³ Though we could not make any definitive determinations from the data, demographic information suggests that 19-31 of the 42 repeat callers might actually be the same person. (In 19 cases, city, age, disability status, gender, and marital status all matched; in an additional 12 cases, city, disability status, gender, and marital status all matched the previous cases, but age was not provided.) If 45-74% of repeat callers are actually one individual, this might lead to a different recommendation.

Table 4: Evidence for Separated Helplines: Demographics of Helpline Callers

	Gambling Helpline Callers			Substance Use Helpline Callers		
	Overall	First-time callers	Repeat callers	Overall	First-time callers	Repeat callers
Age ^a						
Mean	52.5***	44.3**	63.8***	38.8***	38.8**	39.4***
Standard deviation	17.5	17.0	4.3	13.3	13.2	13.7
Range	18-99	18-99	45-65	11-82	11-82	15-78
Gender ^b						
% Female	15.7%***	23.7%	2.4%***	35.7%***	35.9%	30.2%***
DPH Region ^c						
% Western	15.0%***	20.0%	7.5%***	11.5%***	11.6%	9.3%***
% Central	40.0%***	15.0%	77.5%***	13.2%***	13.4%	7.8%***
% Northeast	19.0%***	25.0%	10.0%***	20.5%***	20.4%	22.5%***
% Metro West	6.0%***	10.0%	0.0%***	17.8%***	17.7%	20.9%***
% Southeast	12.0%***	18.3%	2.5%***	21.6%***	21.6%	20.2%***
% Boston	8.0%***	11.7%	2.5%***	15.4%***	15.3%	19.4%***

^a Recoded one gambling helpline case in which age was "0" to missing. Information about age missing for 66 gambling helpline callers (48 first-time callers; 18 repeat callers).

^b Information about gender missing for 28 gambling helpline callers (28 first-time callers; 0 repeat callers). 3 substance use helpline callers were transgender.

^c Information about region missing for 30 gambling helpline callers (27 first-time callers; 2 repeat callers; 1 caller whose repeat status was unknown) and 12 substance use helpline callers (12 first-time callers; 0 repeat callers). Regions were defined using the Massachusetts Executive Office of Health & Human Services region map (https://matracking.ehs.state.ma.us/eohhs_regions/eohhs_regions.html)

*Significant difference between gambling and substance use Helpline callers, $p < .05$; results for region are from 2x6 chi square.

**Significant difference between gambling and substance use Helpline callers, $p < .01$; results for region are from 2x6 chi square.

***Significant difference between gambling and substance use Helpline callers, $p < .001$; results for region are from 2x6 chi square.

Other Related Evidence

We did not have specific decision thresholds related to secondary helpline use or treatment experiences. As Table 5 shows, we observed that modest to meaningful numbers of gambling helpline callers who reported having experienced substance use problems interacted with substance use helplines and indicated that they had received treatment for a substance use problem. Similarly, a modest number of gambling helpline callers who reported having experienced mental health problems also reported that they had called a mental health helpline for such problems. These occurrences lend support

to the idea that combined helplines might better address the complex matrix of issues that callers to gambling helplines report. Gambling helpline callers were moderately likely to report that they have participated in treatment for a gambling-related problem, but repeat callers were very much likely to report such experience.

Table 5: Other Related Evidence: Characteristics of Gambling Helpline Callers

	Overall %	% of first-time callers	% of repeat callers
Among Gambling Helpline Callers Who Reported Having Experienced Substance Use Problems (N = 41)			
Ever called the substance use helpline ^a	19.4%	15.0%	25.0%
Ever received treatment for a substance use problem ^b	70.6%	57.9%	86.7%
Among Gambling Helpline Callers Who Reported Having Experienced Mental Health Problems (N = 42)			
Ever called a mental health helpline for a mental health problem other than substance use or gambling problems, such as depression or anxiety ^c	16.1%	15.0%	18.2%
Among All Gambling Helpline Callers (N = 130)			
Ever received treatment for a gambling problem ^d	34.0%	20.5%	73.1%

^a This question was not asked of 2 of the 41 callers who indicated they had a substance use problem; an additional 3 refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (36 total; 20 first-time callers; 16 repeat callers).

^b This question was not asked of 3 of the 41 callers who indicated they had a substance use problem; an additional 4 refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (34 total; 19 first-time callers; 15 repeat callers).

^c This question was not asked of 8 of the 42 callers who indicated they had a mental health problem; an additional 3 refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (31 total; 20 first-time callers; 11 repeat callers). This question was supposed to be about treatment for mental health; however, the question was instead asked about calling a mental health helpline.

^d This question was not asked of 19 of the callers; a value of “unknown” was entered for 2 callers; 9 callers refused the question. The percentages provided are out of the respondents who answered the question either “yes” or “no” (100 total; 73 first-time callers; 26 repeat callers; 1 caller whose repeat status was unknown).

As Table 6 shows, we observed that modest numbers of first-time substance use helpline callers who reported having experienced gambling problems interacted with gambling helplines and indicated that they had received treatment for a gambling-related problem. No repeat callers indicated that they had a gambling-related problem. However, a meaningful number of substance use helpline callers who reported having experienced mental health problems also reported that had received treatment for such problems. These occurrences lend support to the idea that combined helplines might better address the complex matrix of issues that callers to substance use helplines report. Substance use helpline callers were highly likely to report that they have been in treatment for substance-related problems.

Table 6: Other Related Evidence - Characteristics of Substance Use Helpline Callers

	Overall %	% of first-time callers	% of repeat callers
Among Substance Use Helpline Callers Who Reported Having Experienced Gambling Problems (N = 74)			
Ever called the gambling helpline ^a	9.7% (w/ additional 2.8% indicating “not sure”)	9.7% (w/ additional 2.8% indicating “not sure”)	N/A (no repeat callers w/ gambling problem)
Ever received treatment for a gambling problem ^a	11.1% (w/ additional 2.8% indicating “not sure”)	11.1% (w/ additional 2.8% indicating “not sure”)	N/A (no repeat callers w/ gambling problem)
Among Substance Use Helpline Callers Who Reported Having Experienced Mental Health Problems (N = 1,630)			
Ever sought help for a mental health problem, such as depression or anxiety ^b	79.7% (w/ additional 3.4% indicating “not sure”)	79.6% (w/ additional 3.4% indicating “not sure”)	81.7% (w/ additional 4.2% indicating “not sure”)
Among All Substance Use Helpline Callers (N = 3,276)			
Ever received treatment for a substance use problem	69.5%	70.1%	53.5%

^a This question was not asked of 2 of the 74 callers who indicated they had a gambling problem. The percentages provided are out of the respondents who answered the question either “yes”, “no” or “not sure” (72 total; 72 first-time callers; 0 repeat callers).

^b This question was not asked of 20 of the 1630 callers who indicated they had a mental health problem. The percentages provided are out of the respondents who answered the question either “yes”, “no” or “not sure” (1610 total; 1539 first-time callers; 71 repeat callers).

^c The percentage provided is out of the respondents who answered a question about # of SU treatment attempts (3276 total; 3147 first-time callers; 129 repeat callers). Answers of 1 or more were coded as having received SU treatment.

Summary

Our analyses of the caller characteristics for MA-based substance use and gambling helplines provided an inconsistent picture. To start, the primary evidence in support of a combined helpline is stronger among SUD callers than among gambling callers, though some evidence for combining is obvious for both call populations. Secondary evidence suggests the reverse, as few substance use helpline callers who have a gambling problem called gambling helplines or received gambling treatment, but many gambling helpline callers who have a substance use problem called substance use helplines and received substance use treatment. Adding to this complicated picture, we observed that repeat calling evidence to maintain separation is stronger among gambling helpline callers than among substance use helpline callers. Finally, demographic evidence was not consistent for different types of callers. Evidence to maintain separation is stronger among

repeat callers than first time callers. Repeat callers had uniformly distinct demographics, but first-time callers were demographically similar on gender and DPH region, but not age.

4. Service Characteristics for MA-Based Substance Use and Gambling Helplines

Current service characteristics might provide insight into whether either the gambling helpline or the substance use helpline might be suited to manage a helpline that addresses both issues. To better understand the service characteristics of the two helplines, we looked at two sources of data: (1) helpline records and (2) a helpline director survey. More specifically, with respect to helpline records, we reviewed helpline activity characteristics including call volume, typical days of the week and times of day for calls, and call outsourcing. Prior to examining the data, we considered how these activities might inform readiness to assume a combined helpline. We suggested that greater readiness to assume a combined helpline might be reflected by (1) routinely handling large call volumes, (2) having more extensive hours of operation, and (3) infrequent outsourcing of calls.

With respect to helpline service standards, we accessed helpline service certification standards from multiple helpline accreditation sources, including [Alliance for Information and Referral Systems](#), [Contact USA](#), and [Helplines Partnership](#). A comprehensive compilation of service standards from these sources included 109 total standards of varying complexity, some of which were similar in nature and overlapping. We narrowed the standards down to those representing five domains: (1) Operations, (2) Access, Resources, & Referrals, (3) Data & Evaluation, (4) Hiring, Training, & Supervision, and (5) Organization Characteristics. Within those domains, we further narrowed the items that compose each domain by combining and/or removing similar and overlapping standards from the various accreditation sources. This yielded a list of 24 standards, which we converted into questions. We requested that MCCG and HRiA complete these questions for their respective helplines via a Qualtrics survey. Upon receiving responses from MCCG and HRiA, we noted any unclear responses and requested clarification of some answers from each organization.

Observations

From the Helpline Records

Figure 3 provides an overview of calls per week by helpline. During the study period, the substance use helpline fielded an average of 183.5 more calls per week than the gambling helpline.

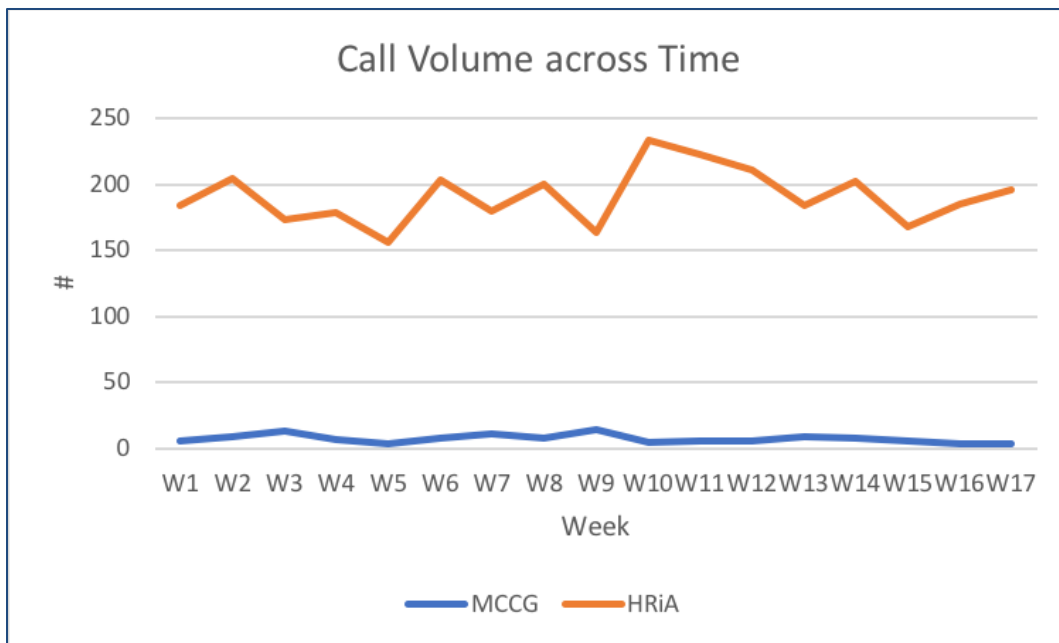


Figure 3: Call Volume by Time. (This Figure does not include 30 calls that occurred on 4/30/19 because week 17 ended on 4/29/19.)

As Table 7 shows, there were no extreme daily pattern differences between helplines. Among first time callers, gambling helpline call rates appeared slightly elevated for Thursdays and Fridays and lowered for Tuesdays and Wednesdays relative to the substance use helpline.

Table 7: Calls by Day of Week

	Gambling Helpline Callers (%)			Substance Use Helpline Callers (%)		
	Overall*	First-time Callers*	Repeat Callers	Overall*	First-time Callers*	Repeat Callers
Monday	15.4%	17.2%	11.9%	18.3%	18.3%	17.8%
Tuesday	10.0%	11.5%	7.1%	17.4%	17.5%	16.3%
Wednesday	13.1%	12.6%	11.9%	17.6%	17.6%	17.8%
Thursday	23.8%	27.6%	16.7%	16.8%	16.7%	18.6%
Friday	23.1%	23.0%	23.8%	16.5%	16.5%	17.8%
Saturday	8.5%	3.4%	19.0%	7.0%	7.1%	4.7%
Sunday	6.2%	4.6%	9.5%	6.4%	6.4%	7.0%

Note. Percentages refer to the percent of calls occurring on each day. Each column totals 100%.

*Significant difference between gambling and substance use Helpline callers, $p < .05$; results are from 2x7 chi square.

As Table 8 shows, hourly pattern differences between helplines were more obvious. Notably, more than 20% of gambling helpline calls occur between the hours of 11pm and 5am. In contrast, calls to the substance use helpline were relatively high during the morning hours.

Table 8: Calls by Time of Day

	Gambling Helpline Callers (%)			Substance Use Helpline Callers (%)		
	Overall***	First-time Callers***	Repeat Callers***	Overall***	First-time Callers*	Repeat Callers***
8:01am-11:00am	3.8%	1.1%	9.5%	23.9%	23.9%	24.0%
11:01am-2:00pm	14.6%	8.0%	28.6%	33.1%	33.0%	33.3%
2:01pm-5:00pm	16.9%	16.1%	16.7%	27.3%	27.0%	33.3%
5:01pm-8:00pm	18.5%	24.1%	7.1%	11.8%	12.0%	7.0%
8:01pm-11:00pm	23.8%	32.2%	7.1%	3.9%	4.0%	2.3%
11:01pm-2:00am	11.5%	8.0%	19.0%	0.0%	0.0%	0.0%
2:01am-5:00am	10.0%	9.2%	11.9%	0.0%	0.0%	0.0%
5:01am-8:00am	0.8%	1.1%	0.0%	0.0%	0.0%	0.0%

Note. Percentages refer to the percent of calls occurring on each day. Each column totals 100%.

****Significant difference between gambling and substance use Helpline callers, $p < .001$; results are from 2x7 chi square.*

During the study period, a third party handled the majority of calls to the gambling helpline. This situation is atypical for the history of the gambling helpline. Most often, MCCG handles calls Monday-Friday during the hours 8:30am to 5:00pm and the contracted third party handles calls during the remaining hours. MCCG handled 12 of 130 gambling helpline calls (one of which was a repeat caller) and the remainder were handled by the third party during the study period. HRIA did not outsource any calls.

From the Directors' Survey

Recall that the director's survey included inquiries related to helpline standards from the following five domains: (1) Operations, (2) Access, Resources, & Referrals, (3) Data & Evaluation, (4) Hiring, Training, & Supervision, and (5) Organization Characteristics. In Appendix C, we display tables of the standards that compose each domain and directors' responses to how their organization does or does not meet those standards. Each table is coded to indicate how well the organization meets the standard using the following descriptors: ES = exceeds expectations for standard; MS = meeting expectations for standard; or, DNMS= does not meet standard. To rate organizations, two researchers coded the responses independently. These researchers' codes indicated that they agreed for about 76% of ratings. The researchers met to resolve discrepancies and obtained 100% agreement. Table 9 provides a summary of counts for the standards ratings by organization and domain. In the sections that follow, we provide a description of how each organization met each standard.

Table 9: Counts of Standards Ratings by Organization and Domain

Organization	Exceeds Standards	Meets Standards	Does Not Meet Standards
<i>Massachusetts Council on Compulsive Gambling – Gambling Helpline</i>			
Operations	0	8	1
Access, Resources, & Referrals	0	3	3
Data & Evaluation	2	2	1
Hiring, Training, & Supervision	0	3	3
Organization	0	0	3
<i>Health Resources in Action – Substance Use Helpline</i>			
Operations	5	1	3
Access, Resources, & Referrals	4	1	1
Data & Evaluation	2	3	0
Hiring, Training, & Supervision	6	0	0
Organization	1	1	1

Operations

As Table C1 indicates, with respect to operations, HRiA and MCCG had one common standard for which they both had satisfactory practices or protocols: *access to a second phone line for emergencies*. Uniquely, MCCG had 7 standards for which they met expectations. These were (1) *availability of helpline specialists*, (2) *call-forwarding policies*, (3) *call-forwarding MoU with written protocol for handling contacts*, (4) *written confidentiality / anonymity policies*, (5) *written call management policies and procedures*, (6) *written emergency handling procedures*, and (7) *written policies for intervention for suicidal clients*. Likewise, HRiA had 5 standards for which it exceeded expectations: (1) *written confidentiality / anonymity policies*, (2) *written call management policies and procedures*, (3) *written emergency handling procedures*, (4) *written policies for intervention for suicidal clients*, and (5) *suicidality risk assessment used as part of standard procedure if suicide ideation is detected*. MCCG had a single standard for which they did not meet standards (i.e., *suicidality risk assessment used as part of standard procedure if suicide ideation is detected*). HRiA did not meet standards for three standards: (1) *availability of helpline specialists*, (2) *call-forwarding policies*, and (3) *call-forwarding MoU with written protocol for handling contacts*. However, HRiA does not offer or contract with a third party to offer 24/7 helpline services, so two of those three standards were not relevant to their situation. (To maintain 24/7 access, the MCCG contracts with a 3rd party and has an appropriate MoU for these services.¹⁴)

¹⁴ The 3rd party currently is handling all of the gambling helpline calls due to a directive from the OPGS at DPH. This report does not specifically evaluate the 3rd party helpline services against these standards, but does consider their programs and policies when described within the MCCG director’s survey responses.

Access, Resources, & Referrals

As Table C2 indicates, with respect to access, resources, and referrals, HRiA and MCCG had two standards for which they both had satisfactory practices or protocols. These included (1) *documented exclusion/inclusion criteria for entries in the referral database* and (2) *documented procedures for identifying new resources for referral database*. HRiA had four additional standards for which they exceeded standards: (1) *barrier-free access to helpline*, (2) *referral database easily accessible*, (3) *policies or procedures for how referrals are provided to callers*, and (4) *documented process for verifying and updating information in referral database on a regular basis*. In contrast, MCCG had two additional standards for which it had satisfactory protocols: (1) *barrier-free access to helpline* and (2) *referral database easily accessible*. MCCG also had two for which it did not meet standards: (1) *policies or procedures for how referrals are provided to callers* and (2) *documented process for verifying and updating information in referral database on a regular basis*.

Data & Evaluation

As Table C3 indicates, MCCG and HRiA had two standards in common for which they had satisfactory programs or protocols and two standards in common for which they exceeded standards. Those with satisfactory standards included (1) *performance indicators collected by helpline* and (2) *customer satisfaction surveys collected*. Those standards that the organizations exceeded included (1) *all interactions documented by helpline specialist* and (2) *helpline performance according to most recent consumer satisfaction survey*. For the standard *helpline performance according to most recent collected performance indicators*, MCCG did not meet this standard, but HRiA had satisfactory reported performance.

Hiring, Training, & Supervision

As Table C4 indicates, HRiA had 6 standards for which they uniquely exceeded standards: (1) *measurable objectives in training curriculum that must be demonstrated as part of training*, (2) *basic training about suicide awareness and intervention*, (3) *continuing education related to helpline services*, (4) *structured program of supervision*, (5) *system of support available for helping specialists*, and (6) *annual system of evaluation for helpline specialists*. MCCG had three standards for which it uniquely had satisfactory practices. These included (1) *basic training about suicide awareness and intervention*, (2) *continuing education related to helpline services*, and (3) *annual system of evaluation for helpline specialists*. However, MCCG also had three standards for which it uniquely did not meet standards. These included (1) *measurable objectives in training curriculum that must be demonstrated as part of training*, (2) *structured program of supervision*, and (3) *system of support available for helpline specialists*.

Organization Characteristics

As Table C5 indicates, with respect to organization characteristics, both MCCG and HRiA do not meet standards for having a *written sustainability plan* for the helpline. MCCG further does not meet standards for: (1) *having facilities dedicated to helpline operations* and (2) *broad-based funding*. HRiA had a satisfactory response to the standard for *broad-based funding* and exceeded the standard for *facilities dedicated to helpline operations*.

Other Related Evidence

As Table 10 shows, the top three referral sources for the gambling helpline were GA/Recovery Support Programs, the Lottery website, and the MCCG website. For the substance use helpline, the top three referral sources were Internet/social media, family/friend, and GA/Recovery Support Programs.

Table 10: Calls by Referral Source (First-Time Callers Only)

Referral Sources	Gambling Helpline Callers (n=88 first-time callers)		Substance Use Helpline Callers (n=3147 first-time callers)	
	#	%	#	%
211	0	0.0%	5	0.2%
311 (Boston)	0	0.0%	3	0.1%
411	0	0.0%	12	0.4%
Billboard	0	0.0%	4	0.1%
Bus/Subway Ad	0	0.0%	3	0.1%
Card/Flyer/Brochure	0	0.0%	75	2.4%
CSS	0	0.0%	7	0.2%
Detox	0	0.0%	137	4.4%
DPH/BSAS	0	0.0%	23	0.7%
Emergency Room	0	0.0%	56	1.8%
Employer	0	0.0%	19	0.6%
Family/Friend	2	2.3%	476	15.1%
GA/Recovery Support Program	8	9.1%	372	11.8%
Gambling Industry	2	2.3%	0	0.0%
GameSense Advisor	3	3.4%	0	0.0%
Healthcare Provider	0	0.0%	134	4.3%
Human/Social Service Agency	0	0.0%	332	10.5%
Insurance	0	0.0%	33	1.0%
Internet / Social Media	1	1.1%	945	30.0%
Judicial /Legal System	1	1.1%	59	1.9%
Lottery Website	5	5.7%	0	0.0%
MCCG Website	7	8.0%	0	0.0%
National Hotline	2	2.3%	0	0.0%
Newspaper/Print Media	1	1.1%	4	0.1%

Table 10 (cont.)

Referral Sources	Gambling Helpline Callers (n=88 first-time callers)		Substance Use Helpline Callers (n=3147 first-time callers)	
	#	%	#	%
Parent	0	0.0%	7	0.2%
Place of Worship	0	0.0%	2	0.1%
Police/Fire	0	0.0%	7	0.2%
Radio / TV	0	0.0%	13	0.4%
RMV	0	0.0%	6	0.2%
Residential Treatment Program	0	0.0%	93	3.0%
SAMHSA	0	0.0%	26	0.8%
Sober Home	0	0.0%	4	0.1%
State Agency (other than DPH)	0	0.0%	234	7.4%
Stigma Campaign	0	0.0%	1	0.0%
Suicide / Crisis Line	0	0.0%	2	0.1%
Outpatient Counselor	0	0.0%	32	1.0%
TSS	0	0.0%	2	0.1%
Other	7	8.0%	30	1.0%
Unknown	49	5.6%	30	1.0%

Summary

HRiA routinely handles a much larger volume of helpline calls than MCCG, suggesting greater readiness to absorb additional calls were the helplines to be combined. The HRiA program and protocols are advanced in several ways. The substance use helpline exceeded standards for about 64% of all assessed standards and met or exceeded standards for about 89% of all standards. One primary area in need of attention is the availability of the service. Whereas the gambling helpline is available 24/7 and receives more than 20% of its calls during off-hours (e.g., 11pm-8am), the substance use helpline is not available overnight, accepting no calls between 10pm and 5am. MCCG gambling helpline program and protocols require additional attention to meet standards of several domains. It exceeded standards for about 7% of all assessed standards and met or exceeded standards for about 64% of all standards. Domains in need of the most attention include features of the organization, hiring, training, and supervision, and access, resources, and referrals. At this time, should the OPGS decide to combine helplines, HRiA appears to be better prepared to manage an expanded service with the caveat that it would need to address its current lack of availability during overnight hours.

5. Recommendations & Considerations

Researchers and treatment providers around the world are recognizing the commonalities that many different expressions of addiction share and considering what they mean for services provided. Such recognition has led to changes in diagnostic systems and awareness that similar treatment models might be useful across distinct expressions of addiction. Relatedly, the OPGS at DPH has considered the possibility of optimizing its gambling helpline system by transitioning to a multi-purpose helpline. As part of helping OPGS explore this idea, our work used a variety of empirical methods to weigh the evidence in support of and against a multi-purpose helpline. Had our empirical assessment of these considerations yielded a clearer pattern of findings, definitive recommendations would have been possible. However, our assessments of the literature, services in other states, and the state's helpline caller characteristics indicated a complicated and mixed picture. Ultimately, this decision might not be entirely evidence based; rather, DPH might weigh the mixed evidence here with its own administrative, contractual, and strategic preferences for combined or segregated gambling and substance use helpline services. The proof of concept for mixed purpose helplines in other states assists DPH with a preference for either proposition.

The service characteristics we observed for each helpline presented a more straightforward picture. Although not entirely uniform, the HRiA model has several advantages over the MCCG model. The HRiA substance use helpline has more comprehensive written policies, procedures, and manuals that govern helpline specialists' actions, the referrals provided, and the organization's management of the helpline than the MCCG gambling helpline, and these written documents meet or exceed standards. The substance use helpline also has more clear and detailed training procedures for its employees. We took this as evidence that HRiA would be better prepared to assume a combined helpline, generally, and more quickly than MCCG. However, the HRiA model might be improved by adopting some MCCG practices including 24/7 access and, if necessary to provide such access, in partnership with a subcontractor. Notably, the MCCG helpline is very low volume, even after four years of gambling expansion and additional helpline promotional activity by high profile sources, GameSense and the Massachusetts Gaming Commission. The HRiA helpline is relatively high volume but rolling in an additional 30-40 gambling-related calls per month should not strain its resources inordinately.

According to recent budgets provided by the OPGS, the MCCG gambling helpline costs roughly \$400 per interaction and the substance use helpline costs roughly \$107 per interaction.¹⁵ A purely financial decision-point related to combining helplines is unwarranted, however, should DPH maintain separate helplines, it might want to examine ways to align costs per interaction and/or determine why interaction costs are different for these helplines.

Currently, we recommend maintaining the gambling helpline, at least temporarily, given its distinct population of callers, especially repeat callers, high repeat caller rate, and the absence of definitive comorbidity support for combining helplines. In addition, it is clear that even if the helplines remain separate, the substance use helpline needs to be required to address mental health *and* gambling, and there is proof of concept supporting such practices. Hence, there exists a cooperative training opportunity for MCCG/HRiA that would lay the foundation for a future change. In addition, creating a combined resource database that includes substance use and gambling service providers would benefit both helplines. Eventually, as gambling becomes routinized within the HRiA services, DPH might want to revisit the idea of combining helplines to

¹⁵ These numbers are only rough estimates of cost per interaction and are not definitive cost-benefit analyses. We estimated annual calls and performed a crude analysis to give the OPGS a rough sense of cost per interaction. A formal cost-benefit analysis with an evaluator experienced in this area will provide the DPH with more definitive observations. Nonetheless, at the most basic level, there appear to be large cost differences associated with the helplines that should be explored.

optimize resources and services. This might involve the services of one or both organizations. Nonetheless, it would be immediately useful to identify ways to build innovative bridges between these helplines, for referrals, for info sharing, for training, for resource materials, and for more. Operating fully independently as if the other helpline does not exist risks failing to capitalize on each program's strengths and attending to the complicated health background of helpline callers. Formalizing new and inventive avenues of contact, connection, and awareness activities between the substance use and gambling helplines is highly recommended.

Recommendations

- (1) Maintain separate helplines, at least temporarily, and revisit the possibility of combining helplines in the future, including the completion of helpline caller surveys with respect to this issue.
- (2) Require helplines maintain minimum standards certification by 3rd party such as Contact USA.
- (3) Develop a cooperative training agenda to advance helplines' capabilities for addressing mental health, gambling, and substance use problems, as needed.
- (4) Create a shared resource database that informs referrals for both helplines.
- (5) Require helplines to develop and implement plans for addressing mental health, gambling, and substance use problems, as needed.
- (6) Engage with a business consultant to better understand and align helpline costs that currently appear to be disproportionate to services.
- (7) Commence an initiative to explore the development and implementation of innovative bridges between the gambling and substance use helplines.

6. References

- Abbott, M., Hodgins, D. C., Bellringer, M., Vandal, A. C., Palmer Du Preez, K., Landon, J., . . . Feigin, V. (2018). Brief telephone interventions for problem gambling: A randomized controlled trial. *Addiction*, *113*(5), 883-895. doi:10.1111/add.14149
- Amuedo-Dorantes, C., Mach, T., & Clapp, J. D. (2004). The impact of schools on juvenile substance initiation and use. *Prevention Science*, *5*(2), 91-99.
- Biazzo, L. L., Froshaug, D. B., Harwell, T. S., Beck, H. N., Haugland, C., Campbell, S. L., & Helgerson, S. D. (2010). Characteristics and abstinence outcomes among tobacco quitline enrollees using varenicline or nicotine replacement therapy. *Nicotine & Tobacco Research*, *12*(6), 567-573. doi:10.1093/ntr/ntq045
- Bischof, A., Meyer, C., Bischof, G., Guertler, D., Kastirke, N., John, U., & Rumpf, H. J. (2014). Association of sociodemographic, psychopathological and gambling-related factors with treatment utilization for pathological gambling. *European Addiction Research*, *20*(4), 167-173. doi:10.1159/000356904
- Brockman, T. A., Patten, C. A., & Lukowski, A. (2018). Skill sets for family members and friends to help motivate a smoker to seek treatment: Research to practice. *Addiction Research & Theory*, *26*(6), 525-532.
- Brown, R. A., Hecht, J., Bloom, E. L., Minami, H., Kahler, C. W., Abrantes, A. M., . . . Ondersma, S. J. (2017). Development and preliminary pilot evaluation of a brief tablet computer intervention to motivate tobacco quitline use among smokers in substance use treatment. *American Journal of Addiction*, *26*(6), 587-594. doi:10.1111/ajad.12559
- Buller, D. B., Halperin, A., Severson, H. H., Borland, R., Slater, M. D., Bettinghaus, E. P., . . . Woodall, W. G. (2014). Effect of nicotine replacement therapy on quitting by young adults in a trial comparing cessation services. *Journal of Public Health Management Practices*, *20*(2), E7-E15. doi:10.1097/PHH.0b013e3182a0b8c7
- Bush, T. M., McAfee, T., Deprey, M., Mahoney, L., Fellows, J. L., McClure, J., & Cushing, C. (2008). The impact of a free nicotine patch starter kit on quit rates in a state quit line. *Nicotine & Tobacco Research*, *10*(9), 1511-1516. doi:10.1080/14622200802323167
- Carlini, B. H., & Garrett, S. B. (2018). Drug helplines and adult marijuana users: An assessment in Washington, Colorado, Oregon, and Alaska. *Substance Abuse*, *39*(1), 3-5. doi:10.1080/08897077.2017.1355872
- Clemens, S. L., & Ritter, A. (2008). Estimating the prevalence of individuals likely to use publicly funded alcohol treatment services: an indirect estimation technique. *Drug & Alcohol Review*, *27*(5), 504-508. doi:10.1080/09595230802093752
- Courtney, R. J., Clare, P., Boland, V., Martire, K. A., Bonevski, B., Hall, W., . . . Mattick, R. P. (2017). Predictors of retention in a randomised trial of smoking cessation in low-socioeconomic status Australian smokers. *Addictive Behaviors*, *64*, 13-20. doi:10.1016/j.addbeh.2016.07.019
- Cummins, S. E., Wong, S., Bonnevie, E., Lee, H. R., Goto, C. J., McCree Carrington, J., . . . Zhu, S. H. (2015). A multistate Asian-language tobacco quitline: Addressing a disparity in access to care. *Am J Public Health*, *105*(10), 2150-2155. doi:10.2105/AJPH.2014.302418
- Danielsson, A. K., Eriksson, A. K., & Allebeck, P. (2014). Technology-based support via telephone or web: a systematic review of the effects on smoking, alcohol use and gambling. *Addictive Behaviors*, *39*(12), 1846-1868. doi:10.1016/j.addbeh.2014.06.007
- Docherty, G., Lewis, S., McEwen, A., Bauld, L., & Coleman, T. (2014). Does use of 'non-trial' cessation support help explain the lack of effect from offering NRT to quitline callers in a RCT? *Tobacco Control*, *23*(6), 524-525. doi:10.1136/tobaccocontrol-2013-051107
- Ferland, A., Ladouceur, R., Giroux, I., Savard, C., Ruel, S., Leclerc, M.-F., & Guimond, F. (2013). Evaluation of the quality of services provided by a gambling helpline: An empirical study. *Journal of Gambling Issues*, *28*, 1-11.
- Gainsbury, S., Hing, N., & Suhonen, N. (2014). Professional help-seeking for gambling problems: Awareness, barriers and motivators for treatment. *Journal of Gambling Studies*, *30*(2), 503-519. doi:10.1007/s10899-013-9373-x
- Gates, P. J. (2015). The effectiveness of helplines for the treatment of alcohol and illicit substance use. *Journal of Telemedicine & Telecare*, *21*(1), 18-28. doi:10.1177/1357633X14555643
- Gates, P. J., Norberg, M. M., Copeland, J., & Digiusto, E. (2012). Randomized controlled trial of a novel cannabis use intervention delivered by telephone. *Addiction*, *107*(12), 2149-2158. doi:10.1111/j.1360-0443.2012.03953.x
- Glasgow, R. E., Hollis, J. F., McRae, S. G., Lando, H. A., & LaChance, P. (1991). Providing an integrated program of low intensity tobacco cessation services in a health maintenance organization. *Health Education Research*, *6*(1), 87-99. doi:10.1093/her/6.1.87

- Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., . . . Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry*, *61*, 807-816.
- Heinemans, N., Toftgard, M., Damstrom-Thakker, K., & Galanti, M. R. (2014). An evaluation of long-term changes in alcohol use and alcohol problems among clients of the Swedish National Alcohol Helpline. *Substance Abuse Treatment, Prevention, and Policy*, *9*(22), 1-9. doi:10.1186/1747-597X-9-22
- Ingram, S., Ringle, J. L., Hallstrom, K., Schill, D. E., Gohr, V. M., & Thompson, R. W. (2008). Coping with crisis across the lifespan: The role of a telephone hotline. *Journal of Child and Family Studies*, *17*(5), 663-674.
- Marotta, J., Hynes, J., Rugle, L., Whyte, K., Scanlan, K., Sheldrup, J., & Dukart, J. (2017). *2016 Survey of Problem Gambling Services in the United States*. Retrieved from Boston, MA: Association of Problem Gambling Service Administrators
- Miller, W. R., & Rollnick, S. (Eds.). (1991). *Motivational interviewing: preparing people to change addictive behavior*. New York: Guilford Press.
- Mosavel, M. (2004). The role of technology in mediating use of outpatient substance abuse treatment services. *Journal of Social Work Practice in the Addictions*, *4*(2), 65-83.
- Ni, K., Wang, B., Link, A., & Sherman, S. J. (Online First). Does smoking intensity predict cessation rates? A study of light-intermittent, light-daily, and heavy smokers enrolled in two telephone-based counseling interventions. *Nicotine & Tobacco Research*.
- Ossip-Klein, D. J., Shapiro, R. M., & Stiggins, J. (1984). Freedom line: Increasing utilization of a telephone support service for ex-smokers. *Addictive Behaviors*, *9*(2), 227-230.
- Petry, N. M., Stinson, F. S., & Grant, B. F. (2005). Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, *66*(5), 564-574.
- Rodda, S. N., Hing, N., & Lubman, D. I. (2014). Improved outcomes following contact with a gambling helpline: The impact of gender on barriers and facilitators. *International Gambling Studies*, *14*(2), 318-329.
- Rosenbaum, A., & Calhoun, J. F. (1977). The use of the telephone hotline in crisis intervention: A review. *Journal of Community Psychology*, *5*(4), 325-339.
- Shaffer, H. J., LaPlante, D. A., LaBrie, R. A., Kidman, R. C., Donato, A. N., & Stanton, M. V. (2004). Toward a syndrome model of addiction: Multiple expressions, common etiology. *Harvard Review of Psychiatry*, *12*, 367-374.
- Shaffer, H. J., LaPlante, D. A., & Nelson, S. E. (Eds.). (2012). *The American Psychological Association Addiction Syndrome Handbook*. Washington, D.C.: American Psychological Association Press.
- Shandley, K., & Moore, S. (2008). Evaluation of Gambler's Helpline: A consumer perspective. *International Gambling Studies*, *8*(3), 315-330.
- Shapiro, R. M., Ossip-Klein, D. J., Gerrity, E. T., & Stiggins, J. (1985). Perceived helpfulness of messages on a community-based telephone support service for ex-smokers. *International Journal of Addictions*, *20*(11-12), 1837-1847.
- Shiffman, S. (1982). A relapse-prevention hotline. *Bulleting of the Society of Psychologists in Substance Abuse*, *1*(2), 50-54.
- Teare, J. F., Garrett, C. R., Coughlin, D. G., Shanahan, D. L., & Daly, D. L. (1995). America's children in crisis: Adolescents' requests for support from a national telephone hotline. *Journal of Applied Developmental Psychology*, *16*(1), 21-33.
- Tworek, C., Haskins, A., & Woods, S. (2009). Maine's Tobacco Medication Program: Compliance, patterns of use, and satisfaction among smokers. *Nicotine & Tobacco Research*, *11*(7), 904-907. doi:10.1093/ntr/ntp085
- Valdivia-Salas, S., Blanchard, K. S., Lombas, A. S., & Wulfert, E. (2014). Treatment-seeking precipitators in problem gambling: Analysis of data from a gambling helpline. *Psychology of Addictive Behaviors*, *28*(1), 300-306. doi:10.1037/a0035413
- Weinstock, J., Burton, S., Rash, C. J., Moran, S., Biller, W., Krudelbach, N., . . . Morasco, B. J. (2011). Predictors of engaging in problem gambling treatment: data from the West Virginia Problem Gamblers Help Network. *Psychology of Addictive Behaviors*, *25*(2), 372-379. doi:10.1037/a0023240
- Wong, D. C., Chan, S. S., Fong, D. Y., Leung, A. Y., Lam, D. O., & Lam, T. H. (2011). Quitting trajectories of Chinese youth smokers following telephone smoking cessation counseling: A longitudinal study. *Nicotine & Tobacco Research*, *13*(9), 848-859. doi:10.1093/ntr/ntr086

7. Appendices

Appendix A: Table of Helpline Outcome Studies by Type of Helpline

Citation	Type of Helpline	Summary
(Abbott et al., 2018)	Gambling	First time callers to the New Zealand National Gambling Helpline receiving treatment as usual (i.e., regular helpline support) experienced significant reductions between baseline and 12-month follow-up in days gambled per month and dollars lost per gambling day. Treatment as usual was equally as effective as intensive treatment services, including motivational interviewing, mailed workbooks, and/or follow-up booster calls.
(Amuedo-Dorantes, Mach, & Clapp, 2004)	Other: Homework Helpline	Adolescents aged 12-16 years utilizing a homework hotline, compared to others, do not experience significant effects on past-30-day cigarette, alcohol, or marijuana use.
(Biazzo et al., 2010)	Smoking	Compared to those choosing nicotine replacement therapy, callers to a tobacco quitline choosing varenicline experienced 1.66 greater odds of abstinence at 6-months post-program intake.
(Bischof et al., 2014)	Gambling	This study utilized a random digit dialing procedure and a stratified and clustered telephone design to collect a sample of gamblers, but does not report on outcomes related to usage of a specific hotline
(Brockman, Patten, & Lukowski, 2018)	Smoking	Barriers to effective quitline support for concerned family members and friends of smokers learning how to provide positive support for quitting include (1) smoker is pre-contemplative/contemplative, (2) concerned other is uncertain about how to address smoking or quitting, (3) the smoker is defensive and refuses to talk, (4) the smoker is contemplative but refuses to set a quit date, and (5) the smoker is uninterested in helpline support.
(Brown et al., 2017)	Smoking	This study demonstrates the feasibility of implementing a tablet-based brief intervention to encourage acceptance of tobacco quitline referral among those in SUD treatment.
(Buller et al., 2014)	Smoking	Smokers randomized to a website or self-help booklet were significantly more likely to report use of nicotine replacement therapy.
(Bush et al., 2008)	Smoking	Incorporating two-weeks of free nicotine patches for insured callers into a tobacco quitline boosted calls (7,775 callers compared to 775 callers prior to program implementation), increased engagement with counseling and nicotine replacement therapy (with significant increases in use of patch [86.2% compared to 41.8% prior to program implementation] and decrease in use of bupropion [14.8% compared to 22.0% prior to program implementation]), and led to greater past-seven-day abstinence at six-months (33.6% compared to 18.0%).
(Carlini & Garrett, 2018)	Substance Use	State-funded or endorsed helplines in Washington, Colorado, Alaska, and Oregon do not have adequate information to support reductions in marijuana use and are upfront about lack of knowledge, though it should be noted that only eleven calls were placed and the were conducted by two researchers.
(Clemens & Ritter, 2008)	Substance Use	An alcohol and other drug use helpline was used to estimate the number of people likely to attend face-to-face treatment for publicly funded alcohol treatment.
(Courtney et al., 2017)	Smoking	Participants recruited from a smoking Quitline were more likely to complete a financial counseling for smoking cessation RCT compared to those recruited from other sources
(Cummins et al., 2015)	Smoking	A dissemination and implementation trial showed that an evidence-based Asian-language tobacco quitline has high effectiveness regarding quit outcomes
(Danielsson, Eriksson, & Allebeck, 2014)	Gambling-specific, Substance use-specific, and Smoking-specific helplines	A systematic review of 74 studies on telephone and online smoking, gambling, and alcohol intervention services found evidence that helplines can reduce smoking, but not alcohol use or gambling problems

Citation	Type of Helpline	Summary
(Docherty, Lewis, McEwen, Bauld, & Coleman, 2014)	Smoking	A previous study on a tobacco quitline concluded that offering free NRT vouchers to callers did not increase cessation rates; the present study concluded that this non-significant increase in cessation was not due to callers seeking cessation outside of the trial
(Ferland et al., 2013)	Gambling	An evaluation of the quality of a Quebec gambling helpline found 87% of calls were judged as an overall positive experience, though quality was higher for referral requests than for informational requests
(Gainsbury, Hing, & Suhonen, 2014)	Gambling	In a sample of Australian gamblers, 39% of participants were aware of gambling helpline services, the highest proportion of any problem gambling service assessed
(Gates, 2015)	Substance Use	A systematic review of 36 articles on drug and alcohol helplines concluded that most evidence shows IDA helplines are effective, despite lack of consistency in measures between studies
(Gates, Norberg, Copeland, & Digiusto, 2012)	Substance Use	A combined MI+CBT phone counseling intervention delivered to people calling a cannabis helpline is efficacious for reducing cannabis use
(Glasgow, Hollis, McRae, Lando, & LaChance, 1991)	Smoking	Of a suite of low-intensity tobacco cessation programs/materials offered to community members, tobacco advice line less likely to be used than self-help materials, use of tobacco substitutes, etc.
(Heinemans, Toftgård, Damström-Thakker, & Galanti, 2013)	Substance Use	64% of callers to the Swedish National Alcohol Helpline screened positive for alcohol dependence on the AUDIT at baseline assessment, but only 19% screened positive at twelve-month follow-up, with greatest reductions seen among those having higher scores at baseline.
(Mosavel, 2004)	Substance Use	Among individuals seeking substance abuse treatment, those utilizing substance use helpline services spent significantly less time using outpatient treatment services than others.
(Ni, Wang, Link, & Sherman, 2018)	Smoking	Regardless of smoker type (i.e., light-intermittent, light-daily, and heavy), smokers calling a smoking quitline did not significantly differ from those utilizing intensive counseling interventions on past-30-day abstinence at six-months post randomization.
(Rodda, Hing, & Lubman, 2014)	Gambling	Most callers to an Australian Gambling helpline ended up attending further treatment. There were no difference in outcome by gender
(Shandley & Moore, 2008)	Gambling	Callers to a gambling helpline in Victoria Australia were satisfied with its service; most accepted treatment referral and all those who accessed treatment after helpline referral improved over time on overall life functioning
(Shiffman, 1982)	Smoking	Ex-smokers found a helpline providing counseling in the moment for instances of smoking relapse and near-relapse to be helpful. Many continued to maintain abstinence after having accessed this helpline
(Tworek, Haskins, & Woods, 2009)	Smoking	Free NRT offered as part of Maine Tobacco HelpLine is a draw for a large portion of callers, and has been accessible and helpful to those who've used it
(Valdivia-Salas, Blanchard, Lombas, & Wulfert, 2014)	Gambling	Gambling helpline callers who call because of gambling-related family of financial reasons (compared to calling because of a current crisis) are more likely to attend counselling after getting a referral from the helpline
(Weinstock et al., 2011)	Gambling	Among callers to a West Virginia Gambling helpline, demographic and clinical factors were associated with likelihood of attending first treatment appointment after the call. Callers also more likely to attend tx if first appointment made was offered within 72 hours of helpline call, and if call was precipitated by spouse/family or legal problems
(Wong et al., 2011)	Smoking	Six-month follow-up of Hong Kong youth who called a smoking quitline shows three trajectories of smoking: 56% maintained a slight reduction in smoking, 29% maintained a large reduction in their smoking, and 15% managed to quit smoking altogether

Appendix B: Endorsed Helpline Services Available in 50 States

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
AL	Gambling Disorder (GD)	211	United Way	24/7	-	United Way; Alabama Council on Compulsive Gambling; National Council on Problem Gambling	http://www.211connectsalabama.org/about-us/ https://www.alccg.org/maintenance https://www.ncpgambling.org/state/alabama/
	Substance Use Disorder (SUD)	1-844-307-1760 (dedicated SUD); 211; 888-421-1266 (redirects to 211)	1-844-307-1760: Alabama Department of Mental Health and Recovery Organization of Support Specialists; 211: United Way	All 24/7	text	United Way; Alabama Department of Mental Health: Division of Mental Health & Substance Abuse Services	http://www.211connectsalabama.org/about-us/ http://www.mh.alabama.gov/MHSA/?sm=c
AK	GD	(none)	-	-	-	-	-
	SUD	1-800-478-2221; 211	United Way	8:30 AM-5:00 PM M-F	-	United Way	http://www.alaska211.org/
AZ	GD	1-800-NEXT-STEP; 1-800-777-7207	1-800-NEXT-STEP: Morneau Shepell; 1-800-777-7207: Arizona Council on Compulsive Gambling	All 24/7	-	Arizona Department of Gaming, Division of Problem Gambling; Arizona Council on Compulsive Gambling	https://problemgambling.az.gov/ http://www.azccg.org/
	SUD	(none)	-	-	-	-	-
AR	GD	1-800-522-4700 (NCPG)	Louisiana Problem Gamblers Helpline	24/7	text; live chat	National Council on Compulsive Gambling; Arkansas Lottery	https://www.ncpgambling.org/state/arkansas/ https://www.myarkansaslottery.com/about/play-responsibly
	SUD	(none)	-	-	-	-	-
CA	GD	1-800-GAMBLER	Morneau Shepell	24/7	text ("support") to 53342; live chat	California Council on Problem Gambling; California Department of Public Health Office of Problem Gambling	https://calpg.org/ https://www.cdph.ca.gov/Programs/OPG/Pages/opg-landing.aspx
	SUD	(none)	-	-	-	-	-

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
CO	GD	1-800-522-4700 (NCPG)	Rocky Mountain Crisis Partners	24/7	text; live chat	Problem Gambling Coalition of Colorado;	http://www.problemgamblingcolorado.org/content/help-resources-1
	SUD	1-844-493-8255	Colorado Crisis Services	24/7	text ("TALK" to 38255); live chat; walk-in centers	Colorado Crisis Services; Colorado Department of Human Services	https://coloradocrisiservices.org/
CT	GD	1-888-789-7777	Connecticut Council on Problem Gambling	24/7	text ("CTGAMB" to 533420); live chat	Connecticut Council on Problem Gambling; Connecticut Department of Mental Health and Addiction Services	http://www.ccpog.org/ https://www.ct.gov/dmhas/cwp/view.asp?a=2902&Q=335212&dmhasNav=1
	SUD	1-800-563-4086	DMHAS	24/7	-	Department of Mental Health and Addiction Services	https://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=530890
DE	GD	1-888-850-8888	Delaware Council on Gambling Problems	24/7	text (302-438-8888, 9:00 AM-5:00 PM M-F); live chat	DHHS Division of Substance Abuse and Mental Health; Delaware Council on Gambling Problems	http://www.deproblemgambling.org/
	SUD	800-652-2929 (New Castle County); 800-345-6785 (Kent and Sussex Counties)	Mobile Crisis Intervention Services	All 24/7	-	DHHS Division of Public Health	http://www.helpisherede.com/treatment
FL	GD	1-888-ADMIT-IT	Florida Council on Compulsive Gambling	24/7	-	Florida Council on Compulsive Gambling	http://www.gamblinghelp.org/
	SUD	1-800-622-HELP (SAMHSA)	Substance Abuse and Mental Health Services Administration	24/7	-	SAMHSA	http://www.floridahealth.gov/programs-and-services/prevention/substance-abuse/index.html

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
GA	GD	888-236-4848	Florida Council on Compulsive Gambling	24/7	-	Florida Council on Compulsive Gambling; Georgia Council on Problem Gambling; Georgia Department of Behavioral Health and Developmental Disabilities	http://www.gamblinghelp.org/get_help/helpline https://www.georgiagamblinghelp.org/
	SUD	1-800-715-4225	Behavioral Health Link Crisis Call Center	24/7	-	Georgia Department of Behavioral Health and Developmental Disabilities; The Georgia Collaborative ASO	https://www.valueoptions.com/referralconnect/doLogin.do?e=Z2FjbSAg
HI	GD	(none)	-	-	-	-	-
	SUD	(none)	-	-	-	-	-
ID	GD	(none)	-	-	-	-	-
	SUD	211; 1-800-926-2588 (redirects to 211); 1-800-922-3406 or 1-855-202-0973 (find treatment lines)	Idaho Department of Health and Welfare	CareLine: 8:00 AM-6:00 PM M-F; Treatment lines: unclear	CareLine: text (zip code to 898211); email	Idaho 211 (CareLine) Idaho Department of Health and Welfare	https://211.idaho.gov/ https://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/tabid/382/Default.aspx
IL	GD	1-800-GAMBLER	Morneau Shepell	24/7	text ("ILGAMB" to 53342); live chat	Division of Alcoholism and Substance Abuse; Illinois Department of Human Services; Illinois Council on Problem Gambling; Illinois Alliance on Problem Gambling; Morneau Shepell	http://www.dhs.state.il.us/page.aspx?item=32300 https://www.dhs.state.il.us/page.aspx? http://www.icpg.info/ http://illinoisalliance.org/ https://www.morneaushepell.com/
	SUD	833-2FINDHELP	Health Resources in Action	24/7	-	Illinois Helpline for Opioids and Other Substances; Health Resources in Action; Division of Alcoholism and Substance Abuse; Illinois Department of Human Services	https://helplineil.org/ https://hria.org/ http://www.dhs.state.il.us/page.aspx?item=32300

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
IN	GD	1-800-994-8448	Morneau Shepell	24/7	live chat	Division of Mental Health and Addiction; Indiana Problem Gambling Awareness Program; Indiana Council on Problem Gambling; Morneau Shepell	https://www.in.gov/fssa/dmha/2582.htm https://ipgap.indiana.edu/ https://indianaproblemgambling.org/
	SUD	1-800-622-HELP (SAMHSA)	Substance Abuse and Mental Health Services Administration	24/7	live chat	Division of Mental Health and Addiction	https://www.in.gov/fssa/dmha/2933.htm
IA	GD	1-800-BETSOFF	Iowa State University	24/7	text (855-895-8398); live chat	Iowa Department of Mental Health; Iowa State University	https://yourlifeiowa.org/gambling
	SUD	855-581-8111	Your Life Iowa	24/7	text (855-895-8398); live chat	Iowa Department of Mental Health	https://yourlifeiowa.org/drugs https://yourlifeiowa.org/alcohol
KS	GD	1-800-522-4700 (NCPG)	Kentucky Department of Aging and Disability Services	24/7	text; live chat	Kansas Department of Aging and Disability Services; Kansas Coalition on Problem Gambling	http://www.ksgamblinghelp.com/ https://www.kdads.ks.gov/commissions/behavioral-health/consumers-and-families/services-and-programs/problem-gambling-services
	SUD	(none)	-	-	-	-	-
KY	GD	1-800-GAMBLER	River Valley Behavioral Health	24/7	text; live chat	Kentucky Council on Problem Gambling	https://www.kycpg.org/ http://www.rvbh.com/
	SUD	1-833-8KY-HELP	KY HELP Statewide Call Center	8:30 AM-5:30 PM M-F	text ("HOPE" to 96714)	Kentucky Justice and Public Safety Cabinet; Operation UNITE; Kentucky Department for Public Health	https://operationunite.org/treatment/kyhelp-call-center/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
LA	GD	1-877-770-STOP	Louisiana Association on Compulsive Gambling	24/7	text ("nobet" to 66746); live chat; email	Louisiana Department of Health; Louisiana Casino Association; Community Foundation of Northwest Louisiana; United Way of Northwest Louisiana	http://ldh.la.gov/index.cfm/page/1545 www.helpforgambling.org
	SUD	1-877-664-2248	North Louisiana Community Foundation; United Way of Northwest Louisiana	24/7	-	Louisiana does not host their own website specifically substance use services, although there are websites for individual district authorities, which are responsible for providing substance use services for their respective districts.	
ME	GD	211	Maine Department of Health and Human Services; United Way; Opportunity Alliance	24/7	text (zip code to 898-211); email	State of Maine Department of Health and Human Services; United Way; Opportunity Alliance	https://www.maine.gov/dhhs/mecdc/population-health/prevention/gambling/
	SUD	211	Maine Department of Health and Human Services; United Way; Opportunity Alliance	24/7	text (zip code to 898-211); email	State of Maine Department of Health and Human Services; United Way; Opportunity Alliance	https://211maine.org/ https://www.maine.gov/dhhs/hotlines.htm
MD	GD	1-800-GAMBLER	Maryland Center of Excellence on Problem Gambling at the University of Maryland School of Medicine	24/7	-	Maryland Center of Excellence on Problem Gambling; University of Maryland School of Medicine	http://www.mdproblemgambling.com/
	SUD	211	Maryland 211	24/7	-	Maryland 211; State of Maryland	https://211md.org/ https://beforeitstoolate.maryland.gov/what-is-before-its-too-late/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
MA	GD	1-800-426-1234	Massachusetts Council on Compulsive Gambling	24/7	live chat	Massachusetts Office of Problem Gambling Services; Massachusetts Council on Compulsive Gambling	https://masscompulsivegambling.org/get-help/
	SUD	1-800-327-5050	Bureau of Substance Addiction Services	8:00 AM-10:00 PM M-F; 8:00 AM-6:00 PM Weekends	-	The Massachusetts Bureau of Substance Addiction Services; The Massachusetts Substance Use Helpline	https://helplinema.org/
MI	GD	1-800-270-7117	Michigan Department of Health and Human Services	24/7	-	Michigan Department of Health and Human Services	https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_43661_64090-295819--,00.html
	SUD	There are 83 counties in Michigan. Each county has its own treatment services hotline. Most, if not all, are 24/7.			-	Michigan Department of Health and Human Services	https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_4877--,0.html
MN	GD	1-800-333-HOPE	Minnesota Department of Human Services	All 24/7	text ("HOPE" to 61222); live chat	Department of Human Services	https://getgamblinghelp.com/
	SUD	(none)	-	-	-	-	-
MS	GD	1-888-777-9696	Morneau Shepell	24/7	text ("msgambler" to 53342); live chat	Mississippi Council on Problem and Compulsive Gambling	http://www.msgambler.org/
	SUD	1-877-210-8513	Mississippi Department of Mental Health	24/7	-	Mississippi Department of Mental Health	http://www.dmh.ms.gov/alcohol-and-drug-services/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
MO	GD	1-800-BETSOFF	Missouri Lottery Commission	24/7	-	Missouri Department of Mental Health	https://dmh.mo.gov/ada/progs/gambling.html
	SUD	1-800-273-TALK (suicide hotline)	Missouri Department of Mental Health	24/7	-	Missouri Department of Mental Health	https://dmh.mo.gov/ada/help.html
MT	GD	1-888-900-9979	(unclear)	24/7	-	Montana Council on Problem Gambling	http://www.mtproblemgambling.org/
	SUD	(none)	-	-	-	-	-
NE	GD	1-800-522-4700 (NCPG)	Nebraska Council on Problem Gambling	24/7	text; live chat	Nebraska Council on Problem Gambling; Nebraska Commission on Problem Gambling	http://www.neproblemgambling.com/ https://problemgambling.nebraska.gov/bet-careful
	SUD	1-800-648-4444	Nebraska Department of Health and Human Services	8:00 AM-5:00 PM M-F	-	Nebraska Department of Health and Human Services	http://dhhs.ne.gov/behavioral_health/Pages/behavioral_health_treatment.aspx#Alcohol%20%26%20Substance%20Abuse
NV	GD	1-800-522-4700 (NCPG)	Louisiana Problem Gamblers Helpline	24/7	text; live chat	Department of Health and Human Services	http://dhhs.nv.gov/Programs/Grants/Programs/Problem_Gambling/Problem_Gambling_Services_(PGS)/
	SUD	1-866-535-5654; 211	Money Management International	All 24/7	text (zip code to 898211); live chat	Money Management International; Nevada Department of Health and Human Services	https://www.nevada211.org/addiction-services/
NH	GD	1-603-724-1605	New Hampshire Council on Problem Gambling	8:00 AM-11:00 PM	-	New Hampshire National Council on Problem Gambling	http://nhproblemgambling.org/Home.aspx
	SUD	1-844-711-HELP	Department of Health and Human Services Bureau of Drug and Alcohol Services; The New Hampshire Charitable Foundation	24/7	-	Department of Health and Human Services	https://www.dhhs.nh.gov/dcbcs/bdas/crisis-line.htm http://www.drugfreenh.org/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
NJ	GD	1-800-GAMBLER	Council on Compulsive Gambling of New Jersey	24/7	text	Council on Compulsive Gambling of New Jersey; New Jersey Lottery	https://www.state.nj.us/lottery/about/gambling-resources.htm https://800gambler.org/
	SUD	1-844-276-2777 (addiction); 1-800-NJ-STOPS (smoking); 1-844-ReachNJ (referral services); 211	Rutgers University Behavioral Health Care	All 24/7	-	Department of Health Division of Mental Health and Addiction Services; Rutgers University	https://www.nj.gov/nj/community/counseling
NM	GD	1-800-522-4700 (NCPG)	New Mexico Council on Problem Gambling	24/7	text; live chat	National Council on Problem Gambling	https://www.ncpgambling.org/state/new-mexico/
	SUD	1-800-622-HELP (SAMHSA)	Substance Abuse and Mental Health Services Administration	24/7	-	SAMHSA	https://www.usa.gov/mental-health-substance-abuse
NY	GD	1-877-8HOPENY	New York State Office of Alcoholism and Substance Abuse Services	24/7	text ("HOPENY" to 467369); live chat	New York State Office of Alcoholism and Substance Abuse Services	https://www.oasas.ny.gov/gambling/helpline.cfm
	SUD	1-877-8HOPENY	New York State Office of Alcoholism and Substance Abuse Services	24/7	text ("HOPENY" to 467369); live chat	New York State Office of Alcoholism and Substance Abuse Services	https://www.oasas.ny.gov/accesshelp/index.cfm

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
NC	GD	1-877-718-5543	Morneau Shepell	24/7	text; live chat	North Carolina Department of Health and Human Services; North Carolina Council on Problem Gambling; More Than a Game NC	https://www.ncdhhs.gov/ https://www.ncdhhs.gov/providers/provider-info/mental-health/problem-gambling https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/gambling http://www.nccouncilpg.org/ http://morethanagamenc.com/
	SUD	1-800-688-4232	Substance Abuse and Mental Health Services Administration	24/7	-	Alcohol/Drug Council of North Carolina	https://www.alcoholrughelp.org/
ND	GD	1-877-702-7848; 211	211: Firstlink; 1-877-702-7848: Gamblers Choice (a part of Lutheran Social Services of North Dakota)	1-877-702-7848: 9:00 AM-5:00 PM M-F; 211: 24/7	text; live chat	Lutheran Social Services of North Dakota; Gamblers Choice; Firstlink	http://www.gamblernd.com/ https://www.lss-nd.org/ https://myfirstlink.org/services/2-1-1-helpline/
	SUD	1-800-622-HELP (SAMHSA)	Substance Abuse and Mental Health Services Administration	24/7	-	SAMHSA	https://www.usa.gov/mental-health-substance-abuse
OH	GD	1-800-589-9966	United Way 211 Cleveland	24/7	live chat	Ohio for Responsible Gambling; Ohio Department of Mental Health and Addiction Services; Ohio Casino Control Commission; Ohio Lottery Commission; Ohio State Racing Commission	http://org.ohio.gov/ https://mha.ohio.gov/ https://www.casinocontrol.ohio.gov/ https://www.ohiolottery.com/ http://www.racingohio.net/
	SUD	1-877-275-6364	Ohio Department of Mental Health and Addiction Services	8:00 AM-5:00 PM M-F	-	Ohio Department of Mental Health and Addiction Services; Take Charge Ohio	https://mha.ohio.gov/ http://takechargeohio.ohio.gov/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
OK	GD	1-800-522-4700 (NCPG)	Heartline	24/7	text; live chat	Oklahoma Department of Health and Substance Abuse Services; Oklahoma Association on Problem and Compulsive Gambling; Heartline; National Council on Problem Gambling	https://www.ok.gov/odmhsas/ http://www.oapcg.org/ http://heartlineoklahoma.org/ https://www.ncpgambling.org/
	SUD	1-800-522-9054; 211	1-800-522-9054: Oklahoma Department of Mental Health and Substance Abuse Services; 211: Heartline/Tulsa 211	All 24/7	-	Oklahoma Department of Mental Health and Substance Abuse Services; Heartline; Tulsa 211	https://www.ok.gov/odmhsas/ http://heartlineoklahoma.org/ https://csctulsa.org/2-1-1-helpline-resources-archives/
OR	GD	1-877-695-4648	Emergence	24/7	text (503-713-6000); live chat (NCPG)	Oregon Problem Gambling Resource; Oregon Health Authority; Emergence	http://www.opgr.org/ https://www.oregon.gov/oha/HSD/AMH/Pages/Gambling.aspx http://www.4emergence.com/
	SUD	1-800-923-4357	Lines for Life	24/7	text ("Recovery Now" to 839863, 8:00 AM-11 PM)	Oregon Health Authority Addictions and Mental Health Services; Lines for Life	https://www.oregon.gov/oha/hsd/amh/pages/index.aspx https://www.linesforlife.org/
PA	GD	1-800-GAMBLER; 1-800-848-1880; 1-877-565-2112	Louisiana Problem Gamblers Helpline	All 24/7	-	Pennsylvania Department of Drug and Alcohol Programs; Pennsylvania Gaming Control Board; Council on Compulsive Gambling in Pennsylvania	https://www.ddap.pa.gov/pages/default.aspx https://gamingcontrolboard.pa.gov/ https://www.pacouncil.com/
	SUD	1-800-662-HELP (SAMHSA)	Substance Abuse and Mental Health Services Administration	24/7	-	Pennsylvania Department of Drug and Alcohol Programs; Substance Abuse and Mental Health Services Administration	https://apps.ddap.pa.gov/gethelpnow/CareProvider.aspx https://www.samhsa.gov/

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
RI	GD	1-877-9GAMBLE	United Way of Rhode Island	24/7	-	Rhode Island Council on Problem Gambling; Rhode Island Lottery; United Way of Rhode Island	https://www.ricpg.com/ http://www.rilot.com/ https://uwri.org/
	SUD	401-942-STOP	Prevent Overdose RI	24/7	-	RI Department of Health; Overdose Prevention and Intervention Task Force; Prevent Overdose RI; RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; Brown University School of Public Health	http://www.health.ri.gov/addiction/ http://www.governor.ri.gov/initiatives/odtaskforce/ http://preventoverdoseri.org/get-help/ http://www.bhddh.ri.gov/substance_use/index.php https://www.brown.edu/academics/public-health/
SC	GD	1-877-452-5155	South Carolina Department of Alcohol and Other Drug Abuse Services	24/7	-	South Carolina Department of Alcohol and Other Drug Abuse Services	http://www.daodas.sc.gov/treatment/gambling-addiction-services/
	SUD	(none)	-	-	-	-	-
SD	GD	1-888-781-HELP	Helpline Center (South Dakota 211)	24/7	-	Department of Social Services Addiction Treatment Services; Helpline Center	http://dss.sd.gov/behavioralhealth/community/treatmentservices.aspx http://www.helplinecenter.org/211-community-resources/
	SUD	(none)	-	-	-	-	-
TN	GD	1-800-889-9789	Tennessee REDLINE	24/7	-	Tennessee Association of Alcohol, Drug, and Other Addiction Services; Department of Mental Health & Substance Abuse Services	https://taadas.org/ https://www.tn.gov/behavioral-health/substance-abuse-services/prevention.html
	SUD				-	-	-

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
TX	GD	1-800-522-4700 (NCPG)	Louisiana Problem Gamblers Helpline	24/7	text; live chat	National Council on Problem Gambling; Texas Department of Health Services	https://www.ncpgambling.org/ https://www.dshs.texas.gov/sa/FindingServices/ProblemGambling.shtm
	SUD	211	Texas Department of Health and Human Services	24/7	-	Texas Department of Health and Human Services; Mental Health Texas	https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use https://www.211texas.org/about-211/
UT	GD	(none)	-	-	-	-	-
	SUD	211	211 Utah	24/7	text (zip code to 898-211)	Utah Department of Human Services, Substance Abuse and Mental Health; 211 Utah	https://dsamh.utah.gov/# http://211utah.org/
VT	GD	1-800-522-4700 (NCPG)	Center for Addiction Recognition Treatment Education & Recovery	24/7	text; live chat	Center for Addiction Recognition Treatment Education & Recovery (CARTER); National Council on Problem Gambling; Department of Health, Division of Alcohol and Drug Abuse Programs; Vermont Lottery	http://www.cartervermont.org/ https://www.ncpgambling.org/ http://www.healthvermont.gov/alcohol-drugs https://problemgambling.vermont.gov/
	SUD	211	211 Vermont	24/7	text (zip code to 898211)	United Way; Vermont 211; Vermont Department of Health	http://www.healthvermont.gov/alcohol-drugs http://www.vermont211.org/
VA	GD	1-888-532-3500	Morneau Shepell	24/7	-	Virginia Council on Problem Gambling; Virginia Lottery	http://www.vacpg.org/ https://www.valottery.com/play_responsibly.aspx
	SUD	(none)	-	-	-	-	-

State	Disorder	Helpline Number(s) Provided	Operator	Hours	Additional Modes of Contact Provided	Affiliated Organizations	Affiliated Website Links
WA	GD	1-800-547-6133 (gambling-specific); 1-866-789-1511 (general)	1-800-547-6133: Evergreen Council on Problem Gambling; 1-866-789-1511: Crisis Connections	All 24/7	text (1-800-547-6133); live chat (NCPG)	Evergreen Council on Problem Gambling; Washington State Department of Social and Health Services Division of Behavioral Health and Recovery; Crisis Connections	https://www.evergreencpg.org/ http://www.warecoveryhelpline.org/ https://www.dshs.wa.gov/bhsia/faq?field_bhsia_topics_value=Problem%20Gambling https://www.crisisconnections.org/
	SUD	1-866-789-1511	Crisis Connections	24/7	-	Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery; Crisis Connections	https://www.dshs.wa.gov/mental-health-and-addiction-services http://www.warecoveryhelpline.org/
WV	GD	1-800-GAMBLER	First Choice Services	24/7	live chat	Problem Gamblers Help Network of West Virginia; First Choice Services; West Virginia Bureau for Behavioral Health & Health Facilities	https://www.1800gambler.net/ https://firstchoiceservices.org/ https://dhhr.wv.gov/bhhf/Pages/default.aspx
	SUD	1-844-HELP4WV		24/7	text (844-435-7498); live chat	Help 4 West Virginia; First Choice Services; West Virginia Bureau for Behavioral Health & Health Facilities	https://www.help4wv.com/ https://firstchoiceservices.org/ https://dhhr.wv.gov/bhhf/Pages/default.aspx
WI	GD	1-800-GAMBLE-5	Wisconsin Council on Problem Gambling	24/7	text (850-888-HOPE)	Wisconsin Council on Problem Gambling; Wisconsin Department of Health Services	http://wi-problemgamblers.org/ https://www.dhs.wisconsin.gov/aoda/gambling-awareness.htm
	SUD	211	Wisconsin 211	24/7	-	Wisconsin Department of Health Services; Wisconsin 211	https://www.dhs.wisconsin.gov/ https://211wisconsin.communityos.org/
WY	GD	1-800-522-4700 (NCPG)	Louisiana Problem Gamblers Helpline	24/7	text; live chat	National Council on Problem Gambling; Louisiana Association on Compulsive Gambling; Wyoming Department of Health	https://www.ncpgambling.org/ http://www.helpforgambling.org/ https://health.wyo.gov/behavioralhealth/mhsa/initiatives/problem-gambling/
	SUD	(none)	-	-	-	-	-

Appendix C: Helpline Director’s Survey Tables

Table C1: Helpline Characteristics - Operations

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Availability of Helpline specialists</i></p> <p>AIRS Standard 1: Appropriate number of specialists are scheduled to meet the needs of callers (i.e., that the optimum number of staff are available at the times most inquiries occur). Information and referral through live answer is available to the community 24 hours per day, year round</p> <p>Contact USA Section 601: What is the availability of Helpline specialists?</p>	<p><u>Does not meet standard (DN)</u> Less than 24/7 access</p> <p><u>Meets standard (MS)</u> 24/7 access</p> <p><u>Exceeds standard (ES)</u> 24/7 access & evidence that staffing is appropriate to demand</p>	<p>When a helpline caller dials the 800-426-1234 Helpline number during M-F 9am-5pm, he/she is routed to the primary helpline staffer assigned to the helpline during that scheduled time. If a caller looking for the Helpline directly calls our 617-administrative office number instead of our 800-number helpline, they are immediately told to press “0”, which connects them to the Helpline. For the sake of efficiency, all calls requiring translation services will be routed directly to our Helpline subcontractor/vendor, as they are partnering with a translation company.</p> <p>*The Office of Problem Gambling Services at DPH instructed us NOT answer the phones beginning in October of 2018 and to have our overflow vendor provide 27/7 coverage. We have not been given permission from our funder to answer the calls since that time.</p>	<p>The Helpline is staffed based on recent historic call data and forecasted trends. We have approximately 10 FTE of Helpline SIS (Screening and Information Specialists) on staff. At one time, 3-5 SIS are available during weekdays and 1-2 during later evenings, weekends, and major holidays. We have more staff during the mid-morning and mid-afternoon on weekdays, as these are our busiest times.</p>
<p><i>Access to a second phone line for emergencies</i></p> <p>AIRS Standard 3: The service uses a variety of means to support its ability to connect with rescue services... At a minimum, there is a separate telephone or a separate external line that is available for initiating rescue procedures without interrupting the crisis call.</p> <p>Contact USA Section 604: Are there adequate lines to handle incoming contact volume, with one line available for emergencies?</p>	<p><u>DN</u> No 2nd phone line available</p> <p><u>MS</u> 2nd phone line available</p> <p><u>ES</u> 2nd phone line available and specifically designated for emergency calls</p>	<p>Yes</p> <p>* A helpline specialist has a cell phone as well as an office landline phone in the office.</p>	<p>Yes, access to separate landline phone system as well as a mobile phone.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Call-forwarding policies</i></p> <p>Contact USA Section 602: Does the organization have clear call forwarding policies?</p>	<p><u>DN</u> Calls are forwarded but no written call forwarding policy exists</p> <p><u>MS</u> Written call forwarding policy exists</p> <p><u>ES</u> Written call forwarding policy exists and includes comprehensive detail</p>	<p>If a Mass Council Helpline staff member is already on a Helpline calls and unable to answer the call, the subcontractor/vendor is the final backup option during Mass. Council office hours. All other times, the subcontractor/vendor receives the Helpline call immediately. The subcontractor / vendor continues to capture their Helpline caller information in the same way.</p>	<p>When the Helpline is closed, callers have the option of being transferred to their local ESP (mental health emergency services provider). Calls are not forwarded without caller opt-in.</p>
<p><i>Call-forwarding MoU with written protocol for handling contacts</i></p> <p>Contact USA Section 603: If the organization forwards to another helpline program, is there an MoU between programs that includes a written protocol for handling contacts?</p> <p>Helplines Partnership Standard 1: Identify and develop formal arrangements with partners or suppliers</p>	<p><u>DN</u> Calls are forwarded but no MoU exists</p> <p><u>MS</u> MoU exists</p> <p><u>ES</u> MoU exists and is clear and detailed</p>	<p>Yes [MoU submitted – valid through June 2018, and then month to month afterward]</p>	<p>N/A</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Written confidentiality / anonymity policies</i></p> <p>AIRS Standard 23: Policies and procedures that protect privacy but allow specialists to provide for individual’s safety</p> <p>Contact USA Section 605: Are there written policies regarding anonymity of clients?</p> <p>Helplines Partnership Standard 2: Operate and monitor a clear confidentiality policy in line with the helpline’s requirements and relevant legislation</p>	<p><u>DN</u> Written policy does not exist</p> <p><u>MS</u> Written policy exists</p> <p><u>Exceeds standard</u> Written policy exists and includes comprehensive detail</p>	<p>Individuals seeking help or information through the Massachusetts Council on Compulsive Gambling expect that their contact with us will remain confidential. All staff associated with the Massachusetts Council on Compulsive Gambling agree to comply with the obligation to ensure that the identities of individuals who call, come into the office, or have their information stored in our database, shall be kept completely confidential. Callers’ personal details are not shared with third parties unless consent has been given, and only on a “need to know” basis. Helpline staff will ensure that any correspondence requested by the caller is sent in unmarked packaging and that confidentiality is protected with any return or follow up calls.</p> <p>*Clarified that the above is a written policy, revised March 2019</p> <p>Exceptions to this are detailed below and are made only where there is a potential risk to the caller or others and/or where required by law.</p> <p>Confidentiality in Practice Caller information is recorded only for returning calls or sending out requested literature. This information is kept on a secure electronic database. Any handwritten or printed information is stored in locked drawers.</p> <p>Callers to the helpline are free to speak to staff anonymously or to use a pseudonym if they wish.</p> <p>We do not pass on caller details unless this has been agreed upon with the caller.</p> <p>Email correspondence is kept securely and electronically and will be forwarded only where necessary.</p>	<p>Yes [Policy submitted]</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
		<p>Statistical information relating to calls is collected for managerial and supervisory purposes and may be shared widely. However, this data is collated anonymously.</p> <p>Exceptions to Confidentiality When a caller is perceived as a serious and immediate risk to themselves by helpline staff. This may include being actively suicidal or self-harming.</p> <p>When a caller is perceived as presenting a serious and immediate risk to others.</p> <p>When a call seems to indicate abuse to children or vulnerable adults. When a call seems to indicate possible terrorist action.</p> <p>In many of the cases listed the most appropriate response would be to contact the emergency services. If contacting emergency services does not seem suitable, a decision to break confidentiality will be reconsidered. Wherever possible a caller will be informed of our consideration about passing details to third parties, we will always attempt to collect information openly and honestly. If the Council receives a court order to release confidential records, the request will be reviewed by and responded to by the Executive Director with legal consultation.</p>	

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Written call management policies and procedures</i></p> <p>Contact USA Section 804: Does the organization have written call management policies?</p> <p>Helplines Partnership Standard 3: Provide clear policies and guidance to enable helpline workers to handle different types of service user across all channels</p>	<p><u>DN</u> Written policies/procedures do not exist</p> <p><u>MS</u> Written policies/procedures exist</p> <p><u>ES</u> Written policies/procedures exist and include comprehensive detail</p>	<p>Call Protocol. When a helpline caller dials the 800-426-1234 Helpline number during M-F 9am-5pm, he/she is routed to the primary helpline staffer assigned to the helpline during that scheduled time. In the rare case that the designated Mass Council Helpline staff member is already on a Helpline calls and unable to answer the call, the subcontractor/vendor is the final backup option during Mass. Council office hours. All other times, the subcontractor/vendor receives the Helpline call immediately. The subcontractor/vendor continues to capture their Helpline caller information in the same way. Please note: If a caller looking for the Helpline directly calls our 617-administrative office number instead of our 800-number helpline, they are immediately told to press "0", which connects them to the Helpline. For the sake of efficiency, all calls requiring translation services will be routed directly to our Helpline subcontractor/vendor, as they are partnering with a translation company. All calls are to be answered in a courteous and professional manner and should be recorded in the Helpline Database.</p> <p>*Confirmed this is written policy</p>	<p>Yes [Protocol submitted]</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Written emergency handling procedures</i></p> <p>AIRS Standard 3: Written crisis intervention policies and procedures exist that provide protocols for specific types of emergencies, including lethality assessment procedures, protective measures relating to inquiries from individuals in endangerment situations and protocols that address inquirers who wish to remain anonymous yet require direct intervention</p> <p>Contact USA Section 803: Does the program teach helpline workers emergency handling procedures at initial training and maintain written procedures?</p> <p>Helplines Partnership Standard 2: Operate and monitor a clear safeguarding policy and process and act on any immediate risks to the safety of the service user and others</p>	<p><u>DN</u> Written procedures do not exist</p> <p><u>MS</u> Written procedures exist</p> <p><u>ES</u> Written procedures exist and include comprehensive detail</p>	<p>If a caller indicates suicidality that caller is immediately warm transferred to Samaritans Suicide Prevention hotline.</p> <p>* This is from the handbook for staffing the Helpline</p>	<p>Yes [Protocol submitted]</p>
<p><i>Written policies for intervention for suicidal clients</i></p> <p>AIRS Standard 23: Policies and procedures that protect privacy but allow specialists to provide for individual's safety</p> <p>Contact USA Section 802: Does the program have written policies for intervention for suicidal clients?</p>	<p><u>DN</u> Written policies do not exist</p> <p><u>MS</u> Written policies exist</p> <p><u>ES</u> Written policies exist and include comprehensive detail</p>	<p>If a caller indicates suicidality that caller is immediately warm transferred to Samaritans Suicide Prevention hotline.</p> <p>* This is from the handbook for staffing the Helpline</p>	<p>Yes [Protocol submitted]</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Suicide lethality risk assessment used as part of standard procedure if suicide ideation is detected</i></p> <p>AIRS Standard 3: In situations involving suicide or homicide, the service understands the circumstances under which a lethality risk assessment is required and conducts an appropriate assessment when necessary</p> <p>Contact USA Section 801: Does the program have a suicide lethality risk assessment form and is it used regularly and reviewed regularly?</p>	<p><u>DN</u> Suicide lethality risk assessment not used</p> <p><u>MS</u> Suicide lethality risk assessment available</p> <p><u>ES</u> Suicide lethality risk assessment available with clear instructions for when and how to use</p>	<p>No. If a caller indicates suicidality that caller is immediately warm transferred to Samaritans Suicide Prevention hotline.</p>	<p>Yes, protocol submitted</p>

Note. Green = Exceeds Standard (ES); Yellow=Meets Standard (MS); Red=Does not Meet Standard (DN); * = information obtained upon clarification.

Table C2: Helpline Characteristics – Access, Resources, and Referrals

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Barrier-free access to Helpline</i></p> <p>AIRS Standard 1: Barrier-free access (e.g., access via applicable technology and/or communication methods for people with hearing or speech impairments; language access for inquirers who speak languages other than English)</p> <p>AIRS Standard 23: Ensures individuals with disabilities have access to services comparable to those without disabilities</p>	<p><u>DN</u> No special communication methods available for those with hearing or speech impairments or who speak languages other than English</p> <p><u>MS</u> Special communication methods available for some groups who might otherwise experience barriers</p> <p><u>ES</u> Special communication methods available to increase access for those with disabilities or impairments and those with language barriers</p>	<p>For language translation we transfer caller to our subcontractor.</p> <p>*Promoting the Helpline with priority populations</p>	<p>Yes. Phone and website available in English and Spanish, with additional phone interpretation available in over 240 languages</p> <p>* In addition to the language services listed, the Helpline has a toll-free number to reduce barriers to accessing it. We also keep our initial phone messaging as brief as possible to get individuals connected with a Specialist as soon as possible. The messaging includes that our services are confidential. We operate live online chat services for individuals who may not be able or willing to call the Helpline phone number. The online chat services also work on mobile phones. The entire Helpline website was built to be mobile responsive, since we know many individuals, particularly people with low-income, access the internet via mobile devices. We also offer follow-up calls (with consent) to support consumers in accessing services after their initial call to the Helpline. The Helpline staff uses stigma-reducing language and motivational interviewing techniques to build rapport with callers and support them in accessing services.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Referral database easily accessible</i></p> <p>AIRS Standard 5: Expanded access options for the public by making all or a portion of its resource database available on the Internet at no cost. Publicly accessible resource database includes following design elements: ... The ability to filter by geographic location/area served...</p>	<p><u>DN</u> Referral database is not available to the public</p> <p><u>MS</u> Referral database is available to the public</p> <p><u>ES</u> Referral database is available to the public and includes user interface features to allow easy access and filtering by geographic region</p>	<p>The resource Database where the calls are recorded is not available to the public, but all resources are available on our website, with contact information and locations.</p>	<p>Yes. At HelplineMA.org. Visitors can answer a few questions to be directed to services (https://mahelplineonline.custhelp.com/app/account/opa_interview) or search for specific services in their area (https://mahelplineonline.custhelp.com/app/account/opa_result)</p>
<p><i>Policies or procedures for how referrals are provided to callers</i></p> <p>AIRS Standard 1: Provide at least 3 referrals to give inquirer a choice and protect service from being perceived as making a recommendation</p>	<p><u>DN</u> No written policies/procedures for how referrals are provided to caller</p> <p><u>MS</u> Written policies/procedures for how referrals are provided to caller</p> <p><u>ES</u> Written policies/procedures for how referrals are provided to caller and those policies include instruction to provide at least 3 referrals to caller</p>	<p>Referrals are generally given based on need and geographic location but currently there is no policy that requires a certain amount. We offer referrals in as many categories as the caller is willing to accept (clinical, self help, educational materials).</p>	<p>Yes. SIS are trained to assess consumers' needs and offer services based on that. In terms of the specific programs that offer the services, we provide them to the caller based on eligibility, insurance/payment, geography, and any special considerations (veterans, dual diagnosis, language, etc). We do not make recommendations and are unbiased in referral provision. We aim to provide to a minimum of 3 referrals to each caller.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Documented exclusion/inclusion criteria for entries in the referral database</i></p> <p>AIRS Standard 7: Service has document that describes inclusion/exclusion criteria for the contents of the resource database</p>	<p><u>DN</u> No documented exclusion/inclusion criteria for entries in the referral database</p> <p><u>MS</u> Documented exclusion/inclusion criteria for entries in the referral database</p> <p><u>ES</u> Documented exclusion/inclusion criteria for entries in the referral database with clear justification of each criterion</p>	<p>Clinicians and programs that we refer to must demonstrate a comprehensive knowledge of gambling disorder.</p>	<p>We are currently overhauling our inclusion/exclusion criteria and I do not have a current approved version to share. Essentially, all referral programs must be state licensed or approved. All treatment providers must be state licensed. Other services must be approved by the state, such as Alcoholics Anonymous or Mass211. The Helpline includes these services and the state approves them based on relevance of the service, accessibility, and approach. Approach is what we are working to flesh out some more, and is getting at things such as for-profit/non-profit, mission, conflicts, affiliations, etc. Due to the current attention on opioids, there have been a number of entities appearing that do not operate in the best interest of the consumer. Vetting and excluding these organizations while providing comprehensive referrals to SUD-related referrals is important to the Helpline.</p> <p>* Overhaul planned for July 2019</p>
<p><i>Documented procedures for identifying new resources for referral database</i></p> <p>AIRS Standard 10: Documented procedures in place for identifying new resources, including standardized survey for new organizations to be included in the resource database</p>	<p><u>DN</u> No documented procedures for identifying new resources for referral database</p> <p><u>MS</u> Documented procedures for identifying new resources for referral database</p> <p><u>ES</u> Documented procedures for identifying new resources for referral database w/ clear guidelines for frequency</p>	<p>As soon as clinicians and programs are added to our database they are verified to have comprehensive knowledge of gambling disorder. For example: When a clinician receives a MA Problem Gambling Specialist certificate, we add them to our database, and if there is a new GA group we add them to our database.</p> <p>*Not publicly documented</p>	<p>This is part of above policy which is in a draft currently. Helpline staff are constantly on the lookout for new services. We also annually review the system by service type to address gaps and any other issues.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Documented process for verifying and updating information in referral database on a regular basis</i></p> <p>AIRS Standard 11: Documented process for verifying information in the database annually or throughout the year that involves multiple attempts to achieve a 100% verification rate within a 12-month cycle. There is a mechanism for evaluating success of verification. Information that cannot be verified is considered for removal</p>	<p><u>DN</u> No documented process for verifying and updating information in referral database</p> <p><u>MS</u> Documented process for verifying and updating information in referral database</p> <p><u>ES</u> Documented process for verifying and updating information in referral database that is followed on at least an annual basis</p>	<p>The Helpline Coordinator is responsible for finding, updating and posting all resources used on the Helpline. It is updated weekly.</p> <p>Q16: Weekly.</p> <p>*Not publicly documented</p>	<p>Yes. We receive referral updates from multiple sources (primarily directly from BSAS licensing ongoing with quarterly full refreshes, and from providers through the Helpline Provider Portal). All resources are reviewed annually at minimum if not updated in another way. Frequent referrals are updated regularly enough that they are always on a more frequent review (quarterly at minimum). Information is vetted by the Helpline team, generally with BSAS verification (for treatment services).</p>

Note. Green = Exceeds Standard (ES); Yellow=Meets Standard (MS); Red=Does not Meet Standard (DN); * = information obtained upon clarification.

Table C3: Helpline Characteristics – Data and Evaluation

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>All interactions documented by Helpline specialists</i></p> <p>AIRS Standard 1: Staff are trained and monitored to: ...Accurately record what occurred during the inquiry</p> <p>AIRS Standard 6: The service maintains documentation on all inquiries and has a defined set of inquirer data elements that are used for reporting purposes and recognizes that inquirers have the right to withhold information.</p>	<p><u>DN</u> Not all interactions are documented</p> <p><u>MS</u> All interactions are documented</p> <p><u>ES</u> All interactions are documented in real time, as they occur</p>	<p>Notes are taken and entered into the notes section of the database. Caller demographic and gambling related data is also collected. There is no audio recording of calls that are received.</p>	<p>Yes, during the conversation they enter information into our secure data system. Depending on the call, more or less specific information may be gathered. For example, we document calls that come from outside of Massachusetts and from what state they originated, but do not collect demographic information. On typical Helpline calls for MA residents seeking SUD help, we capture more robust information. Much of this is captured in the reports I shared.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Performance Indicators collected by Helpline</i></p> <p>AIRS Standard 27: Process for tracking key performance indicators such as: Call volume, Abandoned calls, Average abandonment rate, Occupancy rates (target between 65% and 80%), Average speed of answer (target <90seconds), Service level (80% of calls within 90 seconds), Average call handling time, Average talk time, Incoming call patterns</p> <p>Contact USA Section 612: Does the helpline have a clear method of measuring outcomes, which it reports to stakeholders and uses to improve the program?</p> <p>Helplines Partnership Standard 1: Have clear success criteria, that are regularly reviewed and which demonstrate the impact of the service</p> <p>Helplines Partnership Standard 8: Performance standards for the helpline service are set and regularly reviewed, and reliable measures are used for quality assurance</p>	<p><u>DN</u> Helpline does not collect a clear set of performance indicators</p> <p><u>MS</u> Helpline collects a clear set of performance indicators</p> <p><u>ES</u> Helpline collects a clear set of performance indicators and uses them to improve the program</p>	<p>Answering times; Times of transactions; Abandoned calls; Unanswered calls; Complaints and commendations; Incoming call patterns</p>	<p>Call volume; Answering times; Times of transactions; Abandoned calls; Unanswered calls; Complaints and commendations; Incoming call patterns</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Helpline performance according to most recent collected performance indicators</i></p> <p>AIRS Standard 27: Average abandonment rate, Occupancy rates (target between 65% and 80%), Average speed of answer (target <90seconds), Service level (80% of calls within 90 seconds), Average call handling time, Average talk time</p> <p>Contact USA Section 612: Does the helpline have a clear method of measuring outcomes, which it reports to stakeholders and uses to improve the program?</p> <p>Helplines Partnership Standard 1: Have clear success criteria, that are regularly reviewed and which demonstrate the impact of the service</p> <p>Helplines Partnership Standard 8: Performance standards for the helpline service are set and regularly reviewed, and reliable measures are used for quality assurance</p>	<p><u>DN</u> Performance falls short on the majority of indicators</p> <p><u>MS</u> Mixed performance on set of indicators</p> <p><u>ES</u> Performance meets or exceeds the majority of indicators</p>	<p>See Report</p>	<p>See Report</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Consumer satisfaction surveys conducted</i></p> <p>AIRS Standard 27: Consumer satisfaction / quality assurance surveys with a specified percentage of inquirers</p>	<p><u>DN</u> Helpline does not conduct consumer satisfaction surveys</p> <p><u>MS</u> Helpline conducts consumer satisfaction surveys</p> <p><u>ES</u> Helpline conducts consumer satisfaction surveys with a specified percentage of callers on at least an annual basis</p>	<p>See Report</p>	<p>See Report; All callers have the option to leave feedback after the SIS interaction is over.</p> <p>* Caller and chat feedback are collected via an “opt-out” method. At the end of each client interaction (either call or chat), they are connected to a feedback survey. The Specialists alert the consumer of this during the interaction as well. Additional information is gathered from individuals who opt-in to follow-up services, but it is related to their access to services as opposed to satisfaction with the Helpline.</p>
<p><i>Helpline performance according to most recent consumer satisfaction survey</i></p> <p>AIRS Standard 27: Consumer satisfaction / quality assurance surveys with a specified percentage of inquirers</p>	<p><u>DN</u> Consumers express dissatisfaction on a majority of measures</p> <p><u>MS</u> Consumers express mixed satisfaction on measures</p> <p><u>ES</u> Consumers express satisfaction on a majority of measures</p>	<p>[Attached CSS Report]</p>	<p>*In the quarterly report I submitted via email, there is information on feedback outcomes. “Of the 3,284 completed calls this quarter, 740 callers (23%) provided feedback on their experience with the Helpline.” The quarter was January through March 2019. Additional details from the report are included in row below</p>

Note. Green = Exceeds Standard (ES); Yellow=Meets Standard (MS); Red=Does not Meet Standard (DN); * = information obtained upon clarification.

Table C4: Helpline Characteristics – Hiring, Training, & Supervision

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Measurable objectives in training curriculum that must be demonstrated as part of training</i></p> <p>AIRS Standard 25: Training for staff based on predetermined training goals and objectives defining behavioral outcomes for each training module</p> <p>Contact USA Section 503: Are there measurable objectives in the training curriculum that trainees can demonstrate as part of their training?</p> <p>Helplines Partnership Standard 11: Helpline workers can demonstrate appropriate skills and knowledge before taking contacts from service users without close supervision</p>	<p><u>DN</u> Training curriculum does not include measurable objectives</p> <p><u>MS</u> Training curriculum includes measurable objectives</p> <p><u>ES</u> Training curriculum includes measurable objectives and clear guidelines for how to determine whether those objectives are demonstrated during training</p>	<p>All staff answering the Helpline will be trained in the following areas: crisis management, Motivational Interviewing techniques, Suicide Prevention, engagement techniques, data collection, referral process, and resources. All staff who successfully complete the initial trainings will be required to attend an annual refresher training. Initial training will consist of the following:</p> <p>Orientation to the shared drive where up-to-date resources are found</p> <p>Review of materials that are offered to callers and are included in packets</p> <p>Orientation on using the Helpline database</p> <p>Shadowing experienced Helpline staff for a minimum of 8 calls with debriefing after each call</p> <p>Taking a minimum of 8 calls with the assistance of an experienced Helpline staff with debriefing after each call</p> <p>Taking a minimum of 8 calls with the assistance of an experienced Helpline staff with debriefing after each call</p>	<p>Trainees must demonstrate competency in understanding of SUD, SUD treatment, Helpline systems, and information & referral. This is accomplished through quizzes, role play, and shadowing using our QA call-monitoring form.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Basic training about suicide awareness and intervention</i></p> <p>Contact USA Section 504: Is there basic training about suicide awareness and intervention?</p>	<p><u>DN</u> Helpline specialist training does not include training about suicide awareness and intervention</p> <p><u>MS</u> Helpline specialist training includes training about suicide awareness and intervention</p> <p><u>ES</u> Helpline specialist training includes comprehensive training about suicide awareness and intervention</p>	<p>Yes. Samaritans present to staff once a year.</p>	<p>Yes, AIRS training, orientation to processes, and Samaritans conducts trainings for our team periodically as well.</p>
<p><i>Continuing education related to Helpline services</i></p> <p>AIRS Standard 25: Professional development program for employees</p> <p>Contact USA Section 507: Does the organization offer continuing education?</p> <p>Contact USA Section 508: Does the organization require staff to attend continuing education activities?</p>	<p><u>DN</u> Helpline does not offer continuing education</p> <p><u>MS</u> Helpline offers continuing education</p> <p><u>ES</u> Helpline requires staff to complete continuing education activities</p>	<p>A training by the Helpline Coordinator is held for staff at least once a year.</p> <p>* Historically, MCCG staff who answer helpline calls are also trainers in problem gambling issues and have ongoing staff development opportunities in regard to this and other roles within the agency.</p>	<p>Yes, we offer in-service training (monthly on average) for our Helpline team. We also share external training opportunities with the team. Participation in professional development is required by HRiA and for our staff to maintain their required AIRS I&R Specialist/Community Resource Specialist certifications. Certain, specific continuing ed. trainings are required (recent examples: refresher trainings on motivational interviewing and serving priority populations)</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Structured program of supervision</i></p> <p>AIRS Standard 24: Ongoing supervision and evaluation of employees by managers - - written supervision plan</p> <p>Contact USA Section 701: Does the Helpline have a structured program of supervision with at least one staff person whose responsibility is the supervision of helpline specialists?</p> <p>Helplines Partnership Standard 12: Provide regular and structured supervision for all helpline workers</p>	<p><u>DN</u> Helpline does not have a structured program of supervision</p> <p><u>MS</u> Helpline has a structured program of supervision</p> <p><u>ES</u> Helpline has a structured program of supervision with at least one staff person whose responsibility is the supervision of helpline specialists</p>	<p>The Director Programs and Services, in conjunction with the Helpline Coordinator schedules staff for coverage, updates resources, sends out requested packets and organizes Helpline related trainings for staff.</p>	<p>We have a structured program of supervision. Masters level Clinicians supervise the SIS. Each Clinician is assigned 3-5 SIS to supervise and they also act as shift supervisor while working. One on one supervision occurs bi-weekly. The Helpline Director oversees the team.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>System of support available for Helpline specialists</i></p> <p>AIRS Standard 3: Protocol in place for debriefing specialists, as needed, following a crisis call</p> <p>Contact USA Section 706: Does the helpline have a system of support available for helpline workers?</p> <p>Helplines Partnership Standard 9: Implement measures to support the physical and mental health and safety of helpline workers</p> <p>Helplines Partnership Standard 12: Ensure that helpline workers have opportunities for timely support after difficult contacts</p>	<p><u>DN</u> No system of support available for Helpline specialists</p> <p><u>MS</u> System of support available for Helpline specialists</p> <p><u>ES</u> System of support available for Helpline specialists, including protocols in place to provide timely support and debriefing after difficult contacts</p>	<p>[Not addressed.]</p> <p>* As an agency, we are committed to an environment that supports self-care for all of our staff. This includes excellent benefits and time off, access to insurance that covers behavioral healthcare</p>	<p>Having Clinicians supervise the SIS was purposeful. They are able to provide clinical expertise for calls, and also to support the SIS in this hard work. We try to foster a supportive environment and the entire team really does support each other. We also have a wellness room on-site where staff can take time as needed to support their wellness (this could include meditation, a nap, quiet reflection, prayer, yoga, or most any other activity that supports wellness). Please see the section in the protocol on compassion fatigue.</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Annual system of evaluation for Helpline specialists</i></p> <p>Contact USA Section 211: Does the organization have annual personnel evaluations?</p> <p>Contact USA Section 702: Does the helpline program have an annual system of evaluation of each specialist's work performance and skills?</p> <p>Helplines Partnership Standard 9: The organisation has defined acceptable performance levels for staff / volunteer attendance and retention</p> <p>Helplines Partnership Standard 12: Regularly assess how helpline workers handle contacts against clear criteria and provide constructive feedback</p>	<p><u>DN</u> Helpline does not have annual personnel evaluations</p> <p><u>MS</u> Helpline has system for annual personnel evaluations</p> <p><u>ES</u> Helpline has system for annual personnel evaluations with clearly defined acceptable performance levels and constructive feedback</p>	<p>There is no full time Helpline Specialist. All employees received quarterly and annual review for their work.</p> <p>* Customer Satisfaction Surveys are conducted via phone to helpline callers who agree to a call back. These evaluations are submitted annually to DPH</p>	<p>Yes, we review all staff annually, in December with 6 month check-ins. New staff also have 6 month evaluations. We use a system called ReviewSnap and are largely focused on the employee execution of their job duties. We also have a draft call monitoring quality assurance form that is currently being tested that I can share.</p>

Note. Green = Exceeds Standard (ES); Yellow=Meets Standard (MS); Red=Does not Meet Standard (DN); * = information obtained upon clarification.

Table C5: Helpline Characteristics – Organization Characteristics

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Facilities dedicated to Helpline operations</i></p> <p>AIRS Standard 22: Sufficient facilities for staff to perform their duties</p> <p>Contact USA Section 301: Are the facilities adequate for the needs of the program?</p>	<p><u>DN</u> The organization does not have facilities dedicated to Helpline operations</p> <p><u>MS</u> The organization has facilities dedicated to Helpline operations</p> <p><u>ES</u> The organization has facilities dedicated to Helpline operations with space and technology that facilitate the ability of Helpline specialists to perform their duties</p>	<p>No</p>	<p>Yes, to maintain confidentiality we have an enclosed call center with SIS work stations in it. We have worked to make this a productive and comfortable environment for the SIS (we have a white noise system and fabric-covered workstation walls to help with sound, for example). Follow-up calls are also completed within the call center to maintain confidentiality. We currently have seating for 8 SIS at a time within the call center, though we have not needed to seat 8 staff a time.</p>
<p><i>Broad-based funding</i></p> <p>Contact USA Section 201: Does organization have broad-based funding adequate for current needs?</p>	<p><u>DN</u> The organization does not have broad-based funding adequate for current needs</p> <p><u>MS</u> The organization has broad-based funding adequate for current needs</p> <p><u>ES</u> The organization has broad-based funding adequate for current and future needs</p>	<p>The Helpline is currently funded by the Mass. Department of Public Health, Office of Problem Gambling Services</p>	<p>The MA Helpline is funded through the Department of Public Health, Bureau of Substance Addiction Services. While the MA Helpline is funded through a single source, HRIA also has contracts to operate Helplines for other states, enabling us to have more security and sustainability for our team and to share some Helpline expenses across states that historically had to be supported through the MA Helpline alone (ex: AIRS membership, phone service, scheduling software, professional development).</p>

Standard	Rule	Gambling Helpline	Substance Use Helpline
<p><i>Written sustainability plan</i></p> <p>Helplines Partnership Standard 1: Have a realistic plan for the financial sustainability of the helpline</p>	<p><u>DN</u> The organization does not have a written sustainability plan</p> <p><u>MS</u> The organization has a written sustainability plan</p> <p><u>ES</u> The organization has a written and comprehensive sustainability plan</p>	<p>Not at this time.</p>	<p>N/A</p>

Note. Green = Exceeds Standard (ES); Yellow=Meets Standard (MS); Red=Does not Meet Standard (DN); * = information obtained upon clarification.

TO: Public Health Trust Fund Executive Committee
FROM: Victor Ortiz, Director of Problem Gambling Services, DPH
RE: FY20 – Office of Problem Gambling Services (OPGS) Updates
DATE: November 6th, 2019

Background:

- In FY20, OPGS is operating a total budget (staffing and programs) of \$5.7m, of which \$4.7m has been allocated from the PHTF.
- The purpose of this document is to provide a brief update on the following for FY20: staffing, procurements, and upcoming key initiatives.

Office of Problem Gambling Staffing Updates

Status: The position of Asst. Director of Programs and Services was posted on Nov 5th. The positions of Finance & Operations Analyst and Finance & Contracts Analyst will be posted by November 30th.

New Procurements

Community Health Workers and Gambling Training

- In FY20, building to scale from the pilot, OPGS will procure for Community Health Workers and Gambling Trainings in Regions A and B. The proposal is under development and anticipated posting will occur in October

Status: Timeline has been adjusted and procurement will be posted by January 2020.

Key Programmatic Updates

Community Level Health Project (CLHP)

Purpose: Through this initiative a community-based organization within the host communities of Regions A/B (Greater Springfield: Public Health Inst of Western Mass) and (Greater Everett: Boston Chinatown Neighborhood Center) will propose and implement a community level plan that will identify and address a specific gambling-related health concern and outline improvement initiatives to be carried out at the community level. The proposed initiative can include building off of an existing community health planning process that is aimed at improving the health and well-being of the targeted host community and the individuals living in these communities.

Greater Springfield: Public Health Inst of Western Mass: Monthly meetings with community partners have been conducted, and have resulted in three areas of focus that are scheduled for further planning and exploration. The dates and areas of focus are the following:

- October 23: Mental health among youth, adults, people who are homeless, and the impact of gambling on families
- November 27: Safety – human trafficking, domestic violence, crime, and police violence/cultural humility
- December 18: Stress induced chronic disease

Status: Completed meeting about mental health among youth, adults, and people who are homeless. November 27th meeting scheduled as planned.

Greater Everett: Boston Chinatown Neighborhood Center: Finalizing the FY20 scope of service.

Status: A revised scope of service is being developed by BCNC and is due by the end of November.

Community Health Workers (CHWs) Pilot

Purpose: Led by the City of Springfield, the CHW Pilot initiative will create and/or build off of existing multi-sector partnerships (Mass in Motion) to develop and implement community-level engagements and strategies within historically marginalized communities who are at greater risk of gambling harm. Key highlights of the initiative include:

- Engage and educate local neighborhoods of Region B on gambling related harms, casino health impacts, resources, and services. CHWs will conduct educational activities specifically in communities that are historically marginalized and disseminate resources and services.
- CHWs will guide and support interventions to increase opportunities to establish neighborhood partnerships for the prevention and intervention of problem gambling and associated harms and/or the understanding of community health impacts of a resort casino
- CHWs will gather and share local neighborhood concerns to inform local health policy, systems, and environmental change strategies.

Status: The contract has been fully executed with the City of Springfield, and the program will begin November 15th.

2019: Stakeholder Listening Session Report

Purpose: A central part of the Public Health Trust Fund Strategic Plan is ensuring cultural competency within all strategies. The purpose of the annual Stakeholder Listening Sessions is for community members in the casino host communities of Springfield and Everett to make recommendations on cultural competency approaches and strategies for the implementation of the Strategic Plan and services to prevent and mitigate the harms associated with gambling. The highlighted 2019 recommendations are the following:

- Tailor interventions to the needs of the community.
- Incorporate family-level interventions to deliver education and prevention strategies.
- Integrate and coordinate problem gambling mitigation activities with existing mental health, substance abuse, primary care, and social services.

The full report can be found: <https://www.mass.gov/files/documents/2019/08/28/SLS-Annual-Report-07-16-19.pdf>

Status: The 2020 Stakeholder Listening Sessions are in development; dates and location for January 2020 will be finalized by November 30th.

Treatment Gap Analysis (TGA)

Purpose: The Treatment Gap Analysis (TGA) is a three part analysis relating to gambling treatment. The goal of the TGA is to yield actionable information and serve as a baseline to inform the development and enhancement of gambling treatment services in Massachusetts. Each section provided a number of recommendations to be coordinated into an action plan carried out starting this fiscal year.

On January 23rd 2019 at the PHTF meeting we presented two sections of the Treatment Gap Analysis (TGA):

- **State of Service** (This analysis takes a broad view of the treatment system to determine entry and exit points for services and data collection mechanism)
- **Need Fulfillment:** (The purpose of this analysis is to determine treatment demand for problem gambling).

Status: No new updates. The **Capability Gap Analysis** is the last part of the overall TGA, which will be presented at this PHTF meeting.

Helpline Evaluation

Purpose: Evaluate the Statewide Gambling and Substance Abuse Helplines to explore potential advantages, disadvantages, and mechanisms for connecting both helplines. The outcome of the evaluation, which was conducted by the Division on Addiction (DOA), will provide next steps to inform helpline services.

Status: No new updates. Report was completed and distributed to both helpline vendors in early September.

Public Awareness Campaign: Youth and Parents

Purpose: The *Public Awareness Campaign: Youth and Parents* will target parents of teens. The campaign will focus on the many forms that gambling takes in today's culture, how teens engage in gambling, and what the risks are. The campaign will encourage parents to talk to their teens about gambling and the risks.

Status: Initial concepts designs have been tested. Design, results of the testing, and strategies will be presented at the PHTF meeting on Nov 18th.

Public Awareness Campaign: Men of Color

Purpose: To raise awareness about the links between substance use and problem gambling, OPGS developed an awareness campaign aimed at men of color with a history of substance misuse.

Status: No new updates. The third wave of the campaign was completed by August 18th and the total result of the campaign is over 4M impressions on social media, bus lines, and subway. The campaign maintained high levels of performance during the campaign. The campaign results will be presented at the PHTF meeting on Nov 18th.

Programs Serving Veterans, Public Safety, and Marginalized Populations

Purpose: The Public Health Trust Fund allocated additional funding to DPH to focus on work related to veterans, public safety issues, and communities of color/marginalized populations in the casino host cities and surrounding communities. The Office of Problem Gambling Services (OPGS) has partnered with programs at DPH that work in these priority areas to leverage existing projects and optimize public health approaches in programs and services.

Status: Completed internal information gathering with DPH stakeholders. DPH conducted planning and development meetings with EOPPS and DVS; below is a status of each focus area.

- **Veterans:** As a result of meeting with DVS, three areas of focus were identified: Training and Technical Assistance; Data Collection and Analysis to Inform Best Practices in Veteran Services; and Materials Development. Specifications around programs are under discussion.
- **Public Safety:** Planning and development was centered on priority area of human trafficking and child sexual exploitation identified with EOPPS and EHS; pilot project in motion; determining most effective and appropriate use of funds to contribute a public health approach to this project.
- **Marginalized Populations:** DPH's Mass in Motion program supports activities aimed at engaging communities to gain a deeper understanding of health inequities and develop policy, system and environmental change approaches to address these inequities. Building on our problem gambling ecological approach, these activities will lay the foundation for upstream prevention focused on problem gambling and related issues. Leveraged current Mass in Motion contracts to fund the communities of Chelsea, Revere, Salem, and Lynn.



TO: Public Health Trust Fund Executive Committee

FROM: Mark Vander Linden, Director of Research and Responsible Gaming

DATE: November 18, 2019

RE: Research Update

Released Reports & Studies, July – November 2019

Economic Impacts of Plainridge Park Casino: Four Years of Operations

Thomas Peake, Abigail Raisz, and Kazmiera Breest (Released: MGC open meeting, November 7, 2019, Plainville, MA)

In October of 2017, the UMass Donahue Institute’s Economic and Public Policy Research Unit (UMDI), as part of the [SEIGMA](#) research team, published a [report](#) of the first year of operation at Plainridge Park Casino (PPC)—the first casino to open in Massachusetts following the passage of the Expanded Gaming Act in 2011. That report utilized proprietary data from PPC provided to UMDI under PPC’s agreement with the Massachusetts Gaming Commission (MGC) on employment, wages, and spending, along with revenue data from the MGC. The report also included findings from a [survey of PPC patrons](#) conducted on-site during that first year of operation. The data from that survey, along with the operations data from PPC and the MGC, allowed UMDI to produce a full economic impact analysis using a REMI PI⁺ economic impact model.

In subsequent fiscal years, budgetary constraints have prevented the SEIGMA team from dedicating resources to additional patron surveys. Operating data from PPC and the MGC, however, have continued to be collected and tabulated. This report aims to illustrate how operations at PPC have changed in the last three fiscal years, but it does not employ a full economic impact analysis since we do not have information on how patron behavior has changed since the first year of operation. This report is presented as a time-series, as it analyzes the first four years of operation at PPC (FY 2016, FY 2017, FY 2018, and FY 2019) with a focus on Fiscal Years 2017, 2018, and 2019.

This report’s main findings:

- Employment at PPC has declined. When PPC opened in summer 2015, it employed 555 employees at its peak. At the end of fiscal year 2019, PPC employed just over 450 employees.
- Full-time employees represent the majority of PPC’s workforce in all four fiscal years of operation. Median hourly wages for full-time workers have increased faster than for part-time workers.
- In-state spending on private vendors dropped in fiscal year 2019, while out-of-state spending has seen a gradual increase. 54.5% of PPC’s private sector spending was on vendors outside of Massachusetts, and 26.3% was spent in the Metro Boston region.
- Plainridge spent less money on private sector vendors and increased its payment to charitable organizations in fiscal year 2019.



Massachusetts Gaming Commission

- Revenues have been trending slightly upwards (approx. \$160M in FY2016, \$158M in FY2017, \$170M in FY2018, and \$169M in FY2019). However, each successive year has seen lower visitation than the previous year.
- Average annual gross gaming revenue brought in per PPC patron has increased by 27% from fiscal year 2016 to fiscal year 2019. This change in patron behavior has driven the rise in revenues, even as visitation has fallen.

New Employee Survey at Plainridge Park Casino: Analysis of Fiscal Year 2018

Andrew L. Hall (Released: MGC open meeting, November 7, 2019, Plainville, MA)

The findings of this report are based on an analysis of the third year of data collected from the Massachusetts Gaming Commission (MGC) New Employee Survey administered at Plainridge Park Casino in Plainville, Massachusetts. The period captured in this analysis is fiscal year 2018, which roughly spans the time from the summer of 2017 to the summer of 2018. During this period, 193 survey responses were collected. This study follows the [New Employee Survey at Plainridge Park Casino: Analysis of First Two Years of Data Collection](#) report that documented new employee characteristics during the first two years of operation. Survey respondents in both studies include newly hired employees of different types: employees who already worked for Plainridge Racecourse before the Commission designated it as the Commonwealth’s only slots parlor; those who are new to the gaming industry; employees who were permanently transferred from other gaming properties operated by the casino licensee, Penn National; and employees of food-court vendors. Respondents completed the survey during the fingerprinting process, which is the only step in the gaming-licensing process where they appear in person.

In general, we find that the new employment opportunities created at Plainridge Park Casino have benefited people who have experienced unemployment or underemployment and those with little educational attainment, experience, or training. Hiring at Plainridge Park Casino has also generated interest in employment in this industry, evident from the career-related reasons new employees provided for seeking employment at Plainridge Park Casino.

- 46% of respondents hired in 2017-2018 reported being previously unemployed or employed only part-time. 76% of people who were previously unemployed are in full-time positions at the casino. 42% of those who previously worked in part-time jobs now work full-time at the casino.
- 75% of new employees in 2017-2018 have less than a bachelor’s degree, and 82% of casino employees lacked previous casino-related experience.
- The three major reasons why recent hires wanted to work at PPC include 1) the opportunity for career advancement; 2) improved pay; and 3) the opportunity to learn new skills or receive training.
- 67% of people hired in 2017-2018 are Massachusetts residents and 33% commute from out-of-state, mainly from Rhode Island.

Social and Economic Impacts of Plainridge Park Casino: 2018

SEIGMA Research Team (Released: MGC open meeting, November 7, 2019, Plainville, MA)

In September 2018, a comprehensive report on the [Social and Economic Impacts of Expanded Gambling in Massachusetts: 2018](#) (SEIGMA Research Team, 2018) was produced that described both the regional and statewide impacts of expanded gambling in Massachusetts as of mid-2018. The present report is an extraction of information from that report specific to the impacts of the construction and operation of

Plainridge Park Casino (PPC). Two fact sheets summarizing PPC's impacts on traffic and social/public health indicators were also crafted and released. Charts from those fact sheets are presented below.

In general, the overall impacts of PPC to date have largely been positive, with clear positive economic impacts along with relatively minor negative social impacts. The profile of specific impacts is described below.

Social and Health Impacts

- There has been no significant change in the prevalence of problem gambling or related indices (treatment seeking, bankruptcy, divorce/separation, suicides) in the PPC Host and Surrounding Communities (H&SC).
- There has been no significant change in the overall amount of crime in the PPC H&SC.
- There has been a significant change in the PPC H&SC attitudes toward gambling. A greater portion of people in the region now report being satisfied with the availability of gambling. However, there has also been a decrease in the percentage of people who believe casinos will be beneficial to Massachusetts and an increase in the percentage of people with more neutral opinions about PPC (i.e., more people believing it will be neither beneficial nor harmful).
- There has been no significant change in population health (health, happiness, stress, substance use, addictions) in the PPC H&SC that can be attributed to casino introduction.
- There has been no change in overall gambling involvement in the PPC H&SC or the percentage of people who consider gambling to be an important leisure activity.
- There has been no change in the broader population demographics in the PPC H&SC that can be attributed to casino introduction.

Economic and Fiscal Impacts

- The building of PPC has had significant economic benefits. Penn National spent \$150.2 million building PPC and employing a large local workforce in the construction. A total of 87% of this direct spending was within Massachusetts as was 81% of the construction workforce, with the majority of spending and employment occurring in Bristol and Norfolk Counties (where PPC is located). Economic modeling suggests that PPC construction created 1,286 net new jobs, \$104.4 million in net new personal income, and \$121.8 million in net new economic activity in the state, with most of this occurring within Bristol and Norfolk Counties.
- The operation of PPC is also creating significant economic benefits as most of the \$176 - \$186 million annual revenue appears to represent new money from 'recaptured' Massachusetts casino patrons (i.e., Massachusetts residents who reported they would have gambled out-of-state if not for PPC) and out-of-state patrons. Furthermore, the large majority of this revenue stays in the state. Of the \$129.5 million in operational expenses (taxes, wages, supplies) in PPC's first year of operation, 87% were spent within Massachusetts. Also, slightly more than 500 people have ongoing employment at the casino, with approximately 71% being in-state employees. A significant portion of these are 'new' jobs as people taking the positions were either unemployed or working part-time prior to beginning work at the casino. After accounting for losses to other sectors of the economy due to reallocated consumer spending to PPC, economic modelling projects 2,417 net new jobs were created in the first year of operation, as well as \$143.7 million in net new personal income and \$362.4 million in net new economic activity, with most of this occurring within the Metro Boston region.
- There is no strong direct evidence that the overall number of businesses has significantly changed as a direct result of PPC or that the construction and/or operation of PPC has differentially impacted

certain types of businesses. That said, economic modeling does project \$72.4 million in additional economic activity in Bristol and Norfolk Counties due to PPC construction and \$326.3 million in additional economic activity in the Metro Boston and Southeastern regions associated with PPC operation prior to considering reallocation. In addition, there is an unambiguous rejuvenation of racing at Plainridge Racecourse, which is primarily due to the funds provided from the Race Horse Development Fund (which is funded by PPC slot revenue).

- There has been a slight increase in wages and a slight decrease in the poverty rate in Plainville, but it is uncertain whether this is attributable to the casino. However, economic modeling does show significant increases in personal income in Bristol and Norfolk Counties due to PPC construction and to the Metro Boston and Southeast regions due to PPC operation.
- It is unlikely that PPC has impacted local property values or rental costs.
- Government impacts from casino gambling have not been extensively analyzed. There are some financial costs in Plainville due to the strain on infrastructure and local government services as well as the fact that the local populace disproportionately contributes to PPC revenue. However, this is offset by revenue from Host and Surrounding Community agreements with PPC, PPC property taxes, and Local Aid from the state government from taxes on casino gross gaming revenue.

Summary of Impacts

SOCIAL and HEALTH IMPACTS		Change from baseline to follow up
Problem Gambling and Related Indices	Prevalence and Incidence of Problem Gambling; Treatment Seeking for Problem Gambling	↔
	Financial Problems, Bankruptcy, Employment Problems	↔
	Divorce, Separation, Domestic Violence, Child Abuse and Neglect; Suicide	↔
Crime	Overall Crime Rates; Illegal Gambling	↔
Attitudes	Attitudes Towards Gambling	↓ ↑
Population Health & Leisure	Physical and Psychological Health; Substance Use and Addictions; Leisure Activity	↔
Demographics	Population; Educational System	↔
Environment	Traffic (accidents, volume); Noise	↑

ECONOMIC AND FISCAL IMPACTS		Change from baseline to follow up
Direct Casino Expenditure and Revenue	Plainridge Park Casino	↑
Business Establishments	Number of Business Establishments; Impacts on Other Types of Gambling	↑
Employment	Employment Levels, Labor Force Participation	↑
Personal Income	Wages	↑
	Poverty Rate	↓
	Gambling Participation in Relation to Income	TBD
Real Estate and Housing	Property Values; Residential Building Permits; Rental Costs	↔
Government and Fiscal	Expenditure	↑
	Revenue	↑

Assessing the Influence of Gambling on Public Safety in Massachusetts Cities and Towns Baseline analysis of crime, call-for-service, and collision data in the communities near Encore Boston Harbor
Christopher W. Bruce (Release: MGC open public meeting, November 7, 2019, Plainville, MA)

This is the first report concerning the Everett-area agencies likely to be affected by Encore Boston Harbor. It is a baseline report, and as such, there are no particular “findings” in relation to any changes in public safety issues caused by the casino. Those will be covered in a subsequent series of reports. The most important points covered in this report are:

- Everett, Boston, Chelsea, Lynn, Malden, Melrose, Revere, and Somerville all contributed data to this report. Medford was not able to contribute data in time but hopefully will join us in future reports. Cambridge declined to participate.
- Statistics were calculated by fusing data on crimes, calls for service, and collisions extracted from each participating agency’s records management system (RMS) and computer-aided dispatch (CAD) system.
- There are means by which Encore’s presence could cause crime to increase (e.g. a larger population of visitors and vehicles providing more opportunities for offenders) and there are means by which it could decrease (e.g., by supplying more law enforcement presence, economic development, and legitimate activity in the area).
- Full statistics for crimes, calls for service, and traffic collisions are given for each participating agency from the 2012-2018 period. The data tables indicate how much the categories typically fluctuate from year to year and how the trend has been progressing over time. Despite noted errors and pitfalls within the data, it can still be effectively used to compare changes post-Encore.

- Analysis will need to consider the presence of several existing types of facilities have seen increased traffic and usage in other communities across the nation with new casinos, including hotels, gas stations, convenience stores, transportation centers, pawnshops, and social service agencies.
- Local police agencies supply most of the actual crime data from the region, but State Police data was collected primarily to determine patterns on state roadways. Crashes have been on an upward trend (as they have for many area communities), which may be accelerated with extra traffic in the area.

Assessing the Influence of Gambling on Public Safety in Massachusetts Cities and Towns Analysis of changes in police data following eight months of activity at MGM Springfield

Christopher W. Bruce (Release: MGC open meeting, November 7, 2019, Plainville, MA)

The primary purpose of this report is to conduct an analysis of the increases and decreases in activity in the communities surrounding MGM Springfield since the casino opened, to identify which changes in activity might be attributable to the casino, and to triage trends for more detailed analysis in later reports.

Data was collected from the records management systems of the Springfield, Agawam, Chicopee, East Longmeadow, Hampden, Holyoke, Longmeadow, Ludlow, Northampton, West Springfield, and Wilbraham Police Departments and the Massachusetts State Police. Crime, calls for service, and collisions during the period of September 2018–April 2019 were compared to the same months over the previous 5 to 7 years, depending on the data quality of the participating agency. Any significant increases were analyzed in more detail with available quantitative data. To determine likelihood of a casino relation, I used a rubric of my own design that analyzes the data for several variables: logical connection to a casino, complementary increases in other communities, complementary increases in similar crimes, evidence of increased participation from individuals outside the local area, spatial proximity to the casino, comparison to control communities, and specific mention of the casino or gambling in the police reports.

Major Findings:

- The casino itself has been the site of several hundred crimes, including violent crimes, property crimes, and police responses for other types of activity, in the eight months since it opened. As such, it has risen to the top of the local area list of hot spots and has about as much activity as a large shopping mall.
- To the extent that the casino has “caused” crime, however, it seems largely confined to the casino itself. Both the immediate block around the casino, the Metro Center of Springfield, and the surrounding residential and business community all have normal-to-low volumes, suggesting that attractors of more crime (i.e., extra people in the area) and suppressors (i.e., extra natural guardianship, extra police presence) are canceling each other out.
- The surrounding communities saw some increases and decreases but very few consistent trends to which MGM Springfield serves as a clear source. Issues most likely influenced by the casino include:

- An increase in traffic collisions and traffic-related calls for service (disabled vehicles, abandoned vehicles, traffic complaints) on state highways and some local roads, particularly to the south and west of the casino (notably in Agawam and West Springfield).
- An increase in other activities that tend to increase with visitors to an area, such as medical aids in Springfield and “general service” and “lost property” calls in other communities.
- An increase in activity at Union Station in Springfield specifically. (The facility had been closed between 1973 and 2017, but crimes and calls increased even in comparison to the combined values at the previous train station and bus stations.)
- An increase in minor disorder and suspicious activity just across the two bridges in West Springfield.
- The surrounding communities had several joint trends for which there is no logical tie to MGM Springfield but are still worth addressing to improve public safety in the region. These include:
 - An increase in domestic violence and domestic disputes in Agawam, Ludlow, and perhaps Longmeadow.
 - Increases in pornography-related offenses in several communities. Judging by the locations of the incidents and the demographics of those involved, these seem to be a trend of “selfies” and “sexting” among local teenagers, and not anything occasioned by the casino.
- Although there is anecdotal evidence of MGM Springfield appearing among “last drink” locations during drunk driving arrests, in general drunk driving has not increased in the region as reflected either in police arrests or crash statistics. This variable is poorly recorded within regional crash data, however, and we await a more comprehensive state dataset for further analysis

Assessing the Impact of Gambling on Public Safety in Massachusetts Cities and Towns Analysis of changes in police data following four years of activity at Plainridge Park Casino

Christopher W. Bruce (Release: MGC open meeting November 7, 2019, Plainville, MA)

The primary purpose of this report is to conduct an analysis of the increases and decreases in activity in the communities surrounding Plainridge Park since the casino opened and to identify which changes in activity might be attributable to the casino. Data was collected from the records management systems of Plainville, Attleboro, Foxborough, Mansfield, North Attleborough, and Wrentham since 2010. The period of 1 July 2015 through 30 June 2019 (4 years post-casino) was compared to the same periods of previous years. Both crimes and non-crime calls for service were included. Overall crime was down in the communities, but there were significant variations across communities and across crime categories within individual communities. Any significant increases were analyzed in more detail with both quantitative and qualitative data. Rarely was there evidence to establish a casino relationship, and the general sense from the participating agencies was that they did not feel that Plainridge Park Casino had contributed significantly to crime or calls for service. Two agencies cited a heroin epidemic as more likely causing their crime increases.

Major findings:

- During Plainridge Park's first four years of operation, the Gaming Enforcement Unit reported 5,194 "incidents" at the casino, of which 843 incidents were actual crimes. Trends include thefts of gaming credits, drug use, and distribution in the parking areas, angry and intoxicated patrons, and thefts of personal property.
- The casino directly (i.e., incidents on casino property) led to a 2% increase in violent crime (+3 incidents), a 7% increase in property crime (+44 incidents), an 9% increase in total crime (+104 incidents), and a 3% increase in calls for service (+872 incidents) for the Plainville Police Department. Crime by all measures has been declining at PPC since its first year,
- Statistics at the casino are similar to those at the top call-for-service locations in other communities.
- Based on a totality of the quantitative and qualitative evidence, the following trends in the surrounding community are "likely" to be related to the presence of Plainridge Park:
 - Increases in credit card fraud in multiple communities during the first year. (The trend abated in the second and third years.)
 - At least part of an increase in traffic collisions in the area, primarily minor collisions with no injury not reported to the state
 - An increase in traffic complaints along Route 1 south of PPC, including parts of Plainville and North Attleborough
 - Several additional disorderly conduct incidents at Plainville Commons Marketplace, across the street from the casino, in 2017
 - An increase in "lost property" reports in Plainville
 - An increase in "suspicious activity" reports in Plainville
 - Analysis of the latest available year of statewide traffic data (2017) suggests that increases in reported collisions have simply kept track with trends that existed before PPC. Data from the agencies' CAD systems tells a different story, but those datasets include low property-damage, non-injury crashes.
 - A recent increase in drunk driving collisions plus state Alcoholic Beverage Control Commission data on "last drinks" suggests a mild increase in drunk driving in the area, likely influenced more by Patriot Place than Plainridge Park.
 - Total arrests and other charges were down significantly in the area, particularly for liquor-related offenses at the major event venues. Even controlling for liquor-related offenses, arrests were down in most communities.
 - No related increase was seen in state police crime statistics, excepting incidents at Plainridge Park specifically.
 - Increases in domestic violence, identity theft, and fraud remain a major concern in the area, but no evidence ties these crimes directly to PPC.
 - Even though burglary declined 40% in the region, Wrentham Police identified a burglary pattern whose perpetrator was principally motivated by a gambling and drug addiction, and who was known to frequent Plainridge Park.

Talking about Casino Gambling: Community Voices from Boston Chinatown

Carolyn Wong, Giles Li (Release October 24, 2019, MGC public meeting, Boston, MA)

This pilot study examined the casino gambling practices of residents and workers in Boston Chinatown. The aim was to learn about the trajectory and life context of individual participants' gambling activity, including how individual participants describe their motivation, nature, and frequency of gambling and its effects on self and family. The research was conducted by a university-based research team in partnership with the Boston Chinatown Neighborhood Center and with the assistance of the Massachusetts Council on Compulsive Gambling. Twenty-three individuals participated in face-to-face interviews. Most participants were low-wage workers or retirees from the food and services industries in Chinatown.

The stories told by participants illustrate multiple and overlapping risk factors for problem gambling. The conceptual approach took into account the dynamic interaction of risk factors from multiple sources: stressors in participants' daily lives rooted in socio-economic conditions, exposure to targeted marketing aimed at Chinese immigrants inside and outside the casino, casino inducements, family contexts, and individual-level psychological and/or emotional factors. Protective factors include the support of social networks or families.

Findings from this study challenge erroneous notions found in popular media and some misinformed academic writings that homogenize and reify culture by depicting Chinese as "gamblers". Many of interviewees described varying degrees of dependency on gambling in casinos to relieve the drudgery of work in low-paying jobs in the food service industry, and the isolation of life in linguistically isolated neighborhoods with few alternative opportunities for recreation.

Participants expressed concern about increased risk for problem gambling with the establishment of the new Encore Boston Harbor casino. There are no culturally-appropriate prevention and treatment programs in Chinatown. Interview themes point to why there is an urgent need to fill this gap: concentrated poverty, social isolation, language and cultural difference, lack of recreational alternatives, and the longstanding practice of casino targeted advertising to Chinatown community members. The need for evidence-based and culturally appropriate prevention and treatment programs is shared by other low-income Asian American communities in Massachusetts.

Real Estate Impacts of MGM Springfield in Springfield and Surrounding Communities

Henry Renski, Thomas Peake, Andrew Hall, Denis McAuliffe, and Jonathan Astor (Release: MGC open meeting, September 26, 2019, Springfield, MA)

This report details the examination of the initial impacts of MGM Springfield on the residential, commercial, and industrial real estate markets for Springfield and its surrounding communities. It follows the [Baseline Real Estate Conditions, Host Community Profile: Springfield](#) report that documented residential, commercial, and industrial real estate trends prior to the opening of MGM Springfield. The purpose of this study is to document any notable changes to the Springfield area's real estate market following the awarding of a casino license to MGM Springfield in February 2014 and the subsequent opening of the first resort-style casino in Massachusetts in August of 2018. Since MGM

Springfield has been open for less than a year at the time of writing, there are some data sources which we had hoped to use, but which do not include any post-opening data due to lags in publication.

The SEIGMA team also interviewed key informants in Springfield with a specific focus on real estate conditions and housing and concerns surrounding gentrification and displacement. The goals of the qualitative interviews are to: (1) gain an on-the-ground understanding of the social and economic conditions in host communities prior to the development of a casino, during the process of constructing a casino, and while hosting a casino, (2) utilize qualitative data of impacts to triangulate findings from quantitative data, and (3) pinpoint mechanisms to explain quantitative trends and correlations.

Key Findings: Residential Real Estate Indicators

- Sales of single-family homes in Springfield, Massachusetts flattened in the wake of the Great Recession of 2009. However, home sales picked up in 2014, just before the license was awarded to MGM and continued through 2018 when MGM Springfield opened. Since the economic recovery matched the awarding of the MGM Springfield casino license, it is difficult to truly distinguish the impact of the casino from the more general economic recovery on sales of single-family homes.
- Between 2009 and 2011, Springfield's single-family home sales saw decreasing growth rates. After 2011, Springfield's rates were below those of the surrounding communities and the rest of Hampshire and Hampden Counties. However, all three experienced steady growth after the license was awarded to MGM in 2014, although this growth could be interpreted as being due to broader market conditions.
- Between licensing and opening of MGM Springfield, condominium sales in the rest of Hampshire and Hampden Counties experienced quicker growth rates than both Springfield and its surrounding communities.
- Inflation-adjusted median sales prices in Springfield have increased slightly or remained flat for single-family homes and condominiums between the casino's licensing and opening. Only multi-family home prices have increased dramatically during that time. Key informant interviews suggest that this phenomenon could be due to investors buying up multi-family homes.
- Median sales prices in Springfield's surrounding communities and the rest of Hampden and Hampshire Counties experienced very little change during that time for single-family homes, condominiums, and multi-family homes.
- Median gross rents in Springfield, the surrounding communities, Hampden and Hampshire Counties, and the state as a whole increased in the period prior to and following the awarding of the MGM Springfield license. This suggests that increases in the study region could be following larger state trends.
- Springfield's residential vacancy rate saw a 1.2% decrease in the most recent years of data following the license award while the combined surrounding communities and the rest of Hampden and Hampshire Counties saw their vacancy rates increase at rates of 0.6% and 1.5%, respectively.
- Key informants from Springfield noted the increasing pressure on the housing market and increasing rental costs. Key informants were unsure whether these trends could be attributed to the licensing and opening of MGM Springfield and teased out from larger market forces and other development projects.
- Springfield key informants raised concerns regarding the speculative buying of properties in Springfield. For instance, many of the key informants discussed investors buying multi-family buildings and raising rents and/or buying a property and leaving it vacant with the hope of

selling higher. Key informants also discussed concerns regarding displacement and an increase in evictions.

Key Findings: Commercial and Industrial Real Estate Indicators

- For most of the study period (2008-2018), Springfield added new commercial space at a slightly faster rate than the Commonwealth as a whole, but lagged in terms of industrial buildings. That trend reversed at the end of 2018 with the addition of a very large industrial facility.
- Vacancy rates—or the share of rentable building area which is listed on the market—have fallen in Springfield over the last 11 years and were lower than the statewide rates at the end of 2018. It is difficult to determine how much potentially rentable building area remains off the market.
- Average lease rates for office and industrial properties were consistently much lower in Springfield and its surrounding communities than in the Commonwealth as a whole. Lease rates in Springfield and its surrounding communities were more comparable to the state for non-office commercial properties.
- The development and opening of MGM Springfield introduced a substantial amount of new commercial space to the Springfield real estate market and may have contributed to a fall in commercial vacancy rates. Otherwise, there were few obvious breaks from past trends that could plausibly be attributed to the casino.
- Springfield key informants discussed the increased patronage of downtown Springfield as a result of MGM Springfield. Key informants did note that increased foot traffic and spillover impacts onto businesses as a result of the casino are limited to businesses and restaurants adjacent to MGM Springfield.

The Construction of MGM Springfield: Spending, Employment, and Economic Impacts

Rod Motamedi, Andrew Hall, Ellen Aron, Ian Dinnie, and Jonah Swotes (Release MGC open meeting, September 26, 2019, Springfield, MA)

The UMass Donahue Institute ([UMDI](#)) is a member of the Social and Economic Impacts of Gambling in Massachusetts ([SEIGMA](#)) research team charged with carrying out aspects of the research agenda of the Massachusetts Gaming Commission (MGC). This report seeks to inform stakeholders about the construction of the MGM Springfield casino and its economic impacts in the Commonwealth. Over the course of the casino's construction, UMDI worked with the Massachusetts Gaming Commission and MGM Springfield to obtain data on the spending, employment, and wages related to the construction of MGM Springfield. These data are summarized here along with an estimate of the total economic impacts to the Commonwealth of Massachusetts resulting from the casino construction. See *Appendix 4: Note on the Data Vintage Used in This Study* for a discussion of the data snapshot used in this report.

MGM Resorts International spent \$573.3 million to build the MGM Springfield casino. This amount differs from the larger amount that is commonly reported in the press. The larger amount represents total investment of which construction is a component. The difference between investment and construction includes design fees; furniture, fixtures, and equipment (FF&E); operating supplies and equipment (OSE); license/application fees; and pre-opening expenses.

Where were the construction dollars spent?

- Two-thirds of the construction budget (\$373.8M of \$573.3M) went to firms based in Massachusetts. Half of that (\$194.3M) (or a third of the total) remained in Hampden County.
- Nearly \$85 million went to firms based in the City of Springfield.

- Of the remaining third that went out of state (\$199.5M), about half went to firms in nearby Connecticut with the remainder spread across 16 other states and Canada.
- About one-third of the total contract value went to firms that met at least one element of the diversity criteria.

Where did construction workers reside and was it a diverse workforce?

- Over two-thirds (2,963 of 4,249) of the construction workers were Massachusetts residents. Most of the remainder were from Connecticut.
- In total, the most common place of residence was Hampden County, where 36 percent (1,524 of 4,249) of the workers resided. Of this 36 percent, 509 were Springfield residents.
- Workforce diversity statistics suggest that the MGM Springfield construction workforce largely reflected the composition of the populations from which they were drawn.
- One-quarter of Massachusetts-resident construction workers employed during the construction of MGM Springfield were minorities, which is similar to the minority share of the statewide population. Overall, the construction workers were over 90 percent male and non-veteran.
- In Springfield, the population is majority minority. Overall, the shares of White and minority MGM Springfield construction workers from Springfield were similar to their shares of the city's working age population. The largest disparity was with Black construction workers from Springfield who were significantly overrepresented compared to their share of the Springfield population.

What were the total statewide economic impacts of constructing MGM Springfield?

- Increases in company revenues and employment drive larger changes in the economy, which are estimated using an economic model.
- Overall, total statewide economic activity (also known as output) increased by \$849 million over the five-year construction period.
- Net new economic activity (i.e., value added or gross state product) totaled \$512 million.
- About 1,000 jobs were created or supported by this economic activity. These jobs accrued \$397 million of income.
- When the estimates of total economic impacts are compared to MGM Springfield's expenditures, the results show that every \$2 of construction spending created about \$1 of additional economic activity in Massachusetts and every \$1 of compensation to construction workers created an additional \$1.29 of income to others in Massachusetts.

The MA Gambling Impact Cohort: Analysis Across Three Waves

Alissa Mazar, Rachel A. Volberg, Robert J. Williams, Edward J. Stanek III, and Martha Zorn (Released: September 12, 2019)

The Social and Economic Impacts of Gambling in Massachusetts ([SEIGMA](#)) research team at UMass Amherst has released a report on the first major adult cohort study of gambling conducted in the United States—the [Massachusetts Gambling Impact Cohort \(MAGIC\)](#). By surveying the same individuals over time, cohort studies provide information on how gambling and problem gambling develops, progresses, and remits. The goals of the MAGIC study are to 1) uncover and understand populations in Massachusetts who are at a higher risk of experiencing gambling harm and problem gambling and 2) inform the development of effective and efficient prevention and treatment programming in the Commonwealth.

This report specifically looks at the changes in the gambling behaviors of 3,139 Massachusetts adults from 2013/2014 (Wave 1), 2015 (Wave 2), and 2016 (Wave 3)—prior to MGM Springfield and Encore Boston Harbor opening, but after Plainridge Park Casino opened in 2015.

This is what the report found:

- Massachusetts residents gambling at out-of-state casinos significantly decreased from 2015 to 2016.
 - This suggests that the opening of Plainridge Park Casino in Plainville—and near the border of Rhode Island—in June 2015 may have been successful in ‘recapturing’ Massachusetts residents who were previously gambling at out-of-state casinos (see [Plainridge Park Casino First Year of Operation: Economic Impacts Report](#) for a detailed discussion of Plainridge Park Casino’s ‘recapture’ of Massachusetts residents’ casino spending).
- From 2015 to 2016, the problem gambling incidence rate—the proportion of people that newly experience problem gambling over a 12-month time period—was 1.2%, which is similar to other jurisdictions.
- From Wave 2 to Wave 3, the remission rate—the proportion of people who are no longer experiencing problem gambling but were experiencing this disorder 12 months prior—was 44% and slightly more individuals remitted compared with the number becoming new problem gamblers.
 - This suggests that additional treatment resources and prevention efforts may be especially beneficial in continuing the higher remission over incidence rate.
- Concerning stability—an individual’s gambling behavior remaining the same across years—Recreational Gamblers were the most stable, followed by Non-Gamblers. Those who were experiencing problem gambling or who were engaging in gambling in ways that put them at risk of experiencing problem gambling were the least stable.
- Individuals who gambled were unlikely to transition to non-gambling across the three years.
 - Problem and At-Risk Gamblers were unlikely to transition to become Non-Gamblers.
 - This suggests that, when individuals move to less harmful gambling behaviors, they are unlikely to abstain from gambling altogether, but pursue more moderate forms of gambling.
 - These results are consistent with findings that some ‘controlled’ gambling may not be incompatible with remitting from problem gambling.
 - These findings only represent three years of data and, since gambling problems can be transitory and episodic, the UMass Amherst research team looks forward to examining how the cohort members transition in future years and whether this pattern persists.

The next MAGIC report—to be released in 2020—will examine the predictors of problem gambling across years and whether there are racial/ethnic, income, gender, and/or regional differences in these predictors. In later waves, the research team will conduct in-depth interviews with a cross-section of individuals experiencing at-risk or problem/pathological gambling who remit, do not remit, and relapse to more fully understand pathways to remission.

Gender and Gambling Behaviors: a Comprehensive Analysis of (Dis)Similarities

Danielle Venne, Alissa Mazar, and Rachel Volberg (2019), International Journal of Mental Health and Addiction, <https://doi.org/10.1007/s11469-019-00116-y> (Published on July 31, 2018)

Gambling is a gendered activity. Yet, the majority of research focuses on males and treatment seeking/clinical populations—a population that is fundamentally distinct from and ungeneralizable to non-treatment seekers. The objective of this article is to tease out the characteristics that discriminate the subtypes of gambling behavior by gender based on a representative sample of a population. In 2013–2014, 9,523 Massachusetts adults completed a survey examining their past year gambling behavior based on the Problem and Pathological Gambling Measure (PPGM). Unlike male at-risk gamblers, female at-risk gamblers are likely to play bingo and have anxiety and/or depression. Unlike female at-risk gamblers, male at-risk gamblers gamble to “feel good” about themselves. Unlike males, female problem/pathological gamblers are more likely to have a problem with drugs or alcohol in the past 12 months. Unlike females, male problem/pathological gamblers are more likely to have unhappier childhoods, gamble online, and identify as Hispanic. Demographic, health-related, and gambling-related discriminators are largely the same for female and male gambling subtype behaviors. There are, however, a few defining characteristics that differentiate females and males in terms of the likelihood of experiencing problematic gambling behavior.

Significant Research Activities, July – November 2019

Follow-Up Springfield Targeted Population Survey

UMass Amherst research team

The purpose of this survey is to understand the social and health impacts of opening MGM Springfield in Springfield and the surrounding communities. The survey will be based on a random selection of 1,000 adults in Springfield and its surrounding communities with a 100 percent over selection of those who identify as Black, Hispanic, or Asian. Address-based sampling will be utilized, and the surveys will be administered by NORC at the University of Chicago. The Follow-Up Springfield Targeted Population Survey will ensure a sufficient sample size in the local region to identify localized community-specific impacts that can be compared to the Baseline Springfield Targeted Population Survey. Data collection will begin at the end of September 2019 and will be completed at the end of December 2019. A report detailing the results is expected at the end of FY2020.

MGM Springfield Patron Survey Data Collection, completed

SEIGMA research team

The Patron Survey is an essential component of the economic analysis that will clarify patron origin and expenditure. The Patron Survey will also inform analyses of the social impacts of the introduction of casino gambling in Massachusetts. On a team consisting of over 15 surveyors, 1 of every 6 persons exiting MGM Springfield were asked to participate in a 5-7 minute survey concerning their experience at MGM Springfield that day. Dates of the first Wave (winter) of survey data collection were: Saturday, February 23, 2019: 11-5pm; Monday, February 25, 2019: 6-12am; Saturday, March 2, 2019: 11-5pm; and Monday, March 4, 2019: 6-12am. Dates of the second Wave (summer) of survey data collection were: Saturday, July 27, 2019: 11-5pm; Monday, July 29, 2019: 6-12am; Saturday, August 3, 2019: 6-12am; Monday, August 5, 2019: 11-5pm. In total, 880 surveys were collected. A report detailing the results will be released in December 2019.

Massachusetts Gambling Impact Cohort (MAGIC) data collection, Wave 5, completed

While robust in many regards, the SEIGMA methodology provides population-based ‘snap shots’ of the dynamic process of behavior change during a time of gambling expansion. The cross-sectional design of

the SEIGMA project is in contrast to the Massachusetts Gambling Impact Cohort (MAGIC) study design that follows 3,139 Massachusetts adults with a shared experience (exposure to expanded gambling) at intervals over time. From a prevention standpoint, knowing how and where to effectively intervene hinges on having research that clearly identifies the variables that are etiologically involved in problem gambling, their temporal sequence, and their causal connections. MAGIC provides the etiological information necessary to understand how gambling and problem gambling develops, progresses, and remits over time. MAGIC has significant value as it will highlight risk and protective factors important in developing effective prevention, intervention, treatment, and recovery support services. The 5th Wave of data collection from the MA cohort was completed at the end of July 2019. The National Opinion Research Center (NORC) will deliver the 5th Wave of data to the UMass Amherst research team in November 2019.

Forthcoming Reports and Studies

Massachusetts Gambling Impact Cohort (MAGIC)

- To date, five waves of data have been collected from a cohort of 3,139 adult Massachusetts residents. The study includes an over-sample of at-risk and problem gamblers drawn from the SEIGMA baseline population survey. Wave 6 data collection will begin in March 2020.
- **Low-Risk Gambling Guidelines for MA**
 - The report will focus on the operationalization of gambling harm based on the cohort study.
 - **STATUS:** January 31, 2020
- **Longitudinal Predictors of Problem Gambling Across Waves**
 - Analyses will focus on predictors of problem gambling onset and whether there are racial/ethnic, income, gender, and/or regional differences in these predictors across four waves of data.
 - Examine predictors of problem gambling remission and the extent to which accessing treatment is one of these factors.
 - **STATUS:** December 31, 2019

Social and Economic Impacts of Gambling in Massachusetts (SEIGMA)

- **Further Analyses of BGPS Data**
 - Preparation and submission of publishable manuscripts based on (1) deeper analyses of the BGPS (published—*BMC Public Health*), (2) analysis of differences in predictors of problem gambling by gender (published—*International Journal of Mental Health and Addiction*), (3) risk of harm based on analysis of associations between problem gambling and specific forms of gambling, and (4) veterans and problem gambling (published—*Journal of Gambling Studies*).
 - **STATUS:** Risk of harm manuscript will be submitted to a public health journal in the Fall 2019.
- **Submit Manuscript Analyzing CHIA data**
 - Comparing acute to chronic problem gamblers in a longitudinal sample.
 - **STATUS:** January 31, 2020

- **Gambling Harms in Massachusetts Report**
 - Prepare and publish report on deeper analyses of BGPS and BOPS examining gambling harms in Massachusetts.
 - **STATUS:** January 31, 2020

- **Design Based and Model Based Approaches Report**
 - Report containing model results with comparison to weighted analyses.
 - This approach, if successful, may translate to different populations and avoid reliance on weights.
 - **STATUS:** December 31, 2019

- **Springfield Key Informant Interviews**
 - Gain an on-the-ground understanding of conditions in host communities.
 - These interviews will specifically focus on the public health impacts of MGM Springfield in the Springfield community.
 - **STATUS:** December 31, 2019

- **MGM Springfield Patron & License Plate Survey report (w/ fact sheet)**
 - Clarifies patron origin and expenditure and informs analyses of the social and economic impacts of the introduction of casino gambling in Massachusetts.
 - **STATUS:** February 29, 2020

- **Academic publication: Treatment seeking among MA problem gamblers (w/ fact sheet)**
 - Assesses the determinants of wanting and/or seeking help for a gambling problem in the Massachusetts population.
 - **STATUS:** December 31, 2019

- **Springfield Lottery Report (w/ fact sheet)**
 - Assesses the impact of MGM Springfield on lottery sales statewide, in the host and surrounding communities, and for agents at different driving distances from the casino.
 - **STATUS:** December 31, 2019

Data Storage and Sharing

- **Exportable Baseline General Population Survey (BGPS), Baseline Online Panel (BOPS), Targeted Population Surveys, and Plainville Patron Survey datasets and codebooks**
 - Allows other investigators to access and use SEIGMA data for their own analyses.
 - **STATUS:** A solution to store and deliver dataset to eligible parties is being negotiated with MDPH to begin the Fall of 2019. In the interim, the MGC is working with UMass Medical School and Dr. Tom Land to store the data for dissemination.

Springfield Youth Risk Behavioral Surveillance and Youth Health Survey

- To better understand gambling behavior and risk in youth, the MGC provided funding to the Public Health Institute of Western MA to extend questions on the 2019 survey.
- **STATUS:** The survey was administered in Springfield Public Schools in February 2019. Results expected in Fall 2019.

Public Safety

- **Everett and Surrounding Communities:** 6-Month Analysis of Crime, Call-for-Service, and Collision data in the Communities near Encore Boston Harbor.
- **STATUS:** The final baseline report is anticipated March, 2020

- **Springfield and Surrounding Communities:** 8-Month Analysis of Crime, Call-for-Service, and Collision data in the Communities near MGM Springfield.
- **STATUS:** The one-year report is anticipated March, 2020

Community Engaged Research

- The objective of Community Engaged Research is to more deeply understand and address the impact of the introduction of casino gambling in Massachusetts's communities. This type of work emphasizes the collaboration between researchers and community partners who translate findings to key stakeholders.

- **Massachusetts Council on Compulsive Gambling and the University of Massachusetts Gerontology Institute**
 - Through stakeholder engagement and community-based participatory research, the partnership proposes to develop a senior profile about gambling, problem gambling, and ancillary issues among seniors. These profiles will be broken out by community, demographics, and socio-economic status to provide evidence-based support to help the Councils on Aging (COA) with responsible gambling programs and services.

- **JSI Research and Training Institute, Inc.**

The overarching purpose of this study is to understand the ways in which casino gambling influences the life contexts of Hispanic/Latino residents in the Greater Springfield Area. Emphasis will be placed on uncovering how the historical and socio-cultural contexts shaping the life experiences of this population influence their beliefs and behaviors related to casino gambling. We will adopt a rigorous community-based participatory research approach (CBPR) to enhance the existing knowledge base on the impacts of gambling (including the Social and Economic Impacts of Gambling in Massachusetts study (SEIGMA)) on marginalized populations.

- **Boston Chinatown Neighborhood Association**
 - The proposed Asian CARES (Center for Addressing Research, Education, and Services) project is a community engaged research (CER) partnership committed to addressing problem gambling among Asian ethnic communities through research, community education, and culturally-relevant service provision. For this seed proposal, we will conduct preliminary research to expand our understanding of how problem gambling manifests in Asian families and inform the development of tools and community-based resources for prevention and early intervention efforts.

○

Reports & Studies to date, 2014 – November 2019

Reports and publications listed in this section are available at: <https://massgaming.com/about/research-agenda/>

Social

- The MA Gambling Impact Cohort: Analysis Across Three Waves. (September 12, 2019)
- Social and Economic Impacts of Expanded Gambling in Massachusetts: 2018. (December 6, 2018)
- Impacts of Gambling in Massachusetts: Results of a Baseline Online Panel Survey (BOPS). (January 10, 2017)
- Analysis of the Massachusetts Gambling Impact Cohort (MAGIC) Wave 2: Incidence and Transitions. (December 22, 2017)
- Gambling and Problem Gambling in Massachusetts: In-Depth Analysis of Predictors. (March 23, 2017)
- Gambling and Problem Gambling in Massachusetts: Results of a Baseline Population Survey. (September 15, 2017)
- Key Findings from SEIGMA Research Activities: Potential Implications for Strategic Planners of Problem Gambling Prevention and Treatment Services in Massachusetts. (December 18, 2015)

Population and Community

- Talking about Casino Gambling: Community Voices from Boston Chinatown (October 24, 2019)
- Casinos and Gambling in Massachusetts: African-American Perspectives. (October 26, 2018)
- Screening for Gambling Disorder in VA Primary Care Behavioral Health: A pilot study (October 26, 2018)

Publications

- Venne, D., Mazar, A., & Volberg, R. (2019). Gender and Gambling Behaviors: a Comprehensive Analysis of (Dis)Similarities. *International Journal of Mental Health and Addiction*,
- Freeman, J., Volberg, R., & Zorn, M. (2019). Correlates of At-Risk and Problem Gambling Among Veterans in Massachusetts. *Journal of Gambling Studies*.
- Brand, E., Rodriguez-Monguio, R., & Volberg, R. (2018). Gender Differences in Mental Health and Substance Use Disorders and Related Healthcare Services Utilization. *The American Journal on Addictions*.
- Mazar, A., Williams, R. J., Stanek, E. J., Zorn, M., & Volberg, R. A. (2018). The Importance of Friends and Family to Recreational Gambling, At-risk Gambling, and Problem Gambling. *BMC Public Health*.
- Rodriguez-Monguio, R., Brand, E., & Volberg, R. (2017). The Economic Burden of Pathological Gambling and Co-occurring Mental Health and Substance Use Disorders. *Journal of Addiction Medicine*.
- Rodriguez-Monguio, R., Errea, M., & Volberg, R. (2017). Comorbid Pathological Gambling, Mental Health, and Substance Use Disorders: Health-Care Services Provision by Clinician Specialty. *Journal of Behavioral Addictions*.

- Okunna, N. C., Rodriguez-Monguio, R., Smelson, D. A., Poudel, K. C., & Volberg, R. (2016). Gambling Involvement Indicative of Underlying Behavioral and Mental Health Disorders. *The American Journal on Addictions*.
- Okunna, N. C., Rodriguez-Monguio, R., Smelson, D. A., & Volberg, R. A. (2015). An Evaluation of Substance Abuse, Mental Health Disorders, and Gambling Correlations: An Opportunity for Early Public Health Interventions. *International Journal of Mental Health and Addiction*.

Economic

- Economic Impacts of Plainridge Park Casino: Four Years of Operations. (November 7, 2019)
- New Employee Survey at Plainridge Park Casino: Analysis of Fiscal Year 2018. (November 7, 2019)
- Social and Economic Impacts of Plainridge Park Casino: 2018 (November 7, 2019)
- Real Estate Impacts of MGM Springfield in Springfield and Surrounding Communities. (September 26, 2019)
- The Construction of MGM Springfield: Spending, Employment, and Economic Impacts. (September 26, 2019)
- Real Estate Impacts of the Plainridge Park Casino on Plainville and Surrounding Communities. (October 11, 2018)
- Lottery Revenue and Plainridge Park Casino: Analysis After Two Years of Casino Operation. (May 10, 2018)
- Plainridge Park Casino First year of Operations: Economic Impacts Report. (October 6, 2017)
- New Employee Survey at Plainridge Park Casino: Analysis of the First Two Years of Data Collection. (May 10, 2017)
- Lottery Revenue and Plainridge Park Casino: Analysis of the First Year of Casino Operation. (January 19, 2017)
- Real Estate Profiles of Host Communities. (August 30, 2016)
- The Construction of Plainridge Park Casino: Spending, Employment, and Economic Impacts. (September 19, 2016)
- Economic Profiles of Host Communities. (October 20, 2015)
- Measuring the Economic Effects of Casinos on Local Areas: Applying a Community Comparison Matching Method. (November 5, 2014)

Public Safety

Springfield: Assessing the Impact of Gambling on Public Safety Massachusetts Cities and Towns

- Analysis of Changes in Police Data following Eight Months of Activity at MGM Springfield. (November 7, 2019)
- Analysis of Changes in Police Data following Four Months of Activity at MGM Springfield. (May 19, 2019)
- Baseline Analysis of Crime, Call-for-Service, and Collision data in the Communities near MGM Springfield. (October 25, 2018)

Plainville: Assessing the Impact of Gambling on Public Safety Massachusetts Cities and Towns

- Analysis of Changes in Police Data After Four Years of Operation at Plainridge Park Casino. (November 7, 2019)

- Analysis of Change in Police Data After Two Years of Operation at Plainridge Park Casino. (March 1, 2018)
- Analysis of Changes in Police Data After the First Year of Operation at Plainridge Park Casino. (December 12, 2016)
- Analysis of Changes in Police Data After the First Six Months of Operation at Plainridge Park Casino. (April 12, 2016)
- Baseline Analysis of Crime, Call-for-Service, and Collision Data in the Plainville Region. (August 24, 2015)

Everett: Assessing the Impact of Gambling on Public Safety Massachusetts Cities and Towns

- Baseline Analysis of Crime, Call-for-Service, and Collision Data in the Everett Region. (November 7, 2019)

Program Evaluation

- Assessing the Massachusetts Gaming Commission PlayMyWay Play Management System. (January, 2019)
- Evaluation of the Massachusetts Voluntary Self-Exclusion Program: June 24, 2015 – November 30, 2017. (September 27, 2018)
- Comprehensive Evaluation of the Plainridge Park Casino GameSense Program: 2015-2018 Compendium (July 26, 2018)
- Preliminary Study of Patrons’ Use of the Play My Way Play Management System at Plainridge Park Casino: June 8, 2016 – January 31, 2017 (October 2017)
- Summary Analysis of the Plainridge Park Casino GameSense Program Activities & Visitor Survey: December 1, 2015 – May 31, 2016, (July 2016)

Data Presentation

- SEIGMA-MAGIC Fact Sheets. (November 7, 2019 and December 6, 2018)
- MASS-AT-A-GLANCE: An interactive app of social and economic trends in MA communities. (May 10, 2018)