

Strategic Plan

Services to Mitigate the Harms Associated with Gambling in Massachusetts

April, 2016

Presented by the Massachusetts Technical Assistance Partnership for
Prevention (MasTAPP) of Education Development Center, Inc. (EDC)

This plan is supported by the Massachusetts Department of Public Health and
the Massachusetts Gaming Commission



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PURPOSE OF THIS DOCUMENT

This document lays out the first phase of the state's Strategic Plan to provide services to address problem gambling and related issues, thus mitigating the potential harms associated with gaming expansion in Massachusetts. The plan provides detailed strategies to address problem gambling and explores the relationships between problem gambling and other health concerns, laying the groundwork for the development of a strong public health response to those issues most affected by Massachusetts' Expanded Gaming Act of 2011.

Problem gambling¹ is a result of the complex interplay between many different factors, which include a person's knowledge, attitudes, beliefs, personality traits, and personal experience; the influence of peers; the social and cultural norms that surround the person; the gambling environment that he or she has access to (including gambling settings and gambling marketing); and the policies and legislation that affect the availability of gambling (Victoria Responsible Gambling Foundation, 2015). Further complicating the issue, people who are diagnosed with a gambling disorder are more likely than the general population to also misuse substances and to experience depression or anxiety (Petry, Stinson, & Grant, 2005; Shaffer, Vander Bilt, & Hall, 1999). The families and friends of individuals who experience a gambling disorder may also be affected by problem gambling, and communities that surround casinos may experience changes as a result of increased gambling or increased problem gambling.

To affect this complex phenomenon requires a careful, planful, and data-driven approach. With that goal in mind, this document provides an overview of existing problem gambling-related services and includes a Strategic Plan and recommendations to guide the Executive Office of Health and Human Services, the Massachusetts Gaming Commission (MGC), and the Massachusetts Department of Public Health (MDPH) in effectively using funds that are allocated for services to prevent and address problem gambling and related issues. In order to ensure the greatest possible impact from the dollars that are available for services, the plan combines individual and community-level prevention with the provision of quality services in multiple settings.

The plan will be implemented primarily by MDPH and MGC, and will be overseen by the Secretary of Health and Human Services, assisted by members of other state agencies and community-based organizations. This document addresses the data that have been collected in Massachusetts, builds on the evidence base related to problem gambling services nationally and internationally, and lays out a plan for how to enhance every stage of the Continuum of Services (described in more detail on page 14) for

¹ There is some debate about how to refer most respectfully and accurately to people experiencing challenges due to their gambling. For the purposes of this plan, the term *problem gambling* will be used to refer to gambling that has measurable negative effects on the well-being of a gambler, and *gambling disorder* will refer to a formal diagnosis according to the DSM-V. As part of the plan, Massachusetts will attempt to adopt a consistent classification system based on symptomology.

problem gambling and related issues in Massachusetts in order to best respond to the increased demand that may be brought about by expanded gambling.

MDPH regularly develops a statewide plan for health promotion, and the Bureau of Substance Abuse Services within MDPH develops a plan specifically related to addiction. In addition to informing expenditures from the Public Health Trust Fund and the daily work of the Director of Problem Gambling Services, recommendations from this Strategic Plan will ideally be integrated into the strategic plans for health promotion, addiction, and other related issues.

BACKGROUND

On November 22, 2011, the Expanded Gaming Act (Chapter 194) was signed into law, allowing up to three destination resort casinos and a single slots parlor in Massachusetts (Massachusetts Gaming Commission [MGC], 2015a). Penn National Gaming received a license to open up to 1,250 slot machines at the Plainridge Park Casino in Plainville, Massachusetts, on June 24, 2015, three years before resort-style casinos are scheduled to open. The Plainridge Park Casino offers a variety of gambling in addition to slot machines, including KENO, electronic blackjack, and the Massachusetts Lottery. Pari-mutuel betting is available at the adjoining racetrack.²

MGC awarded the resort-casino license for Region B (Western Mass.) to MGM Springfield on June 13, 2014. MGM Resorts International broke ground on March 24, 2015, and is anticipated to open in 2018. The Commission awarded the resort-casino license for Region A (Eastern Mass.) to Wynn MA, LLC, on September 17, 2014, and that casino is expected to open in Everett in 2018. The resort-casino license for Region C (Southeastern Mass.) has not yet been awarded.

The Commonwealth's Expanded Gaming legislation includes principles that were developed to ensure the successful implementation of expanded gaming: a transparent and competitive bidding process, maximum long-term value to the Commonwealth, protection for host and surrounding communities, mitigation for social impacts and costs, and ensuring the nation's best and most rigorous public safety, regulatory, and enforcement mechanisms (MGC, 2015a). As these principles indicate, an emphasis is being placed on protection for communities and mitigation of social impacts. From a public health perspective, the most impactful and cost-effective way to ensure such protection is through community-level prevention, and the best way to mitigate harm is to implement multiple prevention strategies and quality services for gambling disorders and related issues in multiple settings within the Commonwealth.

Public Health Trust Fund

The Expanded Gaming Act established the Public Health Trust Fund (PHTF) to allocate significant resources to research, prevention, intervention, treatment, and recovery support services in order to mitigate the harmful effects of problem gambling and related issues. The MGC describes the PHTF as follows:

An annual fee of not less than \$5,000,000 in proportional shares against each gaming licensee in proportion to the number of gaming positions at each gaming establishment for the costs of service and public health programs dedicated to addressing problems

² The complete text of this law can be found on the website of the 189th General Court of the Commonwealth of Massachusetts (<https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter194>).

associated with compulsive gambling or other addiction services. Such assessed fees shall be deposited into the Public Health Trust Fund . . . (MGC, 2013, p. 4)

The Commonwealth of Massachusetts (2015c) adds the following:

A Gaming Revenue Fund . . . shall receive revenues collected from the tax on gross gaming revenue received from gaming licensees. (§ 1) . . . 5 per cent [of this tax will go] to the Public Health Trust Fund . . . (§ 17)

According to the Commonwealth of Massachusetts (2015b):

The secretary of health and human services shall be the trustee of the fund and may only expend monies in the fund, without further appropriation, to assist social service and public health programs dedicated to addressing problems associated with compulsive gambling including, but not limited to, gambling prevention and addiction services, substance abuse services, educational campaigns to mitigate the potential addictive nature of gambling and any studies and evaluations necessary, including the annual research agenda under section 71, to ensure the proper and most effective strategies. (§ 1)

The PHTF will begin to receive dollars to support problem gambling services when the MGC assesses the current licensees up to \$5 million, and will be funded fully when the Category 1 (major resort) casinos open and generate revenue (MGC, 2015b).

Community Mitigation Fund

In addition to establishing the PHTF, the Expanded Gaming Act of 2012 also specifies the establishment of a Community Mitigation Fund. This fund is available for host communities, surrounding communities, and those who entered into a “nearby community” agreement with a licensee to help offset and address impacts that may result from the development and operation of gaming facilities in the Commonwealth. In the short term, these impacts will be from the construction of the facilities; once casinos are operational, it is likely that other community-level impacts will be identified, and the Community Mitigation Fund can be used to address them (Commonwealth of Massachusetts, 2015e). This Strategic Plan is designed to inform expenditures for services from the PHTF and not from the Community Mitigation Fund.

Decision-Making and Oversight Structure

A Memorandum of Understanding (MOU) between MGC and the Executive Office of Health and Human Services (EOHHS) describes a process for aligning the efforts of MGC and EOHHS to provide services, see that research is used to advance the most effective strategies to prevent and treat problem gambling and related issues and to intervene when necessary, and to help ensure the most effective use of PHTF monies (see the Appendix). The MOU includes an agreement that an Executive Committee of the PHTF will set the overall budget for and protocols for expenditures from the PHTF. This committee

has been established and includes the Secretary of EOHHS (or designee) and the Chair of MGC (or designee), who co-chair the committee, and three members appointed by mutual agreement of the Secretary and the Chair. The additional committee members include at least one with a background in problem gambling/responsible gambling issues, and at least one with a background in addiction, substance abuse, and mental health services. Decisions require an affirmative vote of three, with two of those votes represented by the Chair of MGC and Secretary of EOHHS.

The MOU recognizes the need for a Director of Problem Gambling Services, whose position will be paid for by MGC until PHTF funding is available. In addition, the MOU outlines that the expenditures made by EOHHS or MGC to further the research agenda or to assist social services or public health programs to prepare for the gaming expansion prior to PHTF monies being available may be paid back to the respective agency from the Fund once monies are available, with approval of the Executive Committee of the PHTF (MGC, 2015b).

Responsible Gaming Framework

The Responsible Gaming Framework was created by MGC to provide an overall orientation to responsible gaming, to offer guidance to casino operators on how to implement responsible gaming practices, and to clearly outline MGC's expectation that gaming in the Commonwealth will be conducted in a manner that minimizes harm. The Framework supports the implementation of the Expanded Gaming Act (Chapter 194).³ It is organized into six broad strategies:

- » Commit to corporate social responsibility
- » Support informed player choice
- » Provide protections within the physical environment
- » Ensure responsible marketing
- » Manage high-risk financial transactions
- » Engage the community

Each strategy contains a number of related responsible gaming practices. MGC licensees are responsible for ensuring their commitment to the relevant practices and compliance with related regulations.

The development of the Responsible Gaming Framework included an extensive review of domestic and international academic papers and studies, policy papers, investigative reports, jurisdictional reviews, corporate reporting documents, and legislation relating to gambling issues in Massachusetts, other U.S. jurisdictions, and abroad. The Framework was further informed by input and information from MDPH, the Massachusetts Council on Compulsive Gambling (MCCG), participants in the Massachusetts

³ The complete text of this law can be found on the website of the 189th General Court of the Commonwealth of Massachusetts (<https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter194>).

Partnership for Responsible Gaming, Problem Gambling Solutions, Inc., and a broad range of other stakeholders.

PLAN DEVELOPMENT PROCESS

Brief Assessment

EDC's Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) carried out a brief assessment on behalf of MDPH and MGC. MassTAPP used numerous data collection methods to inform the recommendations included in this Strategic Plan.

A brief review of articles related to best practices in problem gambling prevention and treatment was conducted. More than 200 stakeholders were surveyed or provided expertise through key informant interviews. One hundred and fifty-eight surveys were administered to prevention professionals at the MDPH *Ounce of Prevention* conference and to a group primarily comprising mental health treatment providers at the MCCG annual conference. These surveys assessed awareness of problem gambling treatment and prevention resources, barriers to obtaining resources, gaps in services, and the readiness of respondents' organizations to address problem gambling in Massachusetts. MassTAPP also conducted interviews with 49 key stakeholders (14 people who work in the prevention of problem gambling or issues that may be associated with expanded gambling, 14 representatives of state agencies, 10 members of the communities that will host the licensed casinos, 5 researchers representing different institutions, 3 representatives from the gaming industry, 2 mental health counselors, and 1 legislator). Interview notes were analyzed for content that related to five themes: concerns, vision, resources, data gaps, and sources of data/effective programs.

In addition, the MassTAPP research team reviewed SEIGMA⁴ baseline results and recommendations and worked with the SEIGMA team to determine how these results and SEIGMA's previous in-depth literature review might inform a strategic plan. During the strategic planning process, the SEIGMA team prepared a white paper titled *Key Findings from SEIGMA Research Activities and Potential Implications for Strategic Planners of Problem Gambling Prevention and Treatment Services in Massachusetts* (Haupt, Volberg, Williams, Stanek, & Zorn, 2015). This document summarized findings from the SEIGMA baseline study, an analysis of five years' worth of statewide gambling Helpline data and findings from an online focus group conducted with clinical treatment providers. The white paper included recommendations for strategic planners and was used to reinforce and refine this Strategic Plan.

Prioritization Process

To prioritize the issues that emerged from the assessment, the assessment team first reviewed key findings from the surveys, notes from stakeholder conversations, and SEIGMA data. The team noted

⁴ SEIGMA (Social and Economic Impacts of Gambling in Massachusetts) is a comprehensive, multi-year research project that measures the social, health, economic, and fiscal impacts of gambling expansion in Massachusetts.

areas of concern and proposed interventions that were aligned with findings from the literature and recommendations from the SEIGMA team. The areas of concern were then organized by category along the Continuum of Services (see page 14), and concerns that were not driven directly by data were eliminated. The list of priorities was further refined in consultation with MDPH, MGC, the Executive Committee of the PHTF, and leading problem gambling researchers.

After generating a long list of potential priorities and recommendations, each was ranked on a scale of 1 to 5 according to how well it met the following criteria:

- » The concern is data-driven (based on SEIGMA results, a literature review, and our assessment survey).
- » There could be a strong intervention based on the balance of cost (in terms of time and money) versus benefit (reducing the prevalence of problem gambling, and mitigating harm).
- » There is strong stakeholder interest in addressing this concern.
- » Evidence-based or promising practices can be identified to address the concern.

The rankings for each priority or recommendation were totaled to create a score, and these scores were used to prioritize the list and to guide the elimination of some recommendations. The resulting priority areas are described under Priority Areas (Key Areas of Concern), starting on page 23.

The Strategic Plan and the Strategic Prevention Framework

The Strategic Prevention Framework is a five-step planning process developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to guide the selection, implementation, and evaluation of evidence-based, culturally appropriate, and sustainable prevention activities. The development of this Strategic Plan was guided by these five steps (SAMHSA, 2015c):

1. **Assessment:** The planning process started with an *assessment*—the systematic gathering and examination of relevant data—to learn about the needs of Massachusetts related to problem gambling and the current state of the field of problem gambling service provision. As described above, EDC conducted a literature search, surveys, and interviews with key stakeholders, and used these data and the SEIGMA data to inform the development of this Strategic Plan.
2. **Capacity:** *Capacity* refers to the resources and readiness to support both prevention programs and policies and strategies to address problem gambling. Through the key stakeholder conversations and initial conversations about problem gambling with potential partners conducted during the assessment process, capacity and readiness have increased to allow changes to data collection, infrastructure, and enforcement that may increase the efficacy of this Strategic Plan.
3. **Planning:** The strategic planning process brought together stakeholders to pool their resources and knowledge in order to develop a plan that we believe to be both realistic and

potentially impactful. Planning activities included establishing criteria for prioritizing strategies and developing a logic model that links the behavior and consequences of gambling problems with associated risk and protective factors, evidence-based strategies, and anticipated prevention outcomes. Key stakeholders have offered valuable feedback.

4. **Implementation:** The plan will be implemented under the guiding hand of EOHHS, with primary responsibility sitting with MDPH. The Director of Problem Gambling Services will be responsible for ensuring that, as completely as possible, benchmarks are met, services are evaluated, and the plan is updated as needed. The implementation will be guided by a workplan, which describes the steps required and the people or organizations responsible for each step.
5. **Evaluation:** An evaluation plan is built into this Strategic Plan, linking measurable outcomes to each of the recommended activities. The plan recommends that activities are monitored and outcomes are tracked on at least a yearly basis.

Each step of the Strategic Prevention Framework is guided by the principles of sustainability and cultural competence:

- » **Sustainability:** This plan presents a two-phase process: Phase 1 activities are focused on building capacity and enhancing existing programming and infrastructure before the PHTF dollars become available, and Phase 2 activities include the implementation of new programming, evaluation initiatives, and infrastructure development with additional dollars. This is a six-year plan that will be updated every two years, based on newly available data and changing contexts. Funding for the services described in the plan is assured by the Expanded Gaming Act Research Agenda, Section 71 (Commonwealth of Massachusetts, 2015d). Many of the initiatives included in the plan, particularly those related to capacity building and workforce development, will have long-lasting impacts that will strengthen and sustain the Commonwealth's efforts on many related issues. For example, the increased training of professionals, incorporation of gambling questions into screening tools, and smooth reimbursement for gambling treatment will allow for sustainability that ultimately is not dependent on the PHTF dollars.
- » **Cultural competence:** Problem gambling is an issue that affects both individuals and their social and professional circles. While anyone might be a problem gambler, some groups have been shown to be at higher risk than others. These groups, described in more detail as part of the Strategic Plan, are defined by characteristics that include ethnic identity, socio-economic status, educational attainment, age, gender, and disability status. Some of these characteristics are those of cultural identity groups, and others are not. As a result, this Strategic Plan includes the enhancement of culturally appropriate services and messaging and outreach to particular cultural identity groups, as well as initiatives to reach individuals who are at high risk but who do

not identify with cultural communities that put them at risk. The plan also includes recommendations to promote further research into problem gambling and protective factors among minority populations. This research will then inform future updates of the plan.

Iteration of and Updates to the Plan

Moving forward, MGC and MDPH will have access to data and information from ongoing MDPH surveillance efforts and from the Massachusetts gaming research agenda. Current research efforts related to gambling in Massachusetts include the following:

- » **SEIGMA:** SEIGMA is a comprehensive, multi-year research project that measures the impacts of gambling expansion in Massachusetts. It has four distinct components: Social and Health Impacts, Economic and Fiscal Impacts, Problem Gambling Services Evaluation, and a Data Management Center. The largest element of the study is a general population survey examining gambling behavior, attitudes, awareness of services, and problem gambling prevalence. (See page 19 for more information on SEIGMA.)
- » **Study of Gaming-Related Crime Impacts:** This study examines the impact of casino operations on local crime, calls for service received by public safety officers, and automobile collisions. Bi-annual data will be analyzed and compared to baseline information to assess the impact on public safety.
- » **Massachusetts Gaming Impact Cohort (MAGIC):** This longitudinal research project will provide information about the course of problem gambling and incidence rates in Massachusetts. It will establish the raw number of new problem gamblers each year and seek to identify deterministic factors in the development of and remission from problem gambling. (See page 20 for more information on MAGIC.)
- » **Evaluation of Responsible Gaming Initiatives:** Three responsible gaming initiatives adopted by MGC are being evaluated:
 1. **Voluntary Self-Exclusion** (described on page 19): A diverse range of outcomes of voluntary exclusion will be assessed, including self-reported treatment seeking, gambling behavior, and self-exclusion violations.
 2. **GameSense Information Center:** As part of the Gamesense initiative (described on page 16), the Division on Addiction (DOA) at Cambridge Health Alliance (a teaching affiliate of Harvard Medical School) worked with MGC and MCCG to develop a record-keeping system in which employees use a checklist to document GameSense Information Center activities, and patrons complete surveys regarding their experience with the GameSense Information Center.
 3. **Play Management:** This study will assess whether the Play Management System, a responsible gaming initiative, improves gamblers' behavioral outcomes (e.g., supporting affordable gambling, reducing excessive gambling).

The Strategic Plan will be updated every two years and rewritten every five years to include new research findings and to reflect changes in the context of problem gambling in Massachusetts.

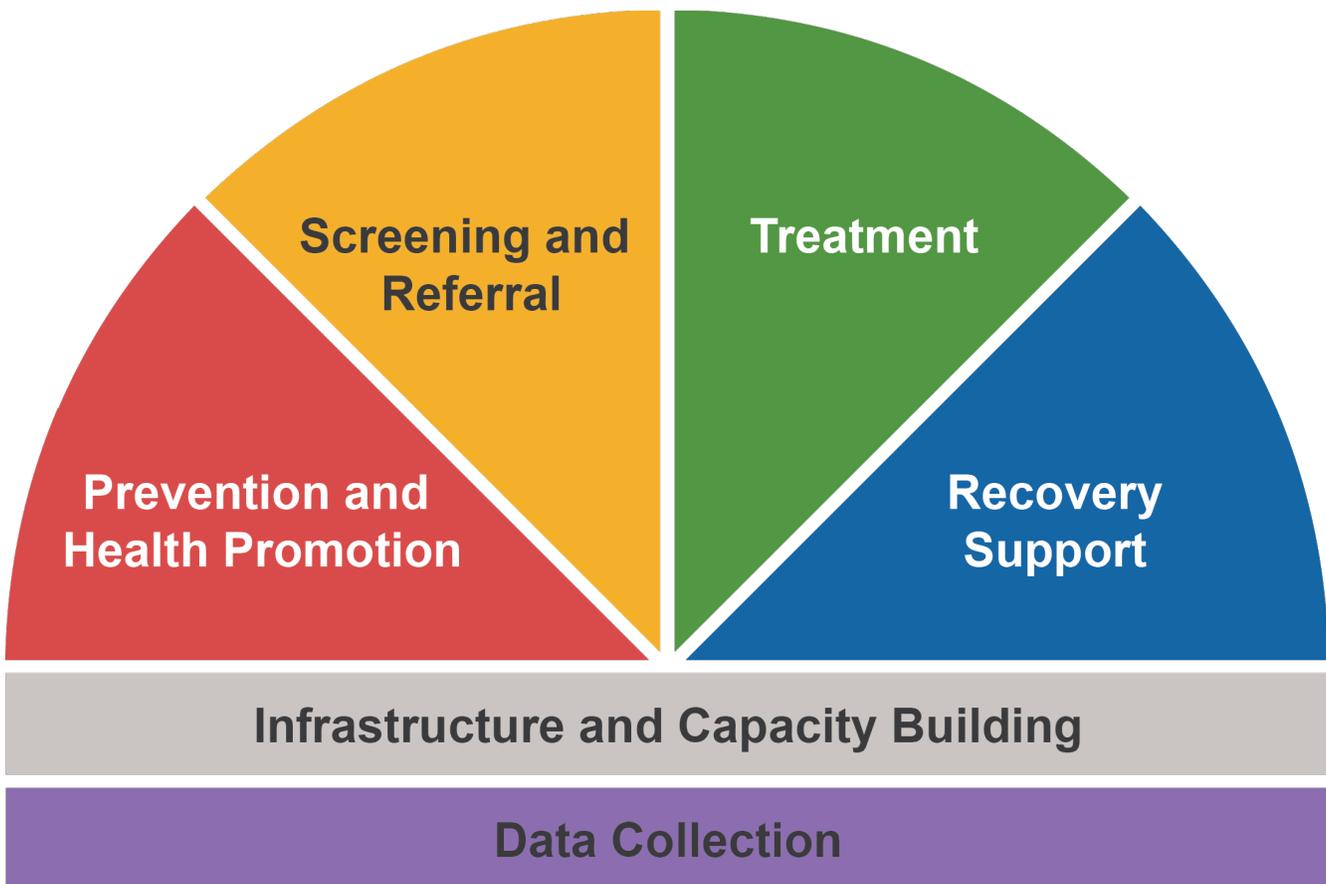
Limitations

The scope of this planning process was designed to complement and supplement the other research and activities already undertaken and funded by MGC and the PHTF. For this reason, the planning process did not include a full independent literature review, deeper analysis of data collected through the SEIGMA study, or an independent assessment of the social and economic impacts of gambling. While these may limit the perspective of this current Strategic Plan, the data-driven recommendations for capacity building and programming that are included in this plan will enhance the Commonwealth's readiness to respond to information that will be collected and analyzed in the coming years.

CONTINUUM OF SERVICES

Programs and services to prevent and address problem gambling and related issues in Massachusetts can be defined within a Continuum of Services—a scope of services for individuals, groups, and communities before, during, and after they experience a behavioral health problem such as problem gambling. These services include prevention and health promotion, screening and referral, treatment, and recovery support. Ideally, the Continuum of Services for problem gambling will offer assistance to people at all levels of need, from prevention and health promotion for those who do not gamble or who gamble only recreationally, to efforts that include screening and referral for at-risk individuals and brief interventions for those in the early stages of problem development, to treatment services for people experiencing a gambling disorder, and finally to rehabilitation and recovery support for people in recovery from a gambling disorder. This continuum must be supported by an appropriate infrastructure and capacity-building efforts and requires ongoing evaluation to meet the changing needs of the target populations. See Figure 1: Continuum of Services.

Figure 1: Continuum of Services



OVERVIEW OF CURRENT SERVICES TO MITIGATE THE HARMS RELATED TO GAMBLING IN MASSACHUSETTS

Currently, funding allocated to problem gambling services in Massachusetts is collected from unclaimed prize winnings from the Massachusetts State Lottery and becomes part of the MDPH budget through an Inter-agency Service Agreement. These funds are made available to service providers through competitive bid processes. At this time, the Massachusetts Council on Compulsive Gambling (MCCG) has been granted the Statewide Capacity Building Contract to implement problem gambling services. MCCG's efforts include education, advocacy, career services, and outreach.

The Division on Addiction (DOA) at Cambridge Health Alliance (a teaching affiliate of Harvard Medical School) also contributes to gambling services. The DOA conducts research to support quality outreach and education, disseminates findings,⁵ provides two conferences a year for allied health workers (including gambling treatment providers), and organizes a Gambling Disorder Screening Day every year in March.⁶

Another key player in providing problem gambling services is MGC, an independent body established through the Expanded Gaming legislation to ensure that gambling expands in a way that brings the most benefit and the least harm to the state. MGC developed and monitors a Responsible Gaming Framework (described in more detail on page 7), which provides a series of mandates and recommendations to guide casino and slots parlor licensees in developing policies and procedures that encourage responsible gambling (MGC, 2014). MGC also funds Responsible Gambling Information Centers and maintains a voluntary self-exclusion list (described on page 19).

Together, MDPH, its grantees, MGC, and service providers, such as psychologists, psychiatrists, social workers, mental health counselors, and substance abuse counselors, provide the majority of the problem gambling services. Most of these services are conducted within independent practices or outpatient services.

An overview of current prevention and intervention services in Massachusetts to mitigate harms related to gambling is provided below. Services are organized and color-coded according to where they fall on the Continuum of Services: Prevention and Health Promotion—red, Screening and Referral—orange Treatment—green, Recovery Support—blue, and Data Collection—purple.

⁵ Weekly updates can be found through BASIS (*Brief Addiction Science Information Source*; <http://www.basionline.org>).

⁶ This screening day is organized as part of the CHARGE (Cambridge Health Alliance Readiness for Gambling Expansion) initiative. More information can be found on the CHARGE homepage (<http://www.divisiononaddiction.org/CHARGE.htm>).

PREVENTION AND HEALTH PROMOTION

Prevention efforts include a wide variety of education and awareness-raising with groups such as parents, educators, residence life and student services staff at colleges and universities, campus mental health centers, doctors, and parole boards. These education efforts can help to increase screening and referral for those experiencing problems due to their gambling but can also help build momentum to change norms and policies to prevent problem gambling and related issues.

Education and awareness-raising often happen through face-to-face workshops and trainings and are also done through media campaigns. A podcast called “Wisdom Exchange” acts as a vehicle for people in recovery from gambling and others who have been affected by gambling to share their stories publicly, thereby raising awareness of problem gambling and reducing the stigma associated with it.

Targeted materials, websites, and events are used to reach particular populations—those who may be at higher risk for problem gambling and related issues and/or those who are difficult to reach through traditional information dissemination techniques. These efforts include a curriculum developed specifically for Chinese-speaking English language learner classes, a booklet about budget-setting for college seniors, Spanish-language materials, and two workshops developed specifically for older adults called “Healthy Aging: You and Your Money” and “Making the Most of Your Leisure Time.” Staff of the Recovery High Schools⁷ work to ensure that problem gambling prevention is incorporated into their programs.

A website and various prevention curricula have been developed for youth in school and in afterschool programs.⁸ Other population-specific curricula and messaging have been developed in the past but are not currently being implemented. Additionally, financial institutions and lawyers connected to the gambling industry and its regulators are being approached with the hope of engaging them in thinking together about increasing financial literacy.

MGC is implementing a responsible gaming initiative called GameSense. The initiative includes a staffed GameSense Information Center located at the garage entrance to the Plainridge Park Casino, media campaigns, and a pilot program at Plainridge Park Casino known as the Play Management System, or “Play My Way.” Play My Way will provide patrons with a voluntary limit-setting option to budget and track their play. The program is designed to allow customers the ability to monitor the amount of money they spend on electronic gaming machines and to support their decision to continue or

⁷ These are public schools where students can earn a high school diploma and are supported in their recovery from alcohol and drug use.

⁸ *Teens Know Your Limits* is a website designed by teens for teens who are interested in learning about gambling disorder. *Creative Activities for Probability and Statistics* (C.A.P.S.) is a free 12-session curriculum that serves to increase protective factors and reduce risk factors for teen gambling problems through the increased knowledge of statistics, probability and number sense, school-afterschool connectedness, and family cohesion.

stop play. The goals are to help players make decisions about gambling, allow them to monitor and understand their playing behavior in real time, and support their decisions. The test program will be offered to the casino's Marquee Reward members, who may enroll in the program at any slot machine, at a GameSense kiosk, or at the GameSense Info Center⁹. Players can unenroll or adjust their budget at any time.

The Responsible Gaming Framework includes guidelines for responsible marketing practices to reduce youth exposure to gambling advertising. These will guide advertising practices throughout Massachusetts for all casino operators.

A Reentry program¹⁰ and an accompanying Advisory Committee work to encourage screening and recognition of gambling problems by parole boards and to help connect those who would like treatment with appropriate services. This program also includes support with important areas of a gambler's life, such as employment, housing, and clothing, which can help to prevent relapse.

SCREENING AND REFERRAL

Massachusetts operates a statewide toll-free gambling Helpline that answers questions for people who are struggling with their own or their loved one's gambling and gambling-related problems, and for professionals who interface with the issue. Helpline Specialists are able to refer to trained problem gambling treatment providers, support groups, and other related services, such as financial counselors and family therapy.

The DOA organizes a yearly Gambling Disorder Screening Day in March, which is Problem Gambling Awareness Month. The event includes screening materials, informational handouts, resource summaries, a seminar series offering CEU credit, and educational trainings for organizations interested in hosting their own gambling disorder screenings. The DOA also supports the implementation and evaluation of Play Management software at gambling venues to help introduce some self-screening techniques for gamblers.

Problem gambling screening is currently part of the intake process for some substance abuse treatment centers, and some independent mental health counselors include problem gambling screening as part of their initial evaluation.¹¹ Ongoing training and education are conducted to increase screening and referral rates. This type of training has been provided to the Massachusetts Parole Board and the

⁹ More information is available at the GameSense website (<http://gamesensema.com/>).

¹⁰ The program is called Square One and is run by the Massachusetts Council on Compulsive Gambling.

¹¹ For more details about current gambling disorder screening processes among clinicians, see the focus group findings in the white paper published by the SEIGMA team (Houpt et al., 2015).

probation academy, through grand rounds for medical professionals, and through in-person regional trainings and online trainings.

Employees of casinos—a group at high risk for developing a gambling disorder (Shaffer, Vander Bilt, & Hall, 1999)—are receiving targeted training and education from the GameSense Advisors who staff the Gambling Services Information Center at Plainridge Park Casino.

Emergency Services mental health crisis teams that are not specific to problem gambling are called to help in situations of suicidality or other mental health crises. They can provide on-site intervention and/or transport people to a hospital for treatment.

TREATMENT

Problem gambling treatment services are provided by psychologists, psychiatrists, social workers, and mental health and substance abuse counselors. The majority of the services are conducted within independent practices or outpatient services. Treatment types vary but may include psychodynamic therapy or cognitive behavioral therapy, provided individually or in a group.

In some cases, clinicians are able to bill insurance companies directly to reimburse their treatment services. In other cases, gambling is a secondary diagnosis, so clinicians bill for reimbursement on the primary diagnosis (substance abuse, mood disorder, etc.). MDPH has established funding referred to as the “blanket,” which is a financial insurance reimbursement resource for Bureau of Substance Abuse Services (BSAS) gambling treatment contracted services that serves as the payer of last resort.

Clinicians can choose to complete gambling-specific trainings in order to meet the training requirements for Massachusetts Problem Gambling Specialist (MAPGS) certificates. They can also obtain national gambling certification. At this time, 140 service providers in Massachusetts have obtained an MAPGS. Some of these providers work in independent practice, and others are employed at mental health and substance abuse treatment facilities. Regional collaborative meetings bring various providers together to share information relevant to problem gambling and to discuss emerging trends in each region.

Currently, gambling treatment services in Massachusetts are conducted within ambulatory services. A few private agencies in Massachusetts are developing the ability to provide intensive outpatient or residential treatment.

RECOVERY SUPPORT

Recovery support for problem gambling in Massachusetts includes gambling-specific supports based on the same 12-step concept as Alcoholics Anonymous.¹² Referrals can be made to these groups and to

¹² Such groups include Gamblers Anonymous, Bettors Anonymous, and, less specific to gambling, Debtors Anonymous.

other services—including SMART (Self-Management and Recovery Training) Recovery programs—through the statewide gambling Helpline. A variety of services, including financial literacy, career services, and housing information, are available to people in recovery from a gambling disorder and their families through the criminal justice system and in community settings.

Problem gambling recovery services are also included in some substance abuse recovery programs. For example, BSAS funds recovery centers across Massachusetts and the Recovery High Schools. Although these centers and schools are used primarily by those in recovery from substance misuse, they are encouraged to follow the BSAS gambling-free guidelines.¹³ Similarly, recovery coaches who work primarily with individuals in recovery from substance addiction have been trained to incorporate problem gambling recovery into the support they provide.

To assist with long-term recovery, individuals will be able to request voluntary self-exclusion from casinos across the state. Residents of Massachusetts who are interested in broader exclusion can also add themselves to the self-exclusion lists for Connecticut and Rhode Island casinos. Third-party exclusion is available through the district trial court system.

Advocacy organizations provide support and advocacy for individuals in recovery from gambling addiction or substance use disorders. Such groups provide an opportunity for individuals in recovery to become more involved in their communities, and offer education and support to individuals and families who are struggling with addiction.

A recovery advisory board¹⁴ helps to plan an annual recovery weekend and has also organized reunion events for participants.

DATA COLLECTION

MGC has already awarded funding for studies of gambling and problem gambling in Massachusetts. The SEIGMA study is a comprehensive, multi-year research project that measures the social, health, economic, and fiscal impacts of gambling expansion in Massachusetts as these develop and change over time. The study addresses many of the essential elements of the MGC research agenda, using a collaborative orientation, mixed-methods research strategy, and comprehensive approach that establishes the impacts of casino gambling at the state, regional, and local levels.¹⁵

¹³ The guidelines are available on the Commonwealth of Massachusetts website (www.mass.gov/eohhs/docs/MDPH/substance-abuse/gambling-guidelines.pdf).

¹⁴ The recovery advisory board is convened and managed by the Massachusetts Council on Compulsive Gambling.

¹⁵ Based at the School of Public Health and Health Sciences at the University of Massachusetts, Amherst (UMass), the project is led by Dr. Rachel Volberg. Key project partners include NORC at the University of Chicago and the UMass Donahue Institute.

The SEIGMA study has three main areas of research: an analysis of the social and health impacts of expanded gambling, an evaluation of problem gambling services, and an analysis of the economic and fiscal impacts of gambling expansion. SEIGMA is a cross-sectional study, which means that the research team will collect data and assess impacts at several points in time both before and after the state's new casinos open. Over the past two years, the SEIGMA team has conducted a number of research activities to establish a clear picture of what Massachusetts looks like at baseline, before any of its new casinos open their doors. The most intensive of these research activities is a large Baseline Population Survey of nearly 10,000 Massachusetts residents, which took place from early September 2013 through late May 2014. The survey measured attitudes about gambling, gambling participation, problem gambling prevalence, awareness of problem gambling prevention efforts, treatment desire, and treatment-seeking. In late May 2015, the SEIGMA team released a report summarizing the results of this survey (Volberg et al., 2015). Many findings from the survey informed the creation of this Strategic Plan and are discussed in later sections of this document. The SEIGMA team will repeat this survey one year after all the new casinos are open to assess changes in gambling attitudes, participation, problems, and treatment-seeking.

In addition to the Baseline Population Survey, the SEIGMA team and its partners have conducted or are in the process of conducting a number of different research activities, which include completing a series of targeted surveys in host and surrounding communities, collecting secondary data, comprehensively analyzing economic and fiscal measures at baseline, conducting an analysis of casino construction impacts, and directing an online focus group with mental health and substance abuse treatment providers. Findings from several of these activities informed the creation of this Strategic Plan. The SEIGMA team will release additional data and findings over time, which will inform ongoing strategic planning efforts.

The same group of researchers are conducting a second research project, the Massachusetts Gambling Impact Cohort (MAGIC) Study, which examines many of the same constructs as the SEIGMA Baseline Population Survey but employs a different design (Volberg, 2014). Rather than collect data snapshots at two widely spaced points in time, MAGIC follows and conducts annual assessments with a single group of survey participants. Collecting data from the same group of people at regular intervals will allow the study to provide insight into how gambling behaviors and problems evolve over time. MAGIC will provide an estimate of the number of new people who develop a gambling problem after the state's new casinos open, as well as information about factors that may protect a person from—or place a person at greater risk of—developing a gambling-related problem.

Together, the data from these two studies will inform how the state strategically allocates resources for prevention, intervention, treatment, and recovery support in order to optimize prevention campaigns and services.

The DOA receives funding allocated through the annual research agenda to evaluate the effectiveness of responsible gambling interventions. A study titled “Assessing Responsible Gambling in

Massachusetts¹⁶ includes multi-year evaluation activities for voluntary self-exclusion, the Play Management System, and the GameSense Information Centers. The research team will collect and analyze GameSense Information Center patron interaction records and patron surveys; voluntary self-exclusion demographic, enrollment, and participant information data; and digital information from electronic gaming machines, player reward card systems, and the Play Management software. The information will allow the team to assess the adoption and use of MGC's Responsible Gambling programs and will inform future decisions about whether to maintain, revise, or eliminate the programs and their associated tools.

MGC examines the impact of gambling on crime by working with law enforcement to track local crime rates, calls for service and collisions.

Two groups have been formed to assist in establishing the gaming research agenda and to oversee and advise the research process. The Gaming Research Advisory Committee (GRAC) provides input into research design and the MGC's annual research agenda. The Research Design and Analysis Committee, a subcommittee of the GRAC, focuses on research methodology. The GRAC and its subcommittee are staffed by MGC and MDPH and meet on a regular basis.

CURRENT SERVICES FOR OTHER RELATED ISSUES

Prevention initiatives are already in place in the Commonwealth for a variety of health concerns that are more prevalent among those with a gambling disorder than among the general population, for example:

- » MDPH funds a network of regional suicide prevention coalitions throughout the Commonwealth.¹⁷ These coalitions include organizations and initiatives focused not only on suicide but also on broader mental health concerns, including depression and anxiety.
- » Local and regional substance abuse prevention coalitions exist across Massachusetts. Some of these are not funded, some receive state funding, and some receive federal funding.
- » Violence prevention programs may exist in schools or community settings, and through statewide initiatives with limited funding.

A wide variety of nonprofit organizations work directly and indirectly on issues of domestic violence, mental health, suicide, obesity, safety, financial stability, and other issues that may be affected by increased gambling.

¹⁶ The study is being led by Debi LaPlante, PhD, and Howard Shaffer, PhD, CAS. Further information about the DOA's research projects is available on the division's website (<http://www.divisiononaddiction.org/research.htm>).

¹⁷ For more information, see the Massachusetts Coalition for Suicide Prevention website (<http://www.masspreventsuicide.org>).

Research initiatives to explore the relationship of other issues to the expansion of legalized gambling are also in place. MDPH conducts literature reviews related to issues of concern, and SEIGMA's research will include the social and economic impacts of gambling. The connections between substance use and gambling will be studied at an individual level through the SEIGMA cohort study.

At a population level, surveillance of many of these health and economic issues is already being done by the state and by individual communities. These data can help track changes that might be related to the opening of casinos. In addition, a crime analyst is employed by MGC to monitor changes in crime over time in casino host communities and across the state.

To address occupational health concerns, MGC has met with unions and other interested parties to discuss ways to ensure that working conditions are as safe as possible. Together these groups are exploring ways to create environments conducive to good health through policy and practice standards.

As mentioned above, both the PHTF and the Community Mitigation Fund are available to address potential impacts of the Expanded Gaming Act. A list of health concerns that may follow from the expansion of legalized gambling, including mental health concerns, crime, violence, domestic violence, sexual trafficking, and substance use, was raised during the period of public comment and during the assessment stage of this Strategic Plan. (These concerns are explored in more depth on page 33.) Current programs address some but not all of these issues. The PHTF is available to support research and services related to problem gambling and its common comorbidities, and the Community Mitigation Fund may be accessed by communities to address harms related more directly to the introduction of casinos and hotels and less directly to problem gambling.

PRIORITY AREAS (KEY AREAS OF CONCERN)

Based on MassTAPP’s assessment results, including surveys, analysis of key stakeholder interviews, and SEIGMA data, 11 key areas of concern have been identified:

1. Prevention for Youth
2. Prevention for High-Risk Populations
3. Focus on Community-Level Interventions
4. Coordination of Problem Gambling Services
5. Integration of Addiction Services, Mental Health Services, and Primary Care
6. Decrease in Stigma and Unsupportive Social Norms
7. Increase in Availability of Support Services
8. Increase in Availability of Culturally Appropriate Services
9. Contribution to the Evidence Base for Problem Gambling Services
10. Establishment of an Evaluation Infrastructure
11. Expansion of Institutional Capacity to Address Problem Gambling and Related Issues

These priorities appear in boldface below and are categorized and color-coded according to where they fall on the Continuum of Services: Prevention and Health Promotion—red, Screening and Referral—orange, Treatment—green, Recovery Support—blue, Data Collection—purple, and Infrastructure—gray.

RELATED TO PREVENTION AND HEALTH PROMOTION

1. Prevention for Youth

Youth who experience an earlier age of onset of gambling are associated with a greater severity of problem gambling behaviors (Hardoon & Derevensky, 2002; Kessler et al., 2008; Rahman et al., 2012) and therefore are an important focus for early prevention and promotion strategies.

One key stakeholder shared that “most problem gamblers in treatment report that they began gambling very early. For boys it is 10–12 years old, for girls it is 13–14 years old. This is generally earlier than the onset of other risky behavior (substance misuse, underage drinking, sex).” Another explained that readiness to prevent problem gambling among youth is not as advanced as readiness to address substance misuse: “No one is telling youth to ‘watch out’ with gambling in the way that they might be hearing the message with substance abuse or alcohol. Parents perceive this to be low risk. [We] need more conversations about risk and protective factors about gambling at a younger age.”

Because Massachusetts has an existing infrastructure for community-level prevention of substance misuse focusing on youth, young people can be effectively reached with prevention messages. It is likely that the same initiatives designed to increase protective factors and decrease risk factors for substance misuse will also affect later incidence of problem gambling (Williams, West, & Simpson, 2012). However, conference survey results indicate that prevention professionals working in substance abuse prevention and prevention of other risky behaviors have only a vague awareness of problem gambling, and the vast majority do not include problem gambling in their community-level prevention efforts or collect local data about gambling among youth.

The SEIGMA baseline study indicates that the majority of the Massachusetts population are not aware of problem gambling prevention campaigns and programs (Volberg et al., 2015). There is an opportunity to increase awareness of the issue by using community-level prevention coalitions to disseminate messaging.

2. Prevention for High-Risk Populations

The SEIGMA baseline data report identified several subpopulations at higher risk of developing a problem with gambling than others (Volberg et al., 2015), and earlier research (Shaffer, Vander Bilt, & Hall, 1999; Williams, Royston, & Hagen, 2005) identified other groups at higher risk. These subgroups need to receive targeted prevention interventions.

These high-risk populations include the following:

- » Youth
- » Males
- » People who are black
- » People with a high school degree or less
- » People with an annual income of less than \$15,000
- » People who are unemployed
- » People with a disability
- » Casino employees
- » People who are incarcerated
- » People who are misusing substances

According to the SEIGMA baseline data report, there are four times more male problem gamblers than female, and 60% more male at-risk gamblers than female. The rate of problem gamblers in the black population is four times that of the white population, and the rate of at-risk gamblers in the black population is double that of the white population. People with a high school education or less are more

than twice as likely to be at-risk gamblers as those with a college degree. People with annual incomes less than \$15,000 are nearly twice as likely to be at-risk gamblers as those making \$50,000 or more. People who are unemployed are twice as likely to be at-risk gamblers than those who are employed. In addition, people who have a disability are more than twice as likely to be at-risk or problem gamblers than those who are not disabled (Volberg et al., 2015).

Both gambling risk and gambling motivation vary among demographic groups. In the SEIGMA baseline study, those who are Hispanic or black were more likely than those who are white or Asian to report that they gamble to win money, and men were more likely than women to say that they gamble primarily in order to win money (Volberg et al., 2015).

At-risk and problem gamblers are more aware of prevention messaging than the general population, but still only about half of them are aware of prevention campaigns, and even fewer are aware of prevention programs (Volberg et al., 2015). Prevention messaging must be carefully developed, tested, and disseminated to all high-risk groups.

Beyond the SEIGMA study and the published literature, other groups have been identified as potentially being at higher risk for problem gambling, either for having higher rates of problem gambling or for having more severe consequences as a result of their gambling. These groups include older adults (Korn & Shaffer, 1999; Lopes, 1987), veterans, and certain ethnic minorities (Shaffer & Korn, 2002). As the research agenda for Massachusetts is refined, gambling patterns of these groups should be studied in more depth to understand the specific needs of each population and to identify appropriate interventions. One study indicated that past-year pathological gambling rates were higher among casino employees than in the general population (Shaffer, Hall, & Vander Bilt, 1999). Problem gambling rates are also higher among the incarcerated population than among the general population. Another study found that as many as one-third of criminal offenders meet the criteria for problem or pathological gambling (Williams, Royston, & Hagen, 2005).

A number of common comorbidities with problem gambling have been identified, including increased risk for suicide (Newman & Thompson, 2007), increased rates of depression, anxiety, and substance misuse (Crockford & el-Guebaly, 1998; Petry, Stinson, & Grant, 2005; Shaffer, Hall, & Vander Bilt, 1999), and increased rates of domestic violence (Afifi, Brownridge, MacMillan, & Sareen, 2010). In addition to working to prevent gambling disorder among high-risk populations, it is important to prevent these co-occurring health concerns.

3. Focus on Community-Level Interventions

Simply addressing problem gambling as an individual issue would not be nearly as impactful as addressing it through a public health lens at the population level.

The public health approach focuses on the well-being of whole populations. This approach to behavioral health issues such as gambling comprises the following tasks (EDC, 2011):

- » Identify problems, underlying influences, and relevant risk and protective factors
- » Consider these issues across the community, as a whole population
- » Strategically apply and implement appropriate best practice prevention strategies
- » Evaluate the effectiveness of these interventions for the whole population

The public health approach to problem gambling is not unique to Massachusetts. A recent publication from Australia points out the value and logic of using such an approach to the issue, saying, “A public health approach is an approach focusing on our community as a whole. It recognizes there is no silver bullet to address the complex issues which contribute to problem gambling” (Victorian Responsible Gambling Foundation, 2015, p. 1). Shaffer and Korn (2002; also Korn & Shaffer, 1999) place problem gambling within a public health context as a way to encourage surveillance, identification of risk factors at multiple levels, and proactive interventions. Additionally, looking at population-level data can help to identify disparities between subpopulations and inform the development of strategies to reduce such disparities.

Despite the value and cost-effectiveness of addressing problem gambling through a public health lens, many community-level interventions and environmental strategies that might affect problem gambling and related issues have not been adequately tested, and other approaches that have been shown to be effective for the prevention of other addictions may not translate well to the issue of problem gambling. Social marketing is a powerful tool for reaching large audiences with health messaging, yet many of the problem gambling campaigns conducted across the world have led to only limited increased awareness among the general population (Williams, Volberg, & Stevens, 2012) and are dwarfed by the advertising and messaging from casinos and other elements of the gambling industry (Volberg, Rugle, Rosenthal, & Fong, 2005).

Despite the challenges, the Commonwealth is beginning to successfully utilize environmental strategies for problem gambling prevention. One key informant described the positive transition of community-level interventions in Massachusetts from individual to population-level, saying, “We’ve learned to move toward a more evidence-based and targeted approach, like . . . incorporating gambling policy into student codes of conduct, which is still the exception rather than the norm; social norms programming, [and] regulating institutional practices like Casino Night fundraisers.”

RELATED TO SCREENING AND REFERRAL

RELATED TO TREATMENT

RELATED TO RECOVERY SUPPORT

4. Coordination of Problem Gambling Services

There is not a visible, consistent, streamlined, and integrated screening, referral, and reimbursement process in Massachusetts.

While estimates from SEIGMA baseline data indicate that Massachusetts is likely home to between 67,000 and 109,000 adult residents who are currently problem gamblers, and about 1 in 6 adults reported that they know someone who gambles too much, very few people in the SEIGMA study said that they would like or had sought help for their gambling problem (Volberg et al., 2015). Also, very few treatments for problem gambling are reimbursed through a fund that the state makes available. While the reasons for this discrepancy are probably complex, including low awareness of problem gambling, stigma, lack of services, and low or no awareness of resources, the difference indicates a significant unmet need for those experiencing a gambling disorder and for their loved ones.

Key stakeholders described a variety of challenges, including the fact that many people who work directly with populations at high risk for problem gambling are not currently screening; that professionals outside the field of problem gambling are not aware of screening tools—and even within the field, screening tools are not aligned; that stigma and social norms can block help-seeking for people in need of services; and that culturally appropriate services are not available for many populations at highest risk for problem gambling. Even when services do exist, conference survey results indicated that awareness of these services is low.

Exacerbating the lack of appropriate services, there is little incentive for mental health providers to engage in problem gambling work. The reimbursement process for outpatient or residential treatment can be complicated, and stakeholders described a concern that some providers might dislike the billing process so much that they would rather identify a secondary diagnosis than try to bill for problem gambling treatment. This can limit access to services and also complicates the tracking of information about who receives treatment.

As one key stakeholder described the current situation, “We currently don’t have a true integrated system as it relates to gambling and mental health. It’s a carve-out within the substance abuse outpatient system. . . . It’s underfunded, with multiple issues when dealing with third-party billing.”

Not only must services exist, they must be linguistically, geographically, and quickly accessible. Research indicates that being able to provide an appointment within 72 hours of a call to a helpline can increase follow-through on referrals (Weinstock et al., 2011). However, to make rapid appointments like this possible, providers must be trained, available, and willing to see patients.

If SEIGMA estimates of the number of problem gamblers in the state are correct, and if, as has been true in other locations, the opening of additional gambling venues increases the number of problem gamblers (Volberg et al., 2005), there will be at least a temporary increase in the number of problem gamblers in Massachusetts after the resort-style casinos open. If the number of people experiencing a gambling disorder increases and efforts to increase screening and referrals are successful, demand for addiction

treatment services is also likely to increase significantly. It is imperative that high-quality services be in place ahead of the increased demand.

5. Integration of Addiction, Mental Health Services, and Primary Care

There is frequent comorbidity between substance misuse, mental illness, and problem gambling, but substance abuse services do not always integrate problem gambling.

Problem gambling is an addiction that shares many characteristics with other addictions. The results of multiple studies indicate that many problem gamblers and pathological gamblers experience higher rates of substance misuse and mental illness than does the general population (Shaffer, Vander Bilt, & Hall, 1999). In Massachusetts, the SEIGMA baseline report confirms and localizes these findings (Volberg et al., 2015):

- » At-risk and problem gamblers in Massachusetts were significantly more likely than recreational gamblers to acknowledge binge drinking in the past 30 days.
- » At-risk and problem gamblers in Massachusetts were significantly more likely than recreational gamblers to say that they had experienced serious problems with depression, anxiety, or other mental health problems both in the past year and in the past 30 days.
- » At-risk and problem gamblers in Massachusetts were more likely than recreational gamblers to use tobacco, and problem gamblers were more likely than recreational gamblers to use illicit drugs.

While causality is not clear, the high rates of comorbidity have important implications for the screening and treatment of problem gambling. One key stakeholder from the research community proposed, “Based on our body of research and this theoretical frame, we should be integrating all addiction prevention, treatment, and policy activities rather than thinking that gambling is something new or different.” Another commented, “We need to address the issue of gambling in addition to substance abuse when they co-occur to make treatment and recovery more efficient. Without talking about these issues together, individuals will drop out of treatment earlier.” Other stakeholders mentioned that despite frequent comorbidity, the state’s recovery centers are focused on recovery from substance misuse and do not adequately address the needs of those in recovery from problem gambling.

6. Decrease in Stigma and Unsupportive Social Norms

Stigma and social norms make it hard for people to recognize that they have a problem with gambling and/or to seek treatment.

Stigma and denial were the barriers to treatment most frequently mentioned by preventionists and problem gambling professionals in Massachusetts on conference surveys. One key stakeholder reinforced the need to “increase access and reduce stigma around treatment.” Another explained, “This is a disease of addiction, but with a great level of stigma and shaming.”

The SEIGMA baseline report noted that only a very small number of those classified as problem gamblers who gambled in the past year indicated that they had wanted help for gambling problems or that they had actually sought help (Volberg et al., 2015). One reason for this could be the stigma described by stakeholders and indicated in survey results. Social norms, including the frequency with which people hear about problem gambling, the way that it is portrayed in the media, the visibility of service-seeking and the ways that friends and family interact with gambling activities in a community can also affect whether someone recognizes harms associated with their own gambling and whether they seek services.

7. Increase in Availability of Support Services

There are not enough support services available.

Many stakeholders commented on the lack of sufficient gambling services. One said, “When we work with families and [they] ask lots of challenging questions, we don’t have a problem gambling screening tool.” Another said, “We find that there are not enough people trained to treat problem gambling.” Still another noted, “[We] need more infrastructure around gambling. There are only a handful of people who are certified that we can refer our clients to.” A key informant explained, “In recovery community services, they might not have even included gambling.” Participants in an online focus group for treatment providers reinforced the need for additional services as well as for additional training and supervision for providers (Haupt et al., 2015).

Requests for additional services spanned the prevention continuum, from prevention to treatment to recovery support, and included resources for services for both gamblers and their loved ones. Stakeholders complained that there are not enough financial supports for people with gambling disorders, not enough support groups for people in recovery from a gambling disorder, and not enough resources for families of those with a gambling disorder.

As noted in the Responsible Gaming Framework (MGC, 2014), in addition to clinical services, all gamblers would benefit from a deeper understanding of how gambling works, or enhanced “gambling literacy” to dispel myths about gambling. Before the Framework was instituted, this type of messaging and programming was available only intermittently and to small groups across Massachusetts.

8. Increase in Availability of Culturally Appropriate Services

Appropriate services for culturally diverse populations are lacking.

The SEIGMA baseline study indicates that awareness of media campaigns is significantly higher for males, older adults, those who are white, and those with a higher household income (Volberg et al., 2015). While messages seem to be reaching one high-risk group (males), this list does not include most of the groups at highest risk for problem gambling: youth, people who are black, low-income individuals, people who are unemployed, people with a disability, casino employees, people who are incarcerated, and people in treatment for substance misuse.

However, the problem goes beyond lack of awareness—the availability of culturally appropriate services is very limited. One key stakeholder described the lack of such services, saying, “There are not many providers that are trained [with] cultural competence and the language skills to work with [diverse populations]. [It’s] hard to find information and even harder to find treatment in Asian languages.” Another stakeholder described the difficulty of finding recovery support groups that felt comfortable for her mother because of her limited English proficiency as well as her gender. The online focus group of treatment providers conducted by the SEIGMA team raised concerns about the lack of linguistic diversity among providers (Haupt et al., 2015).

RELATED TO DATA COLLECTION

9. Contribution to the Evidence Base for Problem Gambling Services

There has been limited research worldwide into problem gambling disease etiology, prevention and services, related treatment-seeking behaviors, and related health concerns.

As Williams, West, and Simpson (2012) note, “The development, implementation and evaluation of most of these initiatives [to prevent problem gambling] has been a haphazard process” (p. 6). The Victorian Responsible Gambling Foundation (2015) echoes their point, stating, “The evidence base is best described as emerging, with much of the scientific literature focused on addressing the harm arising from serious gambling problems rather than the more frequent and less severe difficulties affecting gamblers generally” (p. 9).

Our interviews with key stakeholders reinforce this concern. One researcher explained, “[We are] not sure the field agrees yet on what gambling disorder truly is. . . . This is a ‘youthful’ area of study. We have a lot of ‘grey literature’ in this field which has not been subjected to peer review (or may not survive it).” A local leader in gambling services commented, “None of the prevention efforts have been tested, none are labeled by SAMHSA as ‘promising programs.’ [We] need more evaluation for prevention efforts.”

Another leader in the problem gambling field noted, “[There] is not enough research on what normative gambling looks like. Risk and protective factors are not clearly defined. There is no information on state-level program evaluation besides in Canada.”¹⁸ A key stakeholder commented on the evolving needs for research: “It’s time that we start moving the focus of research in problem gambling from prevalence studies to evaluation of the efficacy of various interventions.”

¹⁸ Canada’s *Stacked Deck* problem gambling prevention curriculum may be ordered from Hazelden Publishing (http://www.hazelden.org/OA_HTML/ibeCCTpItnDspRte.jsp?item=30104).

Research must explore not only the etiology of problem gambling, but also the development of associated health concerns. Massachusetts has an opportunity to track and measure changes in violence, sexual trafficking, occupational health hazards, substance use, and other health issues that change as legalized gambling expands. This information will help to inform the development of a constellation of appropriate prevention and treatment services.

In addition to implementing strong data collection processes to inform programming, Massachusetts should publish its findings in peer-reviewed journals to help advance the field of problem gambling services beyond the Commonwealth.

10. Establishment of an Evaluation Infrastructure

There is not yet a streamlined data collection and analysis process in Massachusetts for problem gambling.

There has been limited research on problem gambling prevention and services worldwide (Oakely-Browne, Adams, & Mobberley, 2000; Stea & Hodgins, 2011; Victorian Responsible Gambling Foundation, 2015; Volberg et al., 2005). As a result, Massachusetts will have to implement programming that has not been thoroughly tested and evaluated. This provides an opportunity to evaluate the efficacy of legislation and programming in the state, while also contributing significantly to the growing knowledge base in the field of problem gambling and related issues.

The mechanisms for this evaluation and for its connections to programming have not yet been developed. According to one researcher who was interviewed as a key stakeholder, although some data collection about problem gambling and its impacts is underway, it has not yet been “linked [to] the public health data collection initiatives and the GRAC” and there is not a clear mechanism by which all relevant information about the impacts of gambling can be considered on a regular basis.

Additionally, the state does not yet have a system for housing data related to gambling prevalence, gambling-related harms, and gambling services. Massachusetts needs an active problem gambling monitoring system, which should include a data warehouse that would allow integration and rapid access to gambling-related data (Volberg et al., 2005).

RELATED TO INFRASTRUCTURE AND CAPACITY BUILDING

11. Expansion of Institutional Capacity to Address Problem Gambling and Related Issues

Because the complexity of gambling issues requires multiple strategies across the Continuum of Services, it is critical to maintain and enhance the existing problem gambling infrastructure, including professional development initiatives, to ensure effective implementation of the Strategic Plan.

In our conversations with stakeholders, they reinforced the need to maintain staff positions devoted to problem gambling within MDPH and to support the maintenance and expansion of service providers' efforts. The results of the SEIGMA team's focus group with treatment providers and comments from stakeholders indicated the importance of professional development in multiple settings to enhance, standardize, and streamline problem gambling services.

RELATED TO OTHER ISSUES

The expansion of legalized gambling is likely to affect health issues other than problem gambling. Considering other related issues at this stage will allow for more coordinated surveillance, shared prevention, and impactful interventions.

Surveillance

As mentioned earlier, there is significant value in considering gambling not only from an individual clinical perspective but also from a public health perspective. Massachusetts has a statutory obligation to respond to issues that are closely connected to problem gambling, such as other addictions and common comorbidities. The Commonwealth also has an opportunity to continue to explore the associations between gambling and a variety of other issues through ongoing research and surveillance. Measuring the effects and determinants of gambling on individuals and communities over time can inform the development of appropriate interventions and can also help to evaluate their outcomes and effectiveness (Korn & Shaffer, 1999). Data collection at the individual and population levels on gambling behavior as well as on common comorbidities and gambling impacts will provide a robust evaluation system for program evaluation as well as a detection system for emerging issues that may require a stronger public health response.

In Massachusetts, a number of barriers exist to collecting data about who is seeking and who is accessing treatment for problem gambling. Additionally, treatment seeking through formal mechanisms is extremely low, and prevention initiatives that are successful may not show an impact on treatment numbers at all. For example, prevention efforts will be concurrent with initiatives to increase treatment-seeking, so treatment numbers may not change in direct response to programming. Given these challenges, it is particularly important to have a variety of indicators beyond clinical treatment-seeking data to measure the success of problem gambling services.

Shared Risk and Protective Factors

A number of *risk factors for problem gambling*—elements that increase the likelihood of someone experiencing a gambling disorder—have been identified, particularly among adolescents. These include poor grades (Winters, Bengston, Door, & Stinchfield 1998), use of illicit drugs, having parents who have experienced gambling problems (Wilber & Potenza, 2006; Winters et al., 1998), low socioeconomic status (Welte, Barnes, Tidwell, & Hoffman, 2008), gambling early in life, being more impulsive, having

peers who gamble, and having parents who approve of gambling (Wilber & Potenza, 2006). Other risk factors at the community and individual level include erroneous beliefs about gambling, less education, societal acceptance of gambling, gambling opportunities being readily available, and gambling being commercially provided in an unsafe manner (Williams, West, & Simpson, 2012).

Hawkins, Catalano, and Miller (1992) identified a number of similar risk factors for adolescent substance use, which include having attitudes favorable to drug use, early age of onset, association with drug-using peers, early and persistent problem behaviors, psychological issues, availability of substances, extreme economic deprivation at the community level, and laws and norms favorable to use. In 2000, Herrenkohl and his co-authors identified risk factors for youth violence that also align in some ways with the risk factors for problem gambling; these include low academic performance, peer delinquency, and the availability of drugs in the neighborhood.

These parallels provide an opportunity to engage in shared prevention strategies, particularly for youth, at the individual and community levels for problem gambling and its common comorbidities. Because some comorbidities are themselves risk factors for problem gambling, preventing them should also impact problem gambling. Also, research and program evaluation from other related fields can inform problem gambling services, which have been studied less extensively.

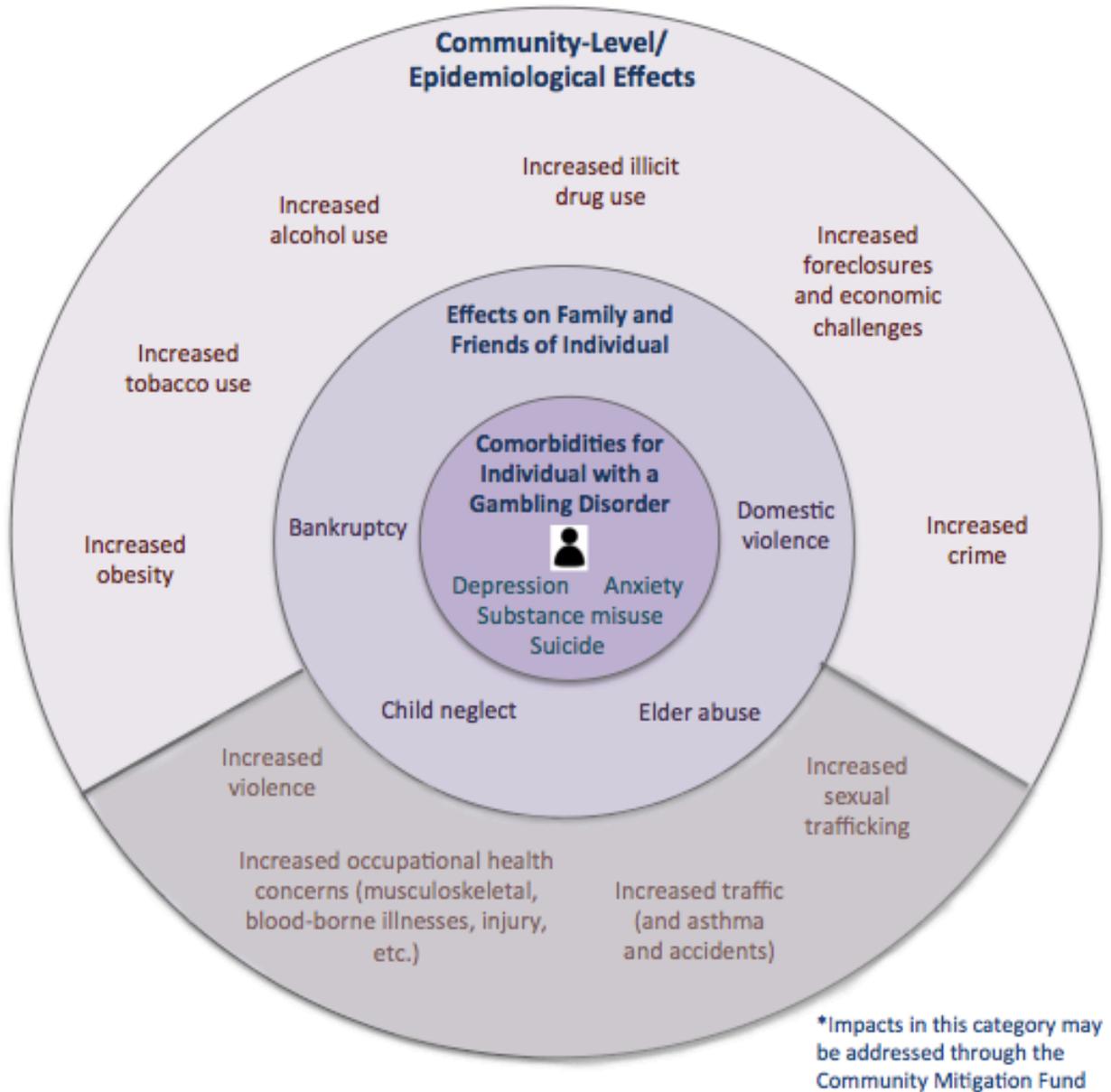
Potentially Related Health Concerns

Through the initial stakeholder interviews conducted during the assessment for this Strategic Plan and through public comment, a number of health concerns that may increase due to expanded legalized gambling were named: substance misuse, depression, anxiety, financial problems, suicide, elder abuse, child neglect, violence (including intimate partner violence), crime, foreclosures, occupational health hazards, sexual trafficking, traffic (and related issues of air quality and asthma rates), and traffic accidents. Some of these are individual-level health concerns, and others are community-level concerns.

The quality and strength of the evidence linking each health concern to gambling is variable. Rigorous research has strongly linked some issues with gambling, but even in these cases it is not clear whether gambling causes the other health concerns or whether they tend to be present in the same individual for other reasons. For other issues, there is not yet a strong enough research base to indisputably establish or disprove their connections with gambling.

Figure 2 categorizes these issues in terms of their proximity to an individual who experiences a gambling problem and also categorizes each potential community-level effect according to whether it would be caused by increased gambling, increased gambling disorder, or the increased presence of casinos and hotels.

Figure 2: Health Concerns that May Increase as a Result of the Expansion of Legalized Gambling



While many issues could potentially belong in more than one category, this framework can help Massachusetts decision-makers and program designers clarify which issues should be assessed and which issues can be addressed using funds from the PHTF. As associations are confirmed between specific health concerns and gambling, decisions can be made about how best to expand or strengthen services to address them.

Some of the evidence linking these issues to gambling is outlined below.

Individual-level comorbidities

As discussed above in the context of high-risk populations, problem gambling is often correlated with drug and alcohol misuse (Crockford & el-Guebaly, 1998; Cunningham-Williams, Cottler, Compton, & Spitznagel, 1998; Huang, Jacobs, Derevensky, Gupta, & Paskus, 2007; Lesieur & Heineman, 1988; Shaffer, Hall, & Vander Bilt, 1999; Slutske, Ellingson, Richmond-Rakerd, Zhu, & Martin, 2005; Smart & Ferris, 1996; Spunt, Lesieur, Hunt, & Cahill, 1995; Steinberg, Kosten, & Rounsaville, 1992; Winters et al., 1998).

Those with a gambling disorder are likely to experience psychiatric conditions, such as depression (Blaszczynski & Steel, 1998; Crockford & el-Guebaly, 1998; Cunningham-Williams et al., 1998; Knapp & Lech, 1987; McCormick, Russo, Ramirez, & Taber, 1984; Rugle & Melamed, 1993; Shaffer, Hall, & Vander Bilt, 1999) and anxiety. In one study, anxiety, mood disorders, and substance use disorders predicted the onset of problem gambling, and problem gambling predicted generalized anxiety disorder, post-traumatic stress disorder, and substance dependence (Kessler et al., 2008). Individuals who experience a gambling disorder may also be at higher risk for suicide (Bland, Newman, Orn, & Stebelsky, 1993; Crockford & el-Guebaly, 1998; Cunningham-Williams et al., 1998; Feigelman, Gorman, & Lesieur, 2006; McCleary & Chew, 1998; Newman & Thompson, 2007; Phillips, Welty, & Smith, 1997).

Health concerns for the loved ones of problem gamblers

Family and friends of people with a gambling disorder may be affected by gambling either directly or indirectly. According to Politzer, Yesalis, and Hudak (1992), each problem gambler negatively affects 10–17 people around him or her; according to the SEIGMA baseline results, about 1 in 6 adults in Massachusetts reported that they know someone who gambles too much (Volberg et al., 2015).

Problem gamblers may experience financial problems (Blaszczynski & McConaghy, 1994), and these in turn can contribute to job loss or poverty for themselves and their families. Intimate partner violence, elder abuse, and child neglect have also been associated with problem gambling (Afifi et al., 2010; Jacobs et al., 1989; Lesieur & Rothschild, 1989; Lorenz & Yaffee, 1988; Wildman, 1989).

Community-level impacts of increased problem gambling

Increases in crime rates have been linked to the establishment of casinos in a community, with one study noting that 8% of criminal activity in the counties where casinos operate can be attributed to the casinos (Grinols & Mustard, 2006). This same study notes that crime rates tend to increase over time, beginning two or three years after the casinos open. The study explains the lag in crime effects by noting that some of the drivers of crime reductions, such as employment and wage increases, will decrease over time, while the drivers of increased crime will be maintained. They also note that problem gamblers often take two or three years to begin gambling. Other studies support the idea that there are connections between crime and gambling (Gerstein et al., 1999; Smith & Wynne, 1999).

As noted above, financial problems may be a result of problem gambling. In addition to affecting a gambler and his or her family, financial problems can lead to foreclosures, which could have a negative effect on the economic stability of the community overall.

Community-level impacts of increased gambling

While there is a clear association between problem gambling and substance use at the individual level, as described above, the connection between gambling as an activity and community-level changes in substance use is not clear. A number of community-level health concerns have been raised that may be related to increased gambling or to the activities that often accompany gambling in casinos, including obesity, tobacco use, alcohol use, and use of illicit drugs. Rates of these health conditions will be monitored, and research should be done to assess the potential connections between any changes and gambling.

Community-level impacts of the establishment and presence of casinos and large hotels

While these issues will most likely not be addressed by the PHTF, a number of potential health impacts may result from the introduction of casinos and large hotels to a community. If the community is found to be significantly affected by the expansion of legalized gambling, individual communities or groups of communities will be able to access Community Mitigation Funds to address the issues.

For example, the construction and subsequent staffing of casinos and accompanying hotels may involve occupational health hazards, such as musculoskeletal ergonomic hazards (Allread, Vossen, Sheikh, & Punnett, 2016; National Institute for Occupational Safety and Health, 2011), blood-borne pathogen exposures, stress, workplace violence, sleep deprivation, and danger from fires and explosions. The presence of a casino and hotels may increase sexual trafficking. One study showed that rates of rape increased over time in the presence of casinos (Grinols & Mustard, 2006). Stitt, Giacomassi, and Nichols (2000) found an increase in prostitution after casinos opened. Other non-peer-reviewed articles have indicated that human trafficking at casinos is a problem. And, as noted above, certain other crimes may increase following the opening of a casino, some of which are violent crimes (Grinols & Mustard, 2006).

Traffic in the vicinity of casinos is likely to increase, and increased traffic can affect air quality and asthma rates. A Health Impact Assessment carried out in Western Massachusetts to evaluate the potential effects of the introduction of a casino noted a likely increase in traffic and air pollution (Partners for a Healthier Community, Inc., 2014). One study also noted a strong link between the presence of a casino and the rates of alcohol-related traffic accidents (Cotti & Walker, 2010).

STRATEGIC PLAN FOR SERVICES TO MITIGATE THE HARMS RELATED TO GAMBLING IN MASSACHUSETTS

This plan is intended to provide a starting point for increasing the capacity within Massachusetts to provide coordinated, effective services for problem gambling and related issues to the many people who already require such services and to the many more who may require services as legal gambling expands over the coming years. The plan is intentionally divided into two phases: Phase 1 focuses on infrastructure development and enhancement of current capacity, and Phase 2 includes programming and services that can be carried out using the dollars that will become available for services through the PHTF after casinos open. Some activities are extremely specific, and others require more refinement.

Phase 1 activities may become key components of work plans for the Director of Problem Gambling at MDPH and for the Director of Research and Responsible Gaming for MGC. They may also be integrated into contracts for MDPH vendors and included in the tasks of other EOHHS agencies who can contribute to their successful implementation. A strong work plan based on this Strategic Plan would include tasks related to programming, policy change, infrastructure development, data collection, and evaluation; specify who will be responsible for each task; and provide timelines for each task to be carried out.

It is recommended that the plan be updated every two years and rewritten every five years to include new research findings and to reflect changes in the context of problem gambling in Massachusetts. While the goals and activities included in this plan focus heavily on services directly related to problem gambling, future iterations of the Strategic Plan are likely to include services to address other health issues that have increased due to the expansion of legalized gambling. Ongoing data collection will help to identify such issues.

Guiding Principles

The following principles guided the development of the recommendations in the Strategic Plan and will guide the implementation of the plan by MDPH, MGC, and others who will participate in its implementation:

- » Begin by evaluating and enhancing existing infrastructure whenever possible, rather than creating something new
- » Engage populations of highest need in designing programs and interventions for problem gambling and related issues
- » Work collaboratively across agency boundaries (at the state and local levels) to make interventions more impactful
- » Address gambling through a public health lens, working at a community level to create norms and environments that support healthy behaviors

- » Base priorities on data
- » Choose interventions based on evidence of efficacy, and use a precautionary approach
- » Provide interventions along the entire Continuum of Services, with an increasing focus on prevention, to increase return on investment
- » Evaluate and adjust as the work progresses

Goals

The recommendations in this Strategic Plan for Services to Mitigate the Harms Associated with Gambling in Massachusetts are designed to address six major goals:

1. Decrease the prevalence of problem gambling and related health issues in Massachusetts
2. Increase the number of high-risk individuals who receive screening for problem gambling
3. Increase participation in problem gambling programs and services, especially from high-risk groups, and decrease the negative consequences of problem gambling
4. Increase participation in problem gambling recovery support programs and services, especially from high-risk groups
5. Increase knowledge about disease etiology, effective practices, and individual and cultural differences related to seeking services for problem gambling and related issues
6. Have in place the appropriate infrastructure and human resources to successfully implement the Strategic Plan

Recommended strategies for reaching these six goals are described below, organized and color-coded according to where they fall on the Continuum of Services: Prevention and Health Promotion—red, Screening and Referral—orange, Treatment—green, Recovery Support—blue, Data Collection—purple, and Infrastructure—gray. Each activity is followed by the abbreviations MGC or MDPH to indicate which agency will be responsible for funding and oversight.

As mentioned above, the activities for implementing each strategy are divided into two phases, reflecting the sequence in which they will begin:

- » Recommended Phase 1 activities enhance existing programming and critical infrastructure and build capacity *before the PHTF is funded for services*. Many of these activities will continue and expand once the PHTF is funded.
- » Recommended Phase 2 activities involve implementation of new programming, evaluation initiatives, and infrastructure development with additional dollars *after the PHTF is funded for services*. Phase 2 activities will be refined and enhanced over the next few years as capacity and infrastructure are built through Phase 1 activities and as more data become available.

Strategies and Activities

PREVENTION AND HEALTH PROMOTION**(to prevent harm before it occurs)**

Strategy: Reach youth and parents with appropriate prevention messaging, and enhance environmental strategies to increase protective factors and decrease risk factors (priority 1)¹⁹

Phase 1 Activities

1. Provide parent education about problem gambling and about how to reduce risk factors and increase protective factors for problem gambling and some of its common comorbidities.
 - ❖ Create high-quality parent education materials about problem gambling. (MGC)
 - ❖ Post public awareness campaigns and information for parents in gambling venues and at the GameSense centers and GameSense website. (MGC)
 - ❖ Identify and disseminate parent education through existing substance abuse, suicide, and violence prevention coalitions. (MDPH)
 - ❖ Engage youth-serving organizations to address problem gambling through their positive youth development/shared risk and protective factor programming.
 - ❖ Pair problem gambling information for parents with financial literacy tips, Internet safety tips, or other information that parents often seek to make the topic easier to introduce.²⁰ (MDPH)
 - ❖ Include programs that increase understanding of advertising pressures, peer pressure, and money management (Korn & Shaffer, 1999). (MDPH)
2. Evaluate and disseminate school-based curricula and problem gambling-focused peer leadership programs and afterschool curricula in communities funded to carry out substance misuse prevention.²¹ (MDPH)
3. Develop and disseminate messaging that can be shared through social media. (MDPH)

¹⁹ Priority numbers refer to the list of priority areas beginning on page 23.

²⁰ See, for example, the financial tips on the Financial First Steps website (financialfirststeps.org) and the National Center for Responsible Gaming's "Talking with Children About Gambling," available in multiple languages (<http://www.ncrg.org/public-education-and-outreach/college-and-youth-gambling-programs/talking-children-about-gambling>).

²¹ One local example is the C.A.P.S. curriculum (see <http://www.masscompulsivegambling.org/services/outreach/youth/>).

Phase 2 Activities

1. Expand the scopes of existing groups working on issues that may be affected by increased gambling (such as substance abuse, violence and suicide) to include problem gambling prevention and/or support the creation of new combined groups and coalitions as needed to increase community-level capacity to address problem gambling. (MDPH)
2. Match problem gambling prevention curricula to the state educational standards to encourage schools to adopt such programs.²² (MDPH)
 - ❖ Pilot a competitive grant program for communities with populations at higher risk, based on proximity to casinos and demographics, to receive, be trained on, implement, and evaluate the curriculum.
3. Introduce evidence-based programs²³ to increase family connections. (MDPH)
 - ❖ Pilot a competitive grant program for communities with populations at higher risk, based on proximity to casinos and demographics, to receive, be trained on, and implement the program.
4. Develop and disseminate bystander intervention campaigns aimed at college-age youth, focusing on finding resources for friends who gamble too much.²⁴ (MGC)

Strategy: Limit youth exposure to gambling promotion and access to gambling opportunities (priorities 1–3)**Phase 1 Activities**

1. Ensure that licensees²⁵ implement policies and practices designed to prevent legally underage persons from gambling and from entering designated gambling areas. (MGC)
2. Ensure that licensees provide clear signage and community education about age limits for gambling. (MGC)
3. Ensure that gambling advertising by casinos and lotteries does not contain images, symbols, celebrity/entertainer endorsements, or language designed to appeal specifically to children or

²² One curriculum that is matched with educational standards is *Facing the Odds*, designed by the DOA to teach middle school students about gambling through math and statistics.

²³ For more information on one such program, see the Strengthening Families Program website (<http://www.strengtheningfamiliesprogram.org>).

²⁴ One such resource is the National Center for Responsible Gaming website (<http://www.CollegeGambling.org>).

²⁵ The term *licensee* is used here to refer to those who receive licenses to operate a gambling venue under the Expanded Gaming Act.

minors. Ensure that casino advertising is not placed before audiences whom one would reasonably expect to comprise high numbers of youth who are below the legal age to participate in gambling activity. (MGC)

Phase 2 Activities

1. Provide Parent-Teacher Associations and other groups that interface frequently with youth with education and materials about reducing gambling fundraisers and other environmental exposure to gambling. (MDPH)
2. Provide the Lottery with examples of retailer training programs about problem gambling prevention, and encourage adoption of such programs in Massachusetts. (MGC)

Strategy: Develop and distribute culturally appropriate campaigns and services for high-risk populations (priority 2)

Phase 1 Activities

1. Target GameSense messaging to groups at higher risk for problem gambling, in terms of the people pictured, specific messages regarding motivations, and media placement. (MGC)
2. Test messages with target audiences before they are distributed. (MGC)
3. Convene an MDPH-based problem gambling Stakeholder Advisory Group that is ethnically and professionally diverse (including faith-based organizations, community health workers, and community-based organizations) and whose members have strong connections to their own cultural communities, providing stipends for advisory group members who otherwise could not participate. Engage members in doing the following: (MDPH)
 - ❖ Reviewing and informing messages and campaigns as they are developed to ensure their cultural competence
 - ❖ Assisting in testing messaging before it is widely disseminated
 - ❖ Informing programming plans to assure cultural acceptability of programs and services
 - ❖ Participating in annual reviews of population data, and considering the implications for practice in particular cultural communities
 - ❖ Participating in the review of program and campaign evaluation data to inform potential modifications
4. Institute policies and practices that include educational programs and resources for casino employees to reduce their risk of gambling-related problems. (MGC)
5. Provide technical assistance and education about problem gambling and related issues to community-based organizations that serve high-risk populations so that they may pass the

information to their clients and congregants in a linguistically and culturally appropriate manner. (MDPH)

6. Encourage the incorporation of qualitative data collection into the statewide problem gambling research agenda to better understand the specific perceptions and needs of high-risk populations and to inform the development of appropriate messaging. (MDPH)

Strategy: Provide safeguards for all gamblers to reduce the risk of overplaying and experiencing financial and health consequences (priorities 2 and 6)

Phase 1 Activities

1. Allow casinos to extend credit to gamblers only in accordance with the MGC recommendations and the Responsible Gaming Framework. (MGC)
2. Ensure that licensees locate ATM services at least 15 feet from gaming areas. (MGC)
3. Ensure that licensees develop and implement a system of internal controls relative to the acceptance of checks presented by patrons for gaming purposes. (MGC)
4. Ensure that licensees provide play-management tools that include limit setting, where players can voluntarily choose to set time limits, loss limits, and/or win limits, and to receive pop-up reminders to help them stay within their pre-determined limits. (MGC)
5. Encourage breaks in play by working with licensees to offer amenities, including hospitality services and non-gaming forms of entertainment in areas where gambling is provided, and to display clocks in prominent locations in the gaming area to help patrons track the passage of time. (MGC)
6. Ensure that both responsible gambling messages and problem gambling signs and symptoms are displayed throughout casinos and slots parlors according to the guidelines included in the Responsible Gaming Framework. (MGC)
7. Ensure that each gaming establishment provides on-site space for player education services staffed by third-party vendors contracted through MGC. (MGC)
8. Work with licensees to limit smoking in all enclosed areas of the gaming establishment, and prohibit the use of e-cigarettes in accordance with local regulations. (MGC)
9. Work with local health departments to limit the use of e-cigarettes where casinos and slots parlors will be located. (MDPH)
10. Ensure that licensees (1) escort visibly intoxicated persons from the gaming area, (2) use a recognized training program for beverage servers, security, valet attendants, and other personnel to reduce potential harm caused by intoxicated patrons, (3) prohibit the distribution of alcoholic

beverages to visibly intoxicated persons, (4) prohibit the distribution of alcoholic beverages to all persons between, at a minimum, the hours of 2 a.m. and 8 a.m., and (5) do not let a visibly intoxicated person drive away from a licensee’s establishment. (MGC)

Phase 2 Activities

1. Make GameSense messaging consistent across gaming platforms (both the Lottery and MGC-regulated casinos). (MGC)
2. Educate credit counseling services about problem gambling, and work with Certified Financial Planners to support gamblers. (MDPH)

SCREENING AND REFERRAL (to prevent progression to more severe problem gambling)

Strategy: Provide professionals who interact with high-risk groups with the tools and resources needed to offer consistent problem gambling screening and referral (priorities 4, 5, and 7)

Phase 1 Activities

1. Choose a single brief screening tool to use across agencies. (MDPH)
 - ❖ Review and decide between various tools, such as (1) the Brief Biosocial Gambling Screen,²⁶ followed by a clinical interview guided by the DSM-V gambling disorder criteria, (2) the National Opinion Research Center Diagnostic Screen—Control, Lying, and Preoccupation,²⁷ (3) the Problem Gambling Severity Index short form,²⁸ and (4) the Lie-Bet screening tool for gambling.²⁹
2. Provide a single brief screening tool along with education on the basics of problem gambling, co-morbidities, motivational interviewing, elements of mental health first aid, the statewide

²⁶ This tool can be found on the National Center for Responsible Gaming website (http://www.ncrg.org/sites/default/files/uploads/imgs/ncrg_bbsg_magnet2.pdf).

²⁷ This tool can be found in the appendix to “A Quick and Simple Screening Method for Pathological and Problem Gamblers in Addiction Programs and Practices” (Volberg, Munck, & Petry, 2011), which is available on the National Center for Biotechnology Information website (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3076109/>).

²⁸ This tool is available on the website of the Problem Gambling Institute of Ontario (<https://www.problemgambling.ca/EN/ResourcesForProfessionals/pages/problemgamblingseverityindexpgsi.aspx>).

²⁹ The Lie-Bet tool can be downloaded from the Delaware Council on Gambling Problems website (www.dcgp.org/pdfs/7%20-Lie%20Bet%20Test.pdf).

gambling Helpline, the importance of referrals, common comorbidities, and how and where to best make referrals through professional organizations to the following groups:³⁰ (MDPH)

- ❖ Primary care providers
 - ❖ Emergency healthcare providers
 - ❖ Substance abuse treatment providers
 - ❖ Mental health professionals
 - ❖ Corrections staff
 - ❖ School nurses
 - ❖ College health services
 - ❖ Faith organizations
 - ❖ Youth workers
 - ❖ Financial planners
 - ❖ Debt counselors
 - ❖ Community health workers in at-risk communities
 - ❖ Established Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs
3. Develop sample guidelines for organizations and institutions who initiate problem gambling screening that include the following: (MDPH)
 - ❖ Integration of screening into existing educational programs
 - ❖ Screening at multiple points in time
 - ❖ Policies that allow those who screen positive to continue receiving services
 - ❖ A detailed protocol for referral and follow-up
 4. Develop recommendations and agreements that include screening as part of standard intake and/or later in the treatment process at as many settings as possible. (MDPH)
 5. Ensure that licensees develop customer assistance policies and practices to offer aid to any patron in need, with emphasis placed on developing training, procedures, and evaluation methods for assisting those with a suspected gambling problem (in connection with the GameSense Information Center at Plainridge Park Casino). (MGC)

³⁰ For guidance on brief interventions, see *Brief Intervention Guide: Addressing Risk and Harm from Alcohol, Other Drugs and Gambling* (Matua Raki, 2012).

6. Ensure that all casino employees participate in MGC-approved responsible gambling employee training programs. (MGC)
7. Regularly screen casino employees regarding their risk for, and experience of, the signs and symptoms of gambling disorder. (MGC)
8. Ensure that licensees provide employees with clear statements of expectations and responsibilities, including an emphasis on the importance of employees in promoting responsible gambling and creating a healthy gaming environment. (MGC)
9. Ensure that within the GameSense Information Center at each casino, licensees designate an office for private meetings between patrons with concerns related to their gambling, and that MGC provides counselors or other staff trained in crisis intervention, mental health triage, facilitated referrals for treatment, and the facilitation of a self-exclusion process. (MGC)

Phase 2 Activities

1. Provide education and screening tools through appropriate avenues to Employee Assistance Programs, unions, financial aid counselors on college campuses, courts, credit card counselors, incarcerated populations, prisoner re-entry programs, Department of Children and Families staff, financial counselors and advisors, Coordinated Care Organizations, Court Appointed Special Advocates (Office of Victims Assistance), casino staff, Lottery retailers, the Treasurer's office, and all frontline staff at EOHHS agencies. (MDPH)

Strategy: Evaluate and explore potential enhancements to the current statewide gambling Helpline (priorities 4, 5, 7, and 8)

Phase 1 Activities

1. Explore potential advantages, disadvantages, and mechanisms for connecting the statewide gambling Helpline to the Massachusetts Substance Abuse Helpline. (MDPH)
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). (MDPH)
3. Explore mechanisms for increasing the number of languages in which the gambling Helpline can be operated. (MDPH)

Strategy: Increase the readiness and capacity of organizations already working in related fields (substance abuse, violence, suicide, etc.) to address problem gambling (priorities 4 and 5)

Phase 1 Activities

1. Identify organizations and coalitions in host communities and surrounding communities that are devoted to issues that may be affected by increased gambling or the presence of casinos and hotels (e.g., violence, suicide, human trafficking, obesity, substance use, asthma), and work with them to build their capacity to concurrently prevent and address problem gambling. (MDPH)
 - ❖ Provide information about comorbidities, prevention, screening, referrals, and disease etiology for problem gambling.
2. Create a map of existing resources and programs in host communities, in surrounding communities, and throughout the state that are dedicated to working on issues that have been correlated with problem gambling or have been associated with increased gambling. (MDPH)
 - ❖ Use the resource map to identify geographical and cultural communities that do not have sufficient resources to work on problem gambling and related issues.
3. Strengthen the capacity of substance abuse treatment providers; mental health professionals who see patients for depression, anxiety, and other commonly co-occurring disorders; and those who work in domestic violence organizations and financial institutions to screen and make appropriate referrals for individuals and families who might be dealing with a gambling disorder. (MDPH)
 - ❖ Connect with professional organizations to offer education about problem gambling.

Strategy: Provide the friends and families of people who have a gambling disorder with information and tools to help their loved ones connect with the supports they need (priorities 6 and 7)

Phase 1 Activities

1. Make screening, referral, and support group information available to the general population through awareness campaigns, both in print and online. (MGC)
2. Adapt bystander intervention techniques from other fields to apply to problem gambling. (MGC)

Phase 2 Activities

1. Disseminate bystander intervention campaigns and information to the loved ones and friends of people with a gambling disorder through the statewide gambling Helpline, population-wide campaigns, and campus student health services, and evaluate the impact of these campaigns. (MDPH)

Strategy: Provide tools that include self-screening to help gamblers understand their own play patterns (priorities 2, 6, and 7)

Phase 1 Activities

1. Ensure that licensees offer self-screening tools that provide patrons with access to cost-of-play messaging; monthly statements that include the patron’s total bets, wins, and losses; tips on keeping play manageable; educational quizzes; and information on how to access assistance. (MGC)
2. Disseminate online self-help materials, such as “Your First Step to Change,” a self-assessment tool.³¹ (MDPH)

**TREATMENT
(to prevent more serious consequences)**

Strategy: Identify gaps in the current treatment and reimbursement system, and develop a plan to address them (priorities 4 and 5)

Phase 1 Activity

1. Assess the current BSAS system for treatment and treatment reimbursement to identify gaps. (MDPH)
2. Determine what is necessary to develop and pilot a flexible, responsive, and timely treatment and reimbursement process for problem gambling. (MDPH)
 - ❖ Consider basing the process, in part, on the successful models currently in place in other states.³²
 - ❖ Incorporate outreach to potential clients, treatment service provision, data reporting, and follow-up care.
 - ❖ Explore ways to incentivize clinicians to increase problem gambling screening or enrollment.
 - ❖ Thoroughly evaluate all interventions to assess the efficacy and cost-effectiveness of each approach and the feasibility of scaling and replication.

³¹ This tool is available on the EOHHS website (www.mass.gov/eohhs/docs/MDPH/substance-abuse/gambling-self-assessment-en.pdf).

³² States whose models were mentioned by stakeholders include California, Connecticut, and North Carolina.

- ❖ Consider the best mechanisms for providing clinical training, certification, and clinical supervision for problem gambling treatment providers.

Strategy: Increase the visibility of services for problem gambling and related issues among gamblers and their loved ones (priorities 6 and 7)

Phase 1 Activities

1. Include gambling Helpline information and referral options on the GameSense website. (MGC)
2. Ensure that within gambling marketing and advertising, responsible gambling messages and/or the toll-free gambling Helpline number are prominently displayed, in a font that is proportionate to the rest of the message, and that advertisements make no false or misleading claims. (MGC)
3. Encourage organizations that employ a problem gambling treatment provider who has completed the Massachusetts Problem Gambling Specialist certification to advertise and publicize this service. (MDPH)
4. Test, adapt, and distribute (in coordination with the GameSense initiative) public awareness campaigns targeting friends and family³³ for the general public, for college-age youth, and for other at-risk populations. (MDPH and MGC)
5. Share information with trained treatment providers and families of people with gambling problems regarding voluntary and involuntary self-exclusion programs that are available to assist patrons who recognize that they have experienced a loss of control over their gambling and wish to invoke external controls. (MGC)
 - ❖ Licensees will inform the public and make available to patrons three forms of self-exclusion: the ability to opt out of marketing lists, the option to be banned from receiving house credit and/or check-cashing privileges, and voluntary exclusion from MGC-licensed gambling venues statewide.

Strategy: Provide alternatives to clinical treatment to reduce the social stigma associated with accessing treatment (priority 6)

Phase 1 Activities

1. Explore the effectiveness and cost-effectiveness³⁴ of alternative treatment models, and choose one or more to introduce in Massachusetts. (MDPH)

³³ Campaigns targeting friends and family can be found in Oregon and within MCCG's current and past messaging (see <http://www.masscompulsivegambling.org/get-help/help-for-family-members/>).

Strategy: Increase the number of providers who are eligible to bill the state for treatment, and work with insurers to make reimbursement for problem gambling more feasible (priorities 4 and 7)

Phase 1 Activities

1. Help mental health clinicians become eligible to be able to bill the state by increasing the number of certificate trainings offered and by publicizing and facilitating training opportunities through stipends or alternate online formats. (MDPH)
2. Convene insurers to talk about problem gambling treatment reimbursement, including billing codes that can be reimbursed and the possibility of screening for problem gambling post-intake during the treatment process. (MDPH)

Phase 2 Activities

1. Help mental health clinicians become eligible to bill the state by providing stipends for training. (MDPH)

RECOVERY SUPPORT (to prevent relapse)

Strategy: Diversify and increase the number of recovery support groups available in Massachusetts (priorities 6–8)

Phase 1 Activities

1. Support research that will lead to multiple recovery support options, including reviewing successful models from other states, local testing and evaluation of distance support, and development and evaluation of non-abstinence-focused recovery support groups. (MDPH)
2. Develop and disseminate messaging conveying that clinical treatment is not the only way to address problem gambling. (MDPH)
3. Offer guidance and resources for people interested in starting additional Gamblers Anonymous, Bettors Anonymous, and Debtors Anonymous meetings. (MDPH)
4. Explore options for diverse recovery support, and choose models to introduce in Massachusetts, for example: (MDPH)

³⁴ Examples of such programs include GamTalk (an online community for people with gambling issues), the Iowa distance treatment model (read more on this at https://idph.iowa.gov/Portals/1/Files/IGTP/problem_gambling_srvs.pdf), and peer recovery coaches.

- ❖ Explore examples of smartphone apps, phone support, and peer support.
- ❖ Explore the appropriateness for Massachusetts of fellowship groups, such as the GamTalk online support community, Rational Recovery, the Buddhist Recovery Network, and the Harm Reduction, Abstinence, and Moderation Support Network.

Phase 2 Activities

1. Introduce technological and interpersonal supports for recovery outside of support groups. (MDPH)
2. Establish fellowship groups to provide group support to people at all stages of recovery, even if they are not abstinent. (MDPH)

Strategy: Reduce the ambient presence of visual and auditory triggers for people in recovery from a gambling disorder (priorities 2 and 6)

Phase 1 Activities

1. Assure that all GameSense prevention and responsible gambling messaging does not include gambling triggers. (MGC)
2. Work with licensees to reduce triggers in their advertisements. (MGC)
 - ❖ Consider incorporating a requirement to reduce gambling triggers into the Responsible Gaming Framework.

DATA COLLECTION (to support health surveillance and the ongoing monitoring and evaluation of services)

Strategy: Expand and institutionalize surveillance systems to monitor problem gambling behaviors³⁵ (priorities 9 and 10)

Phase 1 Activities

1. Work with the Massachusetts Department of Elementary and Secondary Education to include consistent problem gambling questions in the Massachusetts Youth Risk Behavior Survey and/or the Youth Health Survey. (MDPH)

³⁵ Other related issues will also be monitored, described in more detail beginning on page 58.

2. Encourage local coalitions to use an adapted version of the two-page community health survey developed by BSAS and UMass to gather local problem gambling data. (MDPH)
3. Ensure that the statewide gambling Helpline is able to collect consistent demographic information. (MDPH)
4. Collect and review media campaign evaluation data, services output and impact data, and other social and economic indicator information (including all indicators listed in the Problem Gambling Outcome Evaluation Plan on page 72) as it becomes available. (MDPH)
5. Encourage licensees to establish policies and practices to gather customer comments and respond to customer complaints. (MGC)
6. Encourage licensees to regularly engage with parties interested in problem gambling and responsible gaming issues, both formally and informally, and to periodically report activities to MGC. (MGC)
7. Develop a plan to store and manage gambling-related data. (MDPH)

Strategy: Evaluate all problem gambling messaging and services (priorities 9 and 10)

Phase 1 Activities

1. Include funding for prevention and service evaluation in all prevention and service grants; require strong data collection and regular data reporting.³⁶ (MDPH)
2. Ensure strong testing and evaluation of the following: (MGC and MDPH)
 - ❖ Campaign messages, with both the general population and target populations
 - Require that all gambling-related messages be tested in advance with their target populations (including hard-to-reach high-risk populations).
 - Measure the cultural acceptability of messages.
 - Evaluate awareness of campaigns and the information they contain.
 - Measure campaigns’ success at reaching their target populations (particularly the hard-to-reach high-risk populations).
 - Measure awareness and understanding of the messages being disseminated.
 - Measure campaigns’ impact on behavior change.
 - ❖ Prevention programs
 - Measure both outputs and outcomes.

³⁶ Data reporting is mandated in other areas. For one example of treatment data reporting guidelines, see *Five Year Strategic Plan for Problem Gambling Treatment Services Within the State of Nevada* (Nevada Department of Health and Human Services, 2014).

- ❖ Screening efforts
 - Evaluate MDPH vendor screening efforts.
- ❖ Referral services
 - Evaluate gambling Helpline reach and effectiveness.
 - Assess and monitor independent mental health providers' process and practice for referrals.
 - Assess and monitor diverse professionals' screening procedures.
- ❖ Recovery services
 - Assess compliance with the BSAS gambling-free guidelines.
 - Evaluate effectiveness of gambling recovery programs.
- ❖ Treatment services
 - Establish and implement program reviews, program audits, and/or treatment fidelity checks for treatment providers.
- ❖ Professional development initiatives
 - Assess the reach and the effectiveness of professional development.
 - Assess the impact of professional development on screening and referral rates.
- ❖ MGC's Responsible Gaming Framework
 - Develop a checklist for monitoring compliance with the recommendations and regulations in MGC's Responsible Gaming Framework.
 - Enforce the responsible gaming regulations and encourage adoption of the policies endorsed in the Framework.
 - Ensure that licensees effectively implement policies and practices property-wide in accordance with the Framework by conducting internal audits, surveying employees, and reviewing relevant data, on a regular basis, with a Responsible Gaming Committee.
 - Detail a systematic approach to measuring and reporting on each licensee's commitments, actions, and progress on responsible gaming practices.

Strategy: Incorporate questions relevant to service design and delivery that are not answered by current research into the Gambling Research Advisory Committee (GRAC) research agenda (priority 9)

Phase 1 Activities

1. Encourage qualitative data collection to complement quantitative data collection—to clarify questions and to learn deeper, more nuanced information about groups and issues that is difficult to access and assess through traditional survey techniques. (MDPH and MGC)

2. Incorporate relevant questions into the gaming research agenda, for example: (MDPH and MGC)
 - ❖ Why are people not accessing traditional treatment?
 - ❖ What are providers' objections and barriers to providing and billing for problem gambling screening and treatment?
 - ❖ What can we learn about the Asian, Hispanic, and veteran populations that is relevant to problem gambling prevention and service provision?
 - ❖ Are there specific ethnic or racial groups other than African American, Asian, and Hispanic who are at increased risk for problem gambling?
 - ❖ What supports are people in recovery from gambling disorder getting, and what are they lacking?
 - ❖ What puts particular groups (e.g., prisoners, truckers, people who have experienced major losses in their life, people who have had a big win early in their gambling experience) at high risk for problem gambling, and how can we best reach them with prevention and services?
 - ❖ Who is currently in treatment (how many people and from what demographics), and which clinicians are involved?
 - ❖ How strongly are other health concerns associated with the expansion of legalized gambling, and how are the issues connected?
 - ❖ How does lottery gambling compare to casino gambling?
 - ❖ Are older adults, veterans, and ethnic minorities disproportionately affected by problem gambling in Massachusetts?

Strategy: Establish a regular process by which the findings of all research activities will inform the development of appropriate prevention programs and interventions (priorities 4, 9, 10, and 11)

Phase 1 Activities

1. Schedule regular sessions for data review, and specify who will participate. (MDPH and MGC)
2. Schedule sessions for gathering input regarding changes and additions to services based on the new data; establish a schedule to update the Strategic Plan every two years. (MDPH and MGC)
3. Facilitate a yearly roundtable discussion for members of host communities and other stakeholders to learn about findings. (MDPH and MGC)
4. Facilitate Regional Provider Meetings as a way to get input on the enhancement of services based on new data. (MDPH)

INFRASTRUCTURE AND CAPACITY BUILDING

(to support successful implementation of the Strategic Plan)

Strategy: Explore the utility of and the potential process for establishing an Inter-Agency Task Force on Problem Gambling to connect with and coordinate work among EOHHS agencies (priorities 4, 5, and 11)

Phase 1 Activities

1. Learn about each of the other executive offices and their connections to the issue. (MDPH and MGC)
2. Learn about the roles and processes of other Inter-Agency Councils. (MDPH)

Strategy: Create systems to collect, safely store, and analyze data about problem gambling and its associated harms (priorities 9–11)

Phase 1 Activities

1. Develop MOUs and sharing procedures with agencies and institutions that collect data related to problem gambling and its associated harms (including MGC, UMass Amherst, police, crime analysts, bankruptcy courts, and domestic violence organizations). (MDPH)
2. Establish an electronic database or other system to securely house all data related to gambling behavior and gambling-related harms. (MDPH)
3. Establish a procedure for yearly data analysis by MDPH or an outside vendor. (MDPH)
4. Establish a procedure for updating the Strategic Plan every two years in response to changes in the data. (MDPH and MGC)
5. Establish a procedure for yearly review of the security of the data. (MDPH and MGC)

Strategy: Increase the readiness and capacity of prevention professionals in related fields (substance abuse, violence, suicide, etc.) to address problem gambling (priorities 4 and 5)

Phase 1 Activities

1. Educate the prevention workforce about comorbidities and shared risk and protective factors between substance misuse, violence, depression, anxiety, suicide, and problem gambling. (MDPH)
2. Incorporate problem gambling into BSAS-funded substance abuse, violence, and suicide prevention coalitions' scopes of work in upcoming requests for proposals (RFPs). (MDPH)

3. Provide technical assistance and written guides to support the incorporation of problem gambling content into coalitions' work. (MDPH)
4. Maintain the five renewal hours of problem gambling training required for Massachusetts Certified Prevention Specialists (professionals working in prevention of any issue, most often substance abuse), and integrate problem gambling into the primary certification requirements for Certified Prevention Specialists. (MDPH)

Strategy: Increase the capacity of current substance abuse treatment providers and institutions to incorporate problem gambling into their work (priorities 5 and 7)

Phase 1 Activities

1. Educate all BSAS-funded program staff about the basics of problem gambling, co-morbidities with substance misuse, best practices in problem gambling treatment,³⁷ and standardized screening and documentation tools to use in community settings, during clinical intakes, and over the course of the treatment. (MDPH)
2. Establish a centralized and accessible online forum for clinicians to share practical resources and experiences related to treating problem gambling, including discussion of group counseling techniques. (MDPH)
3. Strengthen knowledge and enforcement of the BSAS gambling-free guidelines among prevention coalitions, substance abuse treatment facilities, and recovery centers. (MDPH)
 - ❖ Incorporate the guidelines into licensing requirements for all BSAS grantees.
 - ❖ Establish an enforcement checklist for regional managers to use to assess compliance.

Phase 2 Activities

1. Provide stipends so that substance abuse treatment providers can be trained and receive certification in problem gambling treatment, with a focus on increasing the number of providers who are eligible to bill the state for treatment services. (MDPH)
2. Explore models from other states for how a problem gambling treatment specialist could be hired and maintained by organizations despite a variable caseload (e.g., by doing active outreach when not seeing clients). (MDPH)

³⁷ Although there is no clear evidence indicating that one type of therapy is most effective in treating problem gambling, the use of Feedback Informed Therapy may improve client outcomes regardless of the specific treatment method being used (Haupt et al., 2015).

Strategy: Track the linguistic and cultural capacity of the problem gambling workforce, and train diverse professionals as problem gambling treatment providers to fill the gaps (priority 8)

Phase 1 Activities

1. Capture and track the cultures of and languages spoken by the providers available for referral by the statewide gambling Helpline. (MDPH)
2. Actively recruit more diverse mental health providers to attend trainings on problem gambling treatment by reaching out to them and offering stipends for their participation and completion of problem gambling treatment certificates.³⁸ (MDPH)
3. Train existing community health workers to screen and refer people who may have a gambling disorder. (MDPH)

Phase 2 Activities

1. Provide cultural competence training for substance abuse and problem gambling treatment providers, aligning efforts with MDPH's Culturally and Linguistically Appropriate Services initiative.³⁹ (MDPH)

Strategy: Ensure that recovery support centers provide supportive services and environments for both people with a gambling disorder and those recovering from substance misuse, through mandates and community advocacy (priorities 5 and 6)

Phase 1 Activities

1. Train all recovery centers on the BSAS Gambling-Free Policy Guidelines, and enforce adherence to them. (MDPH)
2. Ensure that recovery centers are inclusive of people in recovery from any addiction, and help build their capacity to host problem gambling-specific support groups. (MDPH)

Strategy: Expand programs to educate financial professionals about problem gambling and related issues, and provide re-entry support for people who have experienced a gambling disorder who are leaving corrections (priority 7)

³⁸ This requires funding but nonetheless should be included in Phase 1 in order to build workforce capacity ahead of increased demand.

³⁹ Information about this MDPH initiative can be found on the U.S. Office of Health and Human Services website (<http://minorityhealth.hhs.gov/omh/content.aspx?lvl=3&lvlID=23&ID=10209>).

Phase 1 Activities

1. Develop Offender Re-Entry Programs in collaboration with corrections, the courts, and other partners.⁴⁰ (MDPH)
2. Support efforts to connect with financial institutions, credit counselors, bankruptcy lawyers, and others who can help gamblers avoid complex financial consequences. (MDPH)
3. Publicize services to help gamblers with complex financial issues. (MDPH)

Phase 2 Activities

1. Build on and expand efforts to connect with financial institutions, credit counselors, bankruptcy lawyers, and others who can help people with gambling problems avoid complex financial consequences. (MDPH)

Strategy: Increase the availability of culturally diverse recovery coaches and cultural ambassadors (priority 8)

Phase 1 Activities

1. Help current BSAS contractors who serve populations at high risk for problem gambling to build their recovery coaching capacity. (MDPH)
2. In an effort to increase diversity among members of the statewide recovery advisory board, provide stipends for those who otherwise could not participate. (MDPH)

Phase 2 Activities

1. Recruit, hire, and train culturally diverse peer recovery coaches. (MDPH)
 - ❖ Work closely with the Massachusetts Association of Community Health Workers to ensure that problem gambling recovery coaching is done in a way that is appropriate for each cultural community.⁴¹

Strategy: Create templates and procedures that will support the successful enhancement and implementation of services (priority 11)

Phase 1 Activities

⁴⁰ More information on these programs is available on the MCCG website (www.masscompulsivegambling.org/services/workforce-development/).

⁴¹ Rhode Island's Substance Abuse Recovery Coach model (<http://ripr.org/post/mass-public-health-looks-rhode-island-overdose-prevention-model>) is one possible guide.

1. Develop membership and recruitment materials for a Stakeholder Advisory Group. (MDPH)
2. Develop RFP templates or language to add to existing RFPs to fund evaluation of problem gambling services. (MDPH)
3. Establish procedures for ongoing collaboration with GameSense developers and all EOHHS agencies and outside partners who will be involved in Strategic Plan activities. (MDPH)

Strategy: Maintain and enhance human and programmatic capacity to implement this Strategic Plan (priority 11)

Phase 1 Activities

1. Develop a workplan for the Director of Problem Gambling based on this Strategic Plan that indicates timelines and who will be responsible for carrying out each strategy; include outreach to other EOHHS commissioners regarding their involvement in the Strategic Plan. (MDPH)
2. Add the following to appropriate job descriptions within MDPH: (MDPH)
 - ❖ The establishment and regular convening of a problem gambling Stakeholder Advisory Group to inform cultural competency efforts
 - ❖ The establishment and oversight of a collection, storage, and analysis process for gambling-related data
3. Ensure sustained and/or increased funding for work regarding problem gambling and related issues. (MDPH)
4. Provide funding and technical assistance to problem gambling service vendors to develop evaluation plans for each of their ongoing initiatives. (MDPH)
5. Use problem gambling service vendors for capacity-building efforts across all EOHHS agencies. (MDPH)
6. Involve problem gambling service vendors in the organization and/or use of a Stakeholder Advisory Group with MDPH. (MDPH)
7. Clarify and/or formalize which entities should provide clinical training, certification, and clinical supervision for gambling disorder treatment providers. (MDPH and MGC)

OTHER RELATED ISSUES

Strategy: Institutionalize surveillance systems to monitor the prevalence of other potentially related issues (priorities 9 and 10)

Phase 1 Activities

1. Receive and incorporate data related to issues that may increase due to increased legalized gambling (such as sexual and domestic violence, sexual trafficking, suicide, substance use, obesity, traffic, asthma, occupational health concerns, neglect, and economic challenges); data sources include SEIGMA, MAGIC, established DPH data collection mechanisms, and crime data. (MGC and MDPH)

Strategy: Establish a working group to identify appropriate individual and environmental strategies and community-level interventions to address harms associated with gambling that emerge from the surveillance data (priorities 2, 3, and 11)

Phase 1 Activities

1. Determine whether the working group should have the same membership as the Executive Committee of the PHTF. (MDPH and MGC)
2. Establish a schedule for the group to review data related to problem gambling and related issues. (MDPH and MGC)
3. Establish a process by which the group would deem an issue worthy of being addressed by the PHTF and a process for identifying potential strategies. (MDPH and MGC)
4. Specify how the group would bring ideas to the PHTF and/or to MDPH for consideration and possible implementation. (MDPH and MGC)

Strategy: Develop awareness campaigns that cross the boundaries between problem gambling and commonly co-occurring disorders (priorities 5 and 6)

Phase 1 Activities

1. Develop and disseminate messaging that addresses needs or risk and protective factors for comorbid conditions, not just for problem gambling specifically. (MDPH)

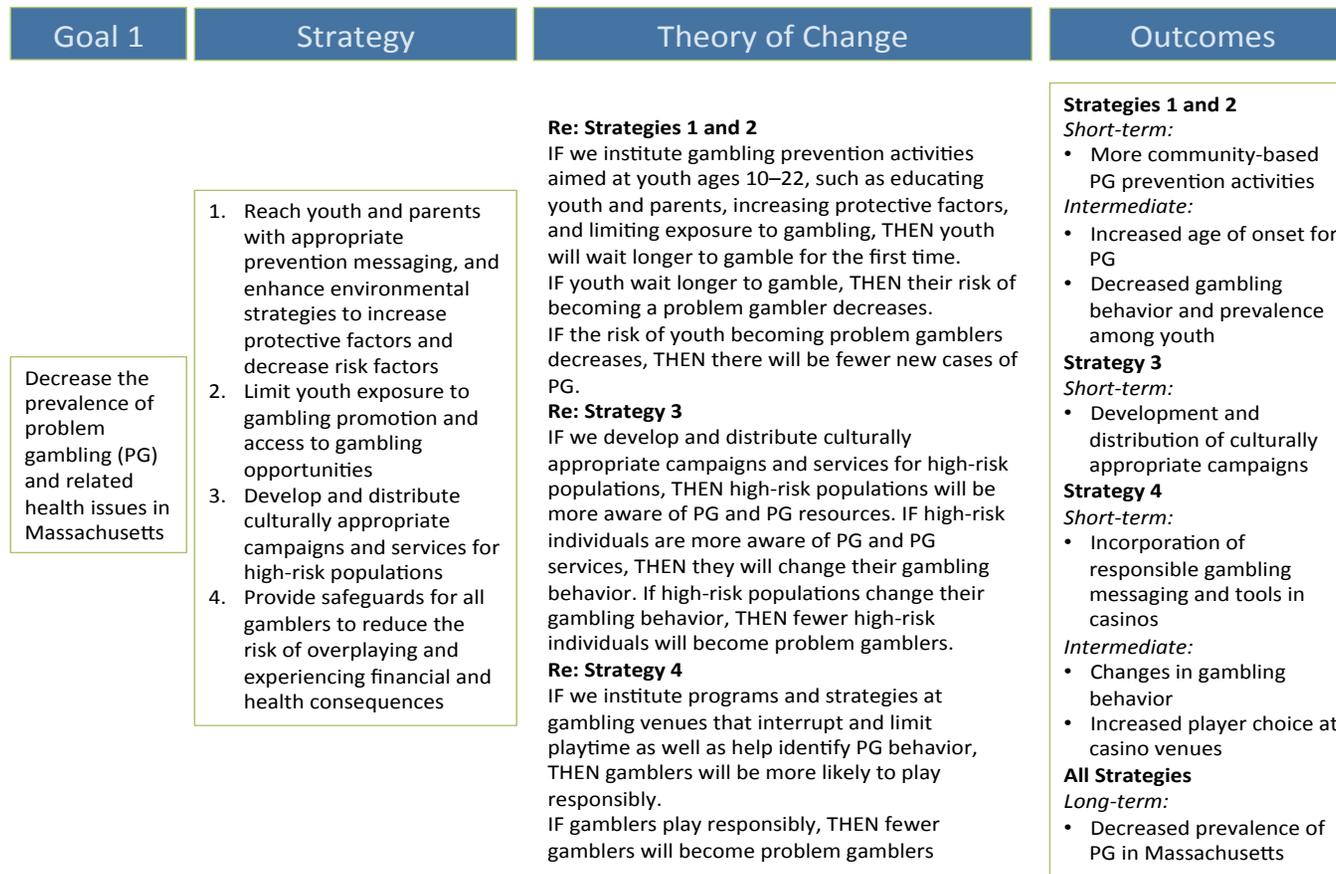
MONITORING, EVALUATION, AND ONGOING ASSESSMENT

Evaluation Logic Model

A *logic model* is a systematic, visual way to represent the major components of an implementation plan and their relationship to one another. It can help to ensure that strategies and activities are linked to goals and their intended outcomes.

As previously noted, the recommendations in this Strategic Plan are designed to address six major goals (see page 38). Figure 3: Problem Gambling Services Strategic Plan Logic Model shows the six goals (column 1), specific strategies planned to achieve each goal (column 2), the theory of change that supports use of the strategies (column 3), and the short- and long-term outcomes anticipated from implementing these strategies (column 4). Figure 4: Problem Gambling Services Logic Model Graphic is another representation that graphically shows how the strategies and activities—within each category of the Continuum of Services—relate to the outcomes.

Figure 3: Problem Gambling Services Strategic Plan Logic Model



Goal 2	Strategy	Theory of Change	Outcomes
<p>Increase the number of high-risk individuals who receive screening for PG</p>	<ol style="list-style-type: none"> 1. Provide professionals who interact with high-risk groups with the tools and resources needed to offer consistent problem gambling screening and referral 2. Evaluate and explore potential enhancements to the current statewide gambling Helpline 3. Increase the readiness and capacity of organizations already working in related fields (substance abuse, violence, suicide, etc.) to address PG 4. Provide the friends and families of people who have a gambling disorder with information and tools to help their loved ones connect with the supports they need 5. Provide tools that include self-screening to help gamblers understand their own play patterns 	<p>IF we increase the capacity of professionals and gamblers to screen for PG, especially those who interact with high-risk groups, and provide them with the tools and knowledge to screen and refer, THEN professionals will become more aware of and comfortable with PG tools and issues. IF professionals and individuals become more aware of and comfortable with PG tools and issues, THEN they will conduct more screenings and referrals for PG.</p>	<p><i>Short-term:</i></p> <ul style="list-style-type: none"> • More providers screening for PG • Increased number of high-risk individuals receiving screening <p><i>Intermediate:</i></p> <ul style="list-style-type: none"> • More problem gamblers identified <p><i>Long-term:</i></p> <ul style="list-style-type: none"> • Decreased prevalence of PG and fewer negative consequences

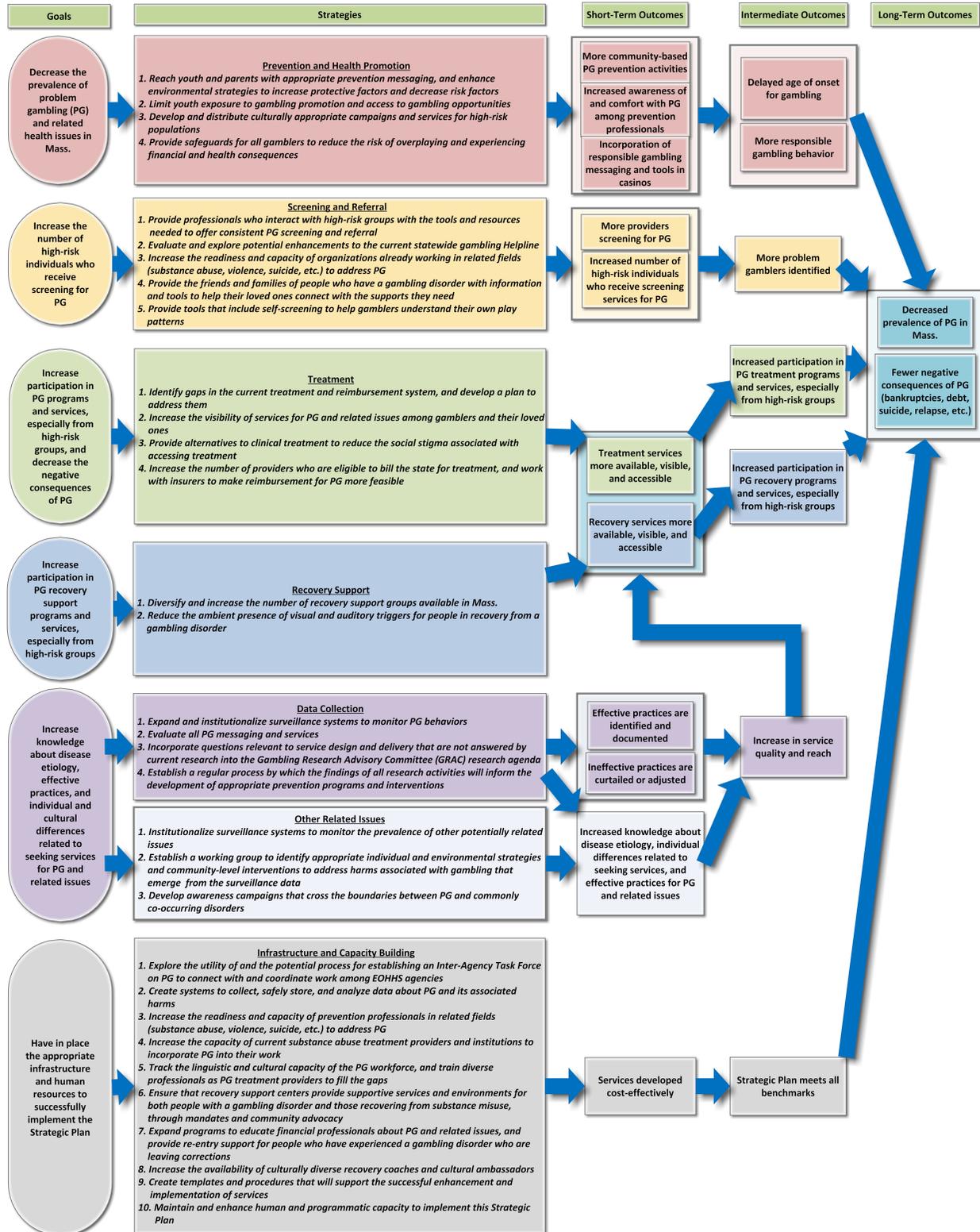
Goal 3	Strategy	Theory of Change	Outcomes
<p>Increase participation in PG programs and services, especially from high-risk groups, and decrease the negative consequences of PG</p>	<ol style="list-style-type: none"> 1. Identify gaps in the current treatment and reimbursement system, and develop a plan to address them 2. Increase the visibility of services for PG and related issues among gamblers and their loved ones 3. Provide alternatives to clinical treatment to reduce the social stigma associated with accessing treatment 4. Increase the number of providers who are eligible to bill the state for treatment, and work with insurers to make reimbursement for PG more feasible 	<p>IF we provide a wide array of programs and services designed to meet the needs of various populations of problem gamblers (e.g., hard-to-reach high-risk gamblers, problem gamblers at risk of relapse), increase their visibility with target populations, and make it easier for providers to bill for PG, THEN more problem gamblers and their loved ones, especially from high-risk groups, will be aware of and participate in those programs and services for themselves and their loved ones.</p> <p>IF more problem gamblers and their loved ones are aware of and have access to programs and services, THEN more people affected by PG will seek appropriate services.</p> <p>IF more people affected by PG seek appropriate services, THEN they will experience fewer negative consequences of PG.</p>	<p><i>Short-term:</i></p> <ul style="list-style-type: none"> • More available, visible, and accessible treatment and recovery services <p><i>Intermediate:</i></p> <ul style="list-style-type: none"> • Increased participation in PG programs and services, especially from high-risk groups <p><i>Long term:</i></p> <ul style="list-style-type: none"> • Decreased prevalence of PG • Decreased negative consequences of PG (bankruptcies, debt, suicide, relapse, etc.)

Goal 4	Strategy	Theory of Change	Outcomes
<p>Increase participation in PG recovery support programs and services, especially from high-risk groups</p>	<ol style="list-style-type: none"> 1. Diversify and increase the number of recovery support groups available in Massachusetts 2. Reduce the ambient presence of visual and auditory triggers for people in recovery from a gambling disorder 	<p>IF we provide a wide array of programs and services designed to meet the needs of various populations of problem gamblers (e.g., hard-to-reach high-risk gamblers, problem gamblers at risk of relapse), THEN more problem gamblers and their loved ones, especially from high-risk groups, will be aware of and participate in those programs and services for themselves and their loved ones.</p> <p>IF more problem gamblers and their loved ones are aware of and have access to programs and services, THEN more people affected by PG will seek appropriate services.</p> <p>IF more people affected by PG seek appropriate services, THEN they will experience fewer negative consequences of PG.</p>	<p><i>Short-term:</i></p> <ul style="list-style-type: none"> • More varied and accessible treatment and recovery services • Reduced triggers for people in recovery from gambling disorders <p><i>Intermediate:</i></p> <ul style="list-style-type: none"> • Increased participation in PG programs and services, especially from high-risk groups • Decreased relapse risk <p><i>Long term:</i></p> <ul style="list-style-type: none"> • Decreased prevalence of PG • Decreased negative consequences of PG (bankruptcies, debt, suicide, relapse, etc.)

Goal 5	Strategy	Theory of Change	Outcomes
<p>Increase knowledge about disease etiology, effective practices, and individual and cultural differences related to seeking services for PG and related issues</p>	<ol style="list-style-type: none"> 1. Expand and institutionalize surveillance systems to monitor PG behaviors 2. Evaluate all PG messaging and services 3. Incorporate questions relevant to service design and delivery that are not answered by current research into the Gambling Research Advisory Committee (GRAC) research agenda 4. Establish a regular process by which the findings of all research activities will inform the development of appropriate prevention programs and interventions <ol style="list-style-type: none"> 1. Institutionalize surveillance systems to monitor the prevalence of other potentially related issues 2. Establish a working group to identify appropriate individual and environmental strategies and community-level interventions to address harms associated with gambling that emerge from the surveillance data 3. Develop awareness campaigns that cross the boundaries between problem gambling and commonly co-occurring disorders 	<p>IF we support research on PG and related issues, evaluation of all interventions, and translation of research into practice, THEN knowledge about disease etiology, individual differences related to seeking services, and effective practices will be gained; in addition, interventions will be modified regularly, and effective interventions will be documented.</p> <p>IF we gain knowledge about disease etiology, individual differences related to seeking services, and effective practices, and modify services regularly, THEN services can be tailored to the needs of specific populations, and service quality and reach will be enhanced.</p>	<p><i>Short-term:</i></p> <ul style="list-style-type: none"> • Effective practices identified and documented • Ineffective practices curtailed or adjusted • Increased knowledge about disease etiology, individual differences related to seeking services, and effective practices • Increased understanding of the connections between gambling and other health concerns <p><i>Intermediate:</i></p> <ul style="list-style-type: none"> • Increase in service quality and reach <p><i>Long term:</i></p> <ul style="list-style-type: none"> • Decreased prevalence of PG • Decreased negative consequences of PG (bankruptcies, debt, suicide, relapse, etc.)

Goal 6	Strategy	Theory of Change	Outcomes
<p>Have in place the appropriate infrastructure and human resources to successfully implement the Strategic Plan</p>	<ol style="list-style-type: none"> 1. Explore the utility of and the potential process for establishing an Inter-Agency Task Force on Problem Gambling to connect with and coordinate work among EOHHS agencies 2. Create systems to collect, safely store, and analyze data about PG and its associated harms 3. Increase the readiness and capacity of prevention professionals in related fields (substance abuse, violence, suicide, etc.) to address PG 4. Increase the capacity of current substance abuse treatment providers and institutions to incorporate PG into their work 5. Track the linguistic and cultural capacity of the PG workforce, and train diverse professionals as PG treatment providers to fill the gaps 6. Ensure that recovery support centers provide supportive services and environments for both people with a gambling disorder and those recovering from substance misuse, through mandates and community advocacy 7. Expand programs to educate financial professionals about PG and related issues, and provide re-entry support for people who have experienced a gambling disorder who are leaving corrections 8. Increase the availability of culturally diverse recovery coaches and cultural ambassadors 9. Create templates and procedures that will support the successful enhancement and implementation of services 10. Maintain and enhance human and programmatic capacity to implement this Strategic Plan 	<p>IF we ensure the appropriate infrastructure to successfully implement the Strategic Plan, THEN PG services will be developed in a cost-effective way and the state will save money on capacity building. IF PG services are developed in a cost-effective way and the state saves money on capacity building, THEN the Strategic Plan will meet its benchmarks and will be successfully implemented and updated.</p>	<p><i>Short-term:</i></p> <ul style="list-style-type: none"> • Services developed cost-effectively <p><i>Intermediate:</i></p> <ul style="list-style-type: none"> • Strategic Plan meets all benchmarks <p><i>Long-term:</i></p> <ul style="list-style-type: none"> • Decreased prevalence of PG • Decreased negative consequences of PG (bankruptcies, debt, suicide, relapse, etc.)

Figure 4: Problem Gambling Services Logic Model Graphic



Program Evaluation

Ongoing evaluation is built into the Strategic Plan as a systematic process for tracking and measuring the progress of the implementation and its anticipated outcomes. Evaluation helps a program respond to changes that may impact its effectiveness, measure progress toward goals, and decide where to best channel resources for the greatest effect. It demonstrates to stakeholders that the programs and strategies are effective and worth sustaining, *or* it points out the need for changes in programming.

It is important to evaluate both the process and the outcomes of a program. Therefore, two kinds of program evaluation are suggested, each of which is described below.

Process evaluation plan

Process evaluation measures if the recommended strategies and activities were implemented as planned, if the target population was reached, and if the goals and objectives of the implementation were attained. Process evaluation helps to not only improve the implementation of strategies and activities, but provides a roadmap on how to replicate successful strategies and activities in the future. For details, see Figure 5: Process and Outcome Evaluation Plans.

Outcome evaluation plan

Outcome evaluation measures whether the strategy and activities implemented had the anticipated effect on the target population, and determines whether the programs and activities worked to achieve the desired outcomes. For this Strategic Plan, the outcomes and their related indicators to be measured are described in Figure 5: Process and Outcome Evaluation Plans.

Figure 5: Process and Outcome Evaluation Plans

Process Evaluation Plan

ACTIVITY	PROCESS MEASURE
Reach youth and parents with appropriate prevention messaging, and enhance environmental strategies to increase protective factors and decrease risk factors	Number and frequency of messages Number and frequency of programming Timing of programming Number and location of towns implementing youth prevention programming Views, clicks, likes, and shares of messages on social media
Limit youth exposure to gambling promotion and access to gambling opportunities	Documentation of use of MGC’s checklist for monitoring and enforcement of policies included in the Responsible Gaming Framework
Develop and distribute culturally appropriate campaigns and services for high-risk populations	Number of campaigns for each high-risk population Documentation of distribution and estimated reach of campaigns
Provide safeguards for all gamblers to reduce the risk of overplaying and experiencing financial and health consequences	Number of safeguards implemented Use rates of safeguards from casino player card data Results of Responsible Gaming Framework evaluation from the DOA
Provide professionals who interact with high-risk groups with the tools and resources needed to offer consistent problem gambling screening and referral	Number of trainings Number of tools developed for these groups
Evaluate and explore potential enhancements to the current statewide gambling Helpline	Documentation of findings and possible models for enhancement New procedures for the Helpline
Increase the readiness and capacity of organizations already working in related fields (substance abuse, violence, suicide, etc.) to address problem gambling	Number of problem gambling trainings and materials provided to preventionists working in other fields List of related fields reached Sectors represented by Stakeholder Advisory Group membership

Provide the friends and families of people who have a gambling disorder with information and tools to help their loved ones connect with the supports they need	Number of service interactions with friends and family Number of tools developed and disseminated for these groups
Provide tools that include self-screening to help gamblers understand their own play patterns	Documentation of casino compliance with the Responsible Gaming Framework Number of Play Management locations in each casino
Identify gaps in the current treatment and reimbursement system, and develop a plan to address them	Documentation of findings and possible models for enhancement A plan to address gaps
Increase the visibility of services for problem gambling and related issues among gamblers and their loved ones	Presence of referral list on GameSense website Number of gambling Helpline number placements in ads and permanent postings Number of treatment providers who specify gambling in their advertisements Number of self-help meetings listed
Provide alternatives to clinical treatment to reduce the social stigma associated with accessing treatment	Number of alternatives to clinical treatment available
Increase the number of providers who are eligible to bill the state for treatment, and work with insurers to make reimbursement for problem gambling more feasible	Number of providers eligible to bill the state Number of insurers who change reimbursement for gambling disorder Number of claims reimbursed through the state
Diversify and increase the number of recovery support groups available in Massachusetts	Number of support groups listed on websites Number of language-, ethnicity-, gender-, or culture-specific groups
Reduce the ambient presence of visual and auditory triggers for people in recovery from a gambling disorder	Documentation of discussions with licensees New agreements and regulations
Expand and institutionalize surveillance systems to monitor problem gambling behaviors	Problem gambling questions added to statewide YRBS Problem gambling-related data collection infrastructure developed
Evaluate all problem gambling messaging and services	Evaluation provided for all social marketing and services Evaluation provided for all problem gambling grantees
Incorporate questions relevant to service design and delivery that are not answered by current research into the GRAC research agenda	Annual recommendations from the GRAC related to the research agenda

Establish a regular process by which the findings of all research activities will inform the development of appropriate prevention programs and interventions	Roles and responsibilities document for a strategic working group Schedule of meetings Documentation of meetings and activities of the group
Explore the utility of and the potential process for establishing an Inter-Agency Task Force on Problem Gambling to connect with and coordinate work among EOHHS agencies	Documentation of structure and process for other Inter-Agency Councils List of the roles of and potential connections with problem gambling for all EOHHS agencies Decision about whether to create an Inter-Agency Task Force on Problem Gambling
Create systems to collect, safely store, and analyze data about problem gambling and its associated harms	MDPH Director of Problem Gambling position maintained and enhanced
Increase the readiness and capacity of prevention professionals in related fields (substance abuse, violence, suicide, etc.) to address problem gambling	Number of problem gambling trainings and materials provided to preventionists working in other fields List of related fields reached Sectors represented by Stakeholder Advisory Group membership
Increase the capacity of current substance abuse treatment providers and institutions to incorporate problem gambling into their work	Number of trainings Training evaluations
Track the linguistic and cultural capacity of the problem gambling workforce, and train diverse professionals as problem gambling treatment providers to fill the gaps	Number of problem gambling treatment providers who speak multiple languages and come from the same background as high-risk populations Number of current treatment providers who complete cultural competency training Number of materials in other languages created and tested
Ensure that recovery support centers provide supportive services and environments for both people with a gambling disorder and those recovering from substance misuse, through mandates and community advocacy	Enforcement checklist from BSAS for Gambling-Free Policy Guidelines Number of recovery coaches trained Number of people recovering from a gambling disorder using recovery centers
Expand programs to educate financial professionals about problem gambling and related issues, and provide re-entry support for people who have experienced a gambling disorder who are leaving corrections	Number of programs Number of re-entries helped

Increase the availability of culturally diverse recovery coaches and cultural ambassadors	Number and geographic location of culturally diverse recovery coaches and cultural ambassadors
Create templates and procedures that will support the successful enhancement and implementation of services	Templates for MDPH vendors New procedure documents
Maintain and enhance human and programmatic capacity to implement this Strategic Plan	Job descriptions and workplans for MDPH employees who will work on elements of this plan Funding to problem gambling services vendors
Institutionalize surveillance systems to monitor the prevalence of other potentially related issues	Roles and responsibilities document for a surveillance working group Schedule of meetings Documentation of meetings and activities of the group
Establish a working group to identify appropriate individual and environmental strategies and community-level interventions to address issues that emerge from the surveillance data	Roles and responsibilities document for a strategic working group Schedule of meetings Documentation of meetings and activities of the group
Develop awareness campaigns that cross the boundaries between problem gambling and commonly co-occurring disorders	Number of cross-themed awareness campaigns

Problem Gambling Outcome Evaluation Plan

OUTCOMES	INDICATORS	TIMING
Short-Term		
Increased age of onset for problem gambling; decreased gambling behavior and prevalence among youth	YRBS and BSAS community survey	Every two years
Increased awareness of and comfort with problem gambling among prevention professionals	<i>Ounce of Prevention</i> conference survey; number of problem gambling prevention programs initiated by community coalitions	Yearly
Increase in problem gambling prevention activities in Massachusetts	Population awareness from SEIGMA survey	Yearly

More responsible gambling behavior at gambling venues	Casino data on length of play	Twice yearly
More providers screening for problem gambling	Self-report by providers; survey at MCCG annual meeting	Yearly
Increased awareness of and access to problem gambling programs and services, especially among high-risk groups	Awareness of campaigns; service-seeking	When SEIGMA releases data
Effective practices identified and documented	Responsible Gaming Framework checklist results	Twice yearly
Ineffective practices curtailed or adjusted	Number of papers about changes based on data	Yearly
Increased knowledge about disease etiology, individual differences related to seeking services, and effective practices	Number of papers published about successful interventions	Yearly
Services developed cost-effectively	Cost-effectiveness data from services pilot evaluation	Yearly
Long-Term		
Decreased prevalence of problem gambling in Massachusetts	SEIGMA data	Yearly
More people with gambling disorders identified and receiving services	SEIGMA cohort study; blanket data	Every two years, or as available
Increased participation in problem gambling programs and services, especially from high-risk groups	Recovery center records and annual reports	Yearly
Decreased negative consequences of problem gambling (bankruptcies, debt, suicide, relapse, etc.), especially among high-risk groups	Bankruptcy files; death records; suicide records through MassCHIP; self-reporting through MCCG recovery survey; local crime data reports from MGC	Yearly
Increase in service quality and reach	Number of support groups listed on websites; self-reports for time in recovery	Yearly
Strategic Plan meets all benchmarks	Timelines and workplan documentation over time	Yearly

REFERENCES

- Afifi, T. O., Brownridge, D. A., MacMillan, H., & Sareen, J. (2010, April). The relationship of gambling to intimate partner violence and child maltreatment in a nationally representative sample. *Journal of Psychiatric Research, 44*(5), 331–337.
- Allread, W. G., Vossenas, P., Sheikh, N. N., & Punnett, L. (2016). Work Design and Health for Hospitality Workers. In A. Hedge (Ed.), *Ergonomic Workplace Design for Health, Wellness, and Productivity* (chapter 14). Oxford, UK: Taylor & Francis.
- Bland, R. C., Newman, S. C., Orn, H., Stebelsky, G. (1993, March). Epidemiology of pathological gambling in Edmonton. *The Canadian Journal of Psychiatry/La revue canadienne de psychiatrie, 38*(2), 108–112.
- Blaszczynski, A. P., & McConaghy, N. (1994). Antisocial personality disorder and pathological gambling. *Journal of Gambling Studies, 10*(2), 129–145.
- Blaszczynski, A., & Steel, Z. (1998). Personality disorders among pathological gamblers. *Journal of Gambling Studies, 14*(1), 51–71.
- Commonwealth of Massachusetts. (2015a). *General Laws: Part I, Title II, Chapter 23K, Section 45: Regulation and procedure for the exclusion and self-exclusion of persons from gaming establishments*. The 189th General Court of The Commonwealth of Massachusetts. Retrieved from <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter23K/Section45>
- Commonwealth of Massachusetts. (2015b). *General Laws: Part I, Title II, Chapter 23K, Section 58: Public Health Trust Fund*. The 189th General Court of The Commonwealth of Massachusetts. Retrieved from <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter23K/Section58>
- Commonwealth of Massachusetts. (2015c). *General Laws: Part I, Title II, Chapter 23K, Section 59: Gaming Revenue Fund*. The 189th General Court of The Commonwealth of Massachusetts. Retrieved from <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter23K/Section59>
- Commonwealth of Massachusetts. (2015d). *General Laws: Part I, Title II, Chapter 23K, Section 71: Annual Research Agenda*. The 189th General Court of The Commonwealth of Massachusetts. Retrieved from <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter23K/Section71>
- Commonwealth of Massachusetts. (2015e). *General Laws: Part I, Title II, Chapter 23K, Section 61: Community Mitigation Fund*. The 189th General Court of The Commonwealth of Massachusetts. Retrieved from <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter23K/Section61>

- Cotti, C. D., & Walker, D. M. (2010). The impact of casinos on fatal alcohol-related traffic accidents in the United States. *Journal of Health Economics*, 29(6), 788–796.
- Crockford, D. N., & el-Guebaly, N. (1998). Psychiatric comorbidity in pathological gambling: A critical review. *Canadian Journal of Psychiatry*, 43(1), 43–50.
- Cunningham-Williams, R. M., Cottler, L. B., Compton, W. M., 3rd, & Spitznagel, E. L. (1998). Taking chances: Problem gamblers and mental health disorders—results from the St. Louis Epidemiologic Catchment Area Study. *American Journal of Public Health*, 88(7), 1093–1096.
- Education Development Center, Inc. (2011). *Realizing the Promise of the Whole-School Approach to Children's Mental Health: A Practical Guide for Schools*. Retrieved from http://safesupportivelearning.ed.gov/sites/default/files/mental_health_guide.pdf
- Emshoff, J., Gilmore, D., & Zorland, J. (2010, February). *Veterans and problem gambling: A review of the literature*. Retrieved from <http://www.ncpgambling.org/files/public/Military/Veterans%20and%20Problem%20Gambling%20Lit%20Review%202010.pdf>
- Feigelman, W., Gorman, B. S., & Lesieur, H. (2006). Examining the Relationship Between At-Risk Gambling and Suicidality in a National Representative Sample of Young Adults. *Suicide and Life-Threatening Behavior*, 36(4), 396–408.
- Gerstein, D., Murphy, S., Toce, M., Hoffmann, J., Palmer, A., Johnson, R., . . . Sinclair, S. (1999). *Gambling Impact and Behavior Study: Report to the National Gambling Impact Study Commission*. Chicago, IL: National Opinion Research Center.
- Grinols, E. L., & Mustard, D. B. (2006, February). Casinos, Crime and Community Costs. *Review of Economics and Statistics*, 88(1), 28–45.
- Hardoon, K., & Derevensky, J. (2002). Child and adolescent gambling behavior: Our current knowledge. *Clinical Child Psychology and Psychiatry*, 7(2), 263–281.
- Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992, July). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 112(1), 64–105.
- Herrenkohl, T. I., Maguin, E., Hill, K. G., Hawkins, J. D., Abbott, R. D., & Catalano, R. F. (2000). Developmental risk factors for youth violence. *Journal of Adolescent Health*, 26(3), 176–186.
- Haupt, A., Volberg, R. A., Williams, R. J., Stanek, E. J., III, & Zorn, M. (2015, December). *Key Findings from SEIGMA Research Activities and Potential Implications for Strategic Planners of Problem Gambling*

- Prevention and Treatment Services in Massachusetts*. Amherst, MA: SEIGMA (Social and Economic Impacts of Gambling in Massachusetts), University of Massachusetts School of Public Health and Health Sciences. Retrieved from <http://massgaming.com/wp-content/uploads/White-Paper-on-Key-Findings-from-SEIGMA-Research-Activities-12-18-15.pdf>
- Huang, J.-H., Jacobs, D. F., Derevensky, J. L., Gupta, R., & Paskus, T. S. (2007). Gambling and health risk behaviors among US college student-athletes: Findings from a national study. *Journal of Adolescent Health, 40*(5), 390–397.
- Jacobs, D. F., Marston, A. R., Singer, R. D., Widaman, K., Little, T., & Veizades J. (1989). Children of problem gamblers. *Journal of Gambling Behavior, 5*(4), 261–268.
- Kessler, R. C., Hwang, I., LaBrie, R., Petukhova, M., Sampson, N. A., Winters, K. C., & Shaffer, H. J. (2008). DSM-IV pathological gambling in the National Comorbidity Survey Replication. *Psychological Medicine, 38*(9), 1351–1360.
- Knapp, T. J., & Lech, B. C. (1987). Pathological gambling: A review with recommendations. *Advances in Behaviour Research and Therapy, 9*(1), 21–49.
- Korn, D. A., & Shaffer, H. J. (1999). Gambling and the health of the public: Adopting a public health perspective. *Journal of Gambling Studies, 15*(4), 289–365.
- LaBrie, R. A., Shaffer, H. J., LaPlante, D. A., & Wechsler, H. (2003). Correlates of college student gambling in the United States. *Journal of American College Health, 52*(2), 53–62.
- Lesieur, H. R., & Heineman, M. (1988). Pathological gambling among youthful multiple substance abusers in a therapeutic community. *British Journal of Addiction, 83*(7), 765–771.
- Lesieur, H. R., & Rothschild, J. (1989). Children of gamblers anonymous members. *Journal of Gambling Behavior, 5*(4), 269–281.
- Linnet, J., & Pedersen, A. S. (2014). Waiting Time Increases Risk of Attrition in Gambling Disorder Treatment. *Journal of Addiction & Prevention, 2*(2), 1–4.
- Lopes, L. L. (1987). Between Hope and Fear: The Psychology of Risk. *Advances in Experimental Social Psychology, 20*, 255–295. doi:10.1016/S0065-2601(08)60416-5
- Lorenz, V. C., & Yaffee, R. A. (1988). Pathological gambling: Psychosomatic, emotional and marital difficulties as reported by the spouse. *Journal of Gambling Behavior, 4*(1), 13–26.
- Massachusetts Council on Compulsive Gambling. (2015). *About Us*. Retrieved from <http://www.masscompulsivegambling.org/about-us/mission-and-history/>

Massachusetts Gaming Commission. (2013, November). *Memorandum re: Proposal for Licensee Cost Assessment*. Retrieved from <http://massgaming.com/wp-content/uploads/Proposal-for-Licensee-Cost-Assessment.pdf>

Massachusetts Gaming Commission. (2014). *Responsible Gaming Framework*. Retrieved from <http://massgaming.com/wp-content/uploads/Responsible-Gaming-Framework-v1-10-31-14.pdf>

Massachusetts Gaming Commission. (2015a). *Expanded Gaming Act*. Retrieved from <http://massgaming.com/about/expanded-gaming-act/>

Massachusetts Gaming Commission. (2015b). *Public Health Trust Fund*. Retrieved from <http://massgaming.com/about/research-agenda/public-health-trust-fund/>

Matua Raki. (2012). *Brief Intervention Guide: Addressing Risk and Harm from Alcohol, Other Drugs and Gambling*. Wellington, New Zealand: Author.

McCleary, R., & Chew, K. (1998). *Suicide and Gambling: An Analysis of Suicide Rates in US Counties and Metropolitan Areas*. Retrieved from https://www.americangaming.org/sites/default/files/research_files/suicide.pdf

McCormick, R. A. (1993). Disinhibition and negative affectivity in substance abusers with and without a gambling problem. *Addictive Behaviors, 18*(3), 331–336.

McCormick, R. A., Russo, A. M., Ramirez, L. F., & Taber, J. I. (1984, February). Affective disorders among pathological gamblers seeking treatment. *The American Journal of Psychiatry, 141*(2), 215–218.

Ministry of Health. (2008). *Problem Gambling Service: Intervention Service Practice Requirements Handbook (version 1.1)*. Wellington, New Zealand: Author. Retrieved from <http://www.health.govt.nz/publication/problem-gambling-service-intervention-service-practice-requirements-handbook>

National Resource Council, & Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. M. E. O'Connell, T. Boat, & K. E. Warner (Eds.). Washington, DC: The National Academies Press.

Nevada Department of Health and Human Services. (2014, August 13). *Five Year Strategic Plan for Problem Gambling Treatment Services Within the State of Nevada: Fiscal Years 2012–2016*. Carson City, NV: Author. Retrieved from

http://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Programs/Grants/Forms/FY16-17_PG_RFA_WFD_Appendix_D_TreatmentStrategicPlan.pdf

Newman, S. C., & Thompson, A. H. (2007). The association between pathological gambling and attempted suicide: Findings from a national survey in Canada. *Canadian Journal of Psychiatry*, 52(9), 605–612.

National Institute for Occupational Safety and Health. (2011). *Safety and health among hotel cleaners. Services Sector: Occupational Safety and Health Needs for the Next Decade of NORA*. Retrieved from <http://www.cdc.gov/niosh/docs/2012-151/pdfs/2012-151.pdf>

Oakley-Browne, M. A., Adams, P., & Mobberley, P. M. (2000, January). Interventions for pathological gambling. *The Cochrane Database of Systematic Reviews*, 1(CD001521). doi:10.1002/14651858.CD001521

Partners for a Healthier Community, Inc. (2014, January). *Western Massachusetts: Casino Health Impact Assessment Report*. Retrieved from http://www.partnersforahealthiercommunity.org/sites/default/files/WMCHIA_Full_Report-FINAL.pdf

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. *The Journal of Clinical Psychiatry*, 66(5), 564–574.

Phillips, D. P., Welty, W. R., & Smith, M. M. (1997). Elevated suicide levels associated with legalized gambling. *Suicide and Life-Threatening Behavior*, 27(4), 373–378.

Politzer, R. M., Yesalis, C. E., Hudak, C. J. (1992). The epidemiologic model and the risks of legalized gambling: Where are we headed? *Health Values: The Journal of Health Behavior, Education & Promotion*, 16, 20–27.

Rahman, A. S., Pilver, C. E., Desai, R. A., Steinberg, M. A., Rugle, L., Krishnan-Sarin, S., & Potenza, M. N. (2012, May). The relationship between age of gambling onset and adolescent problematic gambling severity. *Journal of Psychiatry Research*, 46(5), 675–683. Retrieved from www.ncbi.nlm.nih.gov/pubmed/22410208

Responsible Gambling Council, Centre for the Advancement of Best Practices. (2010). *INSIGHT, Informed Decision Making*. Retrieved from <http://www.responsiblegambling.org/rg-news-research/rgc-centre/insight-projects/docs/default-source/research-reports/informed-decision-making>

Rugle, L., & Melamed, L. (1993). Neuropsychological assessment of attention problems in pathological gamblers. *The Journal of Nervous and Mental Disease*, 181(2), 107–112.

- Shaffer, H. J., Hall, M. N., & Vander Bilt, J. (1999, September). Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health, 89*(9), 1369–1376.
- Shaffer, H. J., & Korn, D. A. (2002). Gambling and related mental disorders: A public health analysis. *Annual Review of Public Health, 23*, 171–212.
- Shaffer, H. J., Vander Bilt, J., & Hall, M. N. (1999). Gambling, drinking, smoking and other health risk activities among casino employees. *American Journal of Industrial Medicine, 36*(3), 365–378.
- Slutske, W. S., Ellingson, J. M., Richmond-Rakerd, L. S., Zhu, G., & Martin, N. G. (2013). Shared genetic vulnerability for disordered gambling and alcohol use disorder in men and women: Evidence from a national community-based Australian twin study. *Twin Research and Human Genetics, 16*(2), 525–534.
- Smart, R. G., & Ferris, J. (1996, February). Alcohol, drugs and gambling in the Ontario adult population, 1994. *The Canadian Journal of Psychiatry/La Revue canadienne de psychiatrie, 41*(1), 36–45.
- Smith, G. J., & Wynne, H. J. (1999). *Summary Report: Gambling and crime in Western Canada: Exploring myth and reality*. Alberta, Canada: Canada West Foundation.
- Spunt, B., Lesieur, H., Hunt, D., & Cahill, L. (1995). Gambling among methadone patients. *International Journal of the Addictions, 30*(8), 929–962.
- Stea, J. N., & Hodgins, D. C. (2011, June). A Critical Review of Treatment Approaches for Gambling Disorders. *Current Drug Abuse Reviews, 4*(2), 67–80.
- Steinberg, M. A., Kosten, T. A., & Rounsaville, B. J. (1992). Cocaine abuse and pathological gambling. *The American Journal on Addictions, 1*(2), 121–132.
- Stitt, B., Giacomassi, D., & Nichols, M. (2000). The Effect of Casino Gambling on Crime in New Casino Jurisdictions. *Journal of Crime and Justice, 23*(1), 1–23. Retrieved from <http://zimmer.fresnostate.edu/~haralds/Gaming/EffectofCasinoGamblingonCrime.pdf>
- Substance Abuse and Mental Health Services Administration. (2014, Summer). Gambling Problems: An Introduction for Behavioral Service Providers. *SAMHSA Advisory, 13*(1). Retrieved from <http://store.samhsa.gov/product/Gambling-Problems-An-Introduction-for-Behavioral-Health-Services-Providers/SMA14-4851>
- Substance Abuse and Mental Health Services Administration. (2015a). *Prevention Approaches*. Retrieved from <https://captus.samhsa.gov/prevention-practice/prevention-approaches>

Substance Abuse and Mental Health Services Administration. (2015b). *Recovery*. Retrieved from <http://www.samhsa.gov/recovery>

Substance Abuse and Mental Health Services Administration. (2015c). *Strategic Prevention Framework*. Retrieved from <https://captus.samhsa.gov/prevention-practice/strategic-prevention-framework>

Toce-Gerstein, M., Gerstein, D. R., & Volberg, R. A. (2003). A hierarchy of gambling disorders in the community. *Addiction*, *98*(12), 1661–1672.

UNESCO World Commission on the Ethics of Scientific Knowledge and Technology. (2005). *The Precautionary Principle*. Retrieved from <http://unesdoc.unesco.org/images/0013/001395/139578e.pdf>

University of Massachusetts, Amherst, Department of Public Health. (2013, August 1). *GRAC Meeting [Overview of SEIGMA study]*. Retrieved from <http://www.umass.edu/seigma/sites/default/files/GRAC%20Meeting%202013-08-01%28final%29.pdf>

Victorian Responsible Gambling Foundation. (2015, May). *Using a Public Health Approach in the Prevention of Gambling-Related Harm*. Retrieved from http://www.responsiblegambling.vic.gov.au/_data/assets/pdf_file/0013/20254/Public-health-approach-web.pdf

Volberg, R. (2014, November 6). *The Massachusetts Gambling Impact Cohort Study (MAGIC): A Cornerstone of the Massachusetts Gaming Commission's Research Agenda*. Retrieved from <http://massgaming.com/wp-content/uploads/MAGIC-Overview-November-2014.pdf>

Volberg, R. A., Munck, I. M., & Petry, N. M. (2011, May). A Quick and Simple Screening Method for Pathological and Problem Gamblers in Addiction Programs and Practices. *The American Journal on Addictions*, *20*(3), 220–227.

Volberg, R. J., Rugle, L., Rosenthal, R. J., & Fong, T. (2005, March). *Situational Assessment of Problem Gambling Services in California*. Sacramento, CA: Office of Problem Gambling, California Department of Alcohol and Drug Programs. Retrieved from <http://www.calpg.org/wp-content/uploads/2012/06/2005-California-Situational-Assessment.pdf>

Volberg, R. A., Williams, R. J., Stanek, E. J., Houpt, K. A., Zorn, M., & Rodriguez-Monguio, R. (2015, May 28). *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. Retrieved from www.umass.edu/seigma/sites/default/files/SEIGMA%20Baseline%20Survey%20Report_Final.pdf

- Weinstock, J., Burton, S., Rash, C. J., Moran, S., Biller, W., Krudelbach, N., . . . Morasco, B. J. (2011, June). Predictors of Engaging in Problem Gambling Treatment: Data From the West Virginia Problem Gamblers Help Network. *Psychology of Addictive Behaviors*, 25(2), 372–379.
- Welte, J. W., Barnes, G. M., Tidwell, M.-C., & Hoffman, J. H. (2008). The Prevalence of Problem Gambling Among U.S. Adolescents and Young Adults: Results from a National Survey. *Journal of Gambling Studies*, 24(2), 119–133.
- Wilber, M. K., & Potenza, M. N. (2006, October). Adolescent Gambling: Research and Clinical Implications. *Psychiatry (Edgmont)*, 3(10), 40–48.
- Wildman, R. W., II. (1989). Pathological gambling: Marital-familial factors, implications, and treatments. *Journal of Gambling Behavior*, 5(4), 293–301.
- Williams, R. J., Royston, J., & Hagen, B. F. (2005). Gambling and problem gambling within forensic populations A review of the literature. *Criminal Justice and Behavior*, 32(6), 665–689.
- Williams, R. J., Volberg, R. A., & Stevens, R. M. (2012, May 8). *The Population Prevalence of Problem Gambling: Methodological Influences, Standardized Rates, Jurisdictional Differences, and Worldwide Trends*. Report prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care. Retrieved from <http://hdl.handle.net/10133/3068>
- Williams, R. J., West, B. L., & Simpson, R. I. (2012, October). *Prevention of Problem Gambling: A Comprehensive Review of the Evidence and Identified Best Practices*. Report prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care. Retrieved from <https://www.uleth.ca/dspace/bitstream/handle/10133/3121/2012-PREVENTION-OPGRC.pdf?sequence=3>
- Winters, K. C., Bengston, P., Door, D., & Stinchfield, R. (1998, June). Prevalence and risk factors of problem gambling among college students. *Psychology of Addictive Behaviors*, 12(2), 127–135.

ACKNOWLEDGMENTS

Thank you to everyone who generously served as a key informant to help us better understand the current status of problem gambling services and the interventions that are being developed to enhance the current infrastructure.

Additionally, special thanks for direct contributions to this report to Steve Keel and Victor Ortiz, Directors of Problem Gambling Services at the Massachusetts Department of Public Health, and Lindsey Tucker, Associate Commissioner at the Massachusetts Department of Public Health; Mark Vander Linden, Director of Research and Responsible Gaming for the Massachusetts Gaming Commission; Jeffrey Marotta, President and Senior Consultant, Problem Gambling Solutions, Inc.; and Marlene Warner, Executive Director of the Massachusetts Council on Compulsive Gambling.

Thank you to Rachel Volberg and Amanda Houpt of the SEIGMA team for collaborating in many ways in the development of this Strategic Plan.

Thank you to the members of the Executive Committee of the PHTF for thinking carefully about the contents and implications of this report and for soliciting input from their constituencies.

Thank you to Lauren Gilman, Emily Bhargava, and Jack Vondras of MassTAPP at Education Development Center, Inc., for coordinating and writing the Strategic Plan.

APPENDIX: MEMORANDUM OF UNDERSTANDING BETWEEN MASSACHUSETTS GAMING COMMISSION AND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MEMORANDUM OF UNDERSTANDING

BETWEEN

MASSACHUSETTS GAMING COMMISSION

AND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

WHEREAS, the **MASSACHUSETTS GAMING COMMISSION** (hereinafter, "MGC") and the **EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES** (hereinafter, "EOHHS") possess shared interests, goals, and responsibilities relative to addressing problem gambling and promoting responsible gaming; and

WHEREAS, one of the principal underpinnings of the Act Establishing Expanded Gaming in the Commonwealth (codified in G.L. c.23K) (hereinafter, the "Act") is the recognition that thoughtful and unique efforts and strategies to combat problem gambling and promote responsible gaming have to be deeply embedded in the regulatory and licensing process for gaming establishments; and

WHEREAS, the Act creates a Public Health Trust Fund (hereinafter, the "Fund") from a percentage of gross gaming revenues as well as fees assessed to gaming licensees; and

WHEREAS, the Fund was created for two primary reasons: (1) to assist social service and public health programs dedicated to addressing problems associated with compulsive gambling including, but not limited to, gambling prevention and addiction services, substance abuse services, educational campaigns to mitigate the potential addictive nature of gambling, and (2) to conduct necessary studies and evaluation, including those identified in the annual research agenda. As outlined in G.L. c.23K, §71, the research agenda is intended to help gain an understanding of the social and economic effects of expanding gaming in Massachusetts, and to obtain scientific information relative to the neuroscience, psychology, sociology, epidemiology and etiology of gambling; and

WHEREAS, the Secretary of EOHHS was designated as the trustee of the Fund and MGC was afforded "advice and consent" authority over expenditures from the Fund related to the implementation of the objectives of the annual research agenda; and

WHEREAS, the successful implementation of the Act by the MGC as it relates to problem gambling is in many respects inextricably bound with the manner in which expenditures from the Fund are made; and

WHEREAS, pursuant to G.L. c.23K, §§4(3) and (4), the MGC is vested with the power to execute all instruments necessary or convenient for accomplishing the purposes of G.L. c.23K and to enter into agreements with a public entity or other governmental instrumentality or authority in connection with its powers and duties under G.L. c.23K;

NOW THEREFORE, in order to align the efforts of MGC and EOHHS, mitigate the potential for inconsistency, redundancy, and conflict in the provision of services, ensure the research is utilized to advance proper and most effective strategies, and help ensure the most effective use of the monies from the Fund, MGC and EOHHS agree that for as long as this *MEMORANDUM OF UNDERSTANDING* is in effect, the following shall apply:

1. The Executive Committee of the Public Health Trust Fund (hereinafter, "committee") shall be established for purposes of setting the overall budget and protocols for expenditures from the Fund. The committee shall consist of no fewer than five members including the Secretary of EOHHS (or designee), the Chair of MGC (or designee), and three members appointed by mutual agreement of the Secretary and the Chair. The Secretary and the Chair shall serve as co-chairs of the committee. Of the additional committee members, at least one shall have a background in problem gambling/responsible gaming issues, and at least one shall have a background in addiction, substance abuse, and mental health services.
2. The committee shall meet quarterly and from time to time as otherwise deemed necessary by the co-chairs. The committee shall be subject to the Open Meeting Law of the Commonwealth of Massachusetts and all applicable Public Records laws.
3. The affirmative vote of three (or if more than five members, a majority of) committee members shall be required for an action by the committee, provided at least two votes represents those of the Chair of MGC (or designee) and Secretary of EOHHS (or designee).
4. The committee may establish goals and/or a mission statement in an effort to instruct its decision making. The budget and goals established by the committee shall be consistent with the purposes identified by G.L. c.23K, §58.
5. The committee shall set an annual budget for expenditures from the Fund. The committee may set aside funds and establish rules allowing for discretionary expenditures below a certain monetary threshold by specific individuals. The committee may amend the budget at any time so as to reflect actual monies credited or transferred to the Fund.
6. 75% of the monies in the Fund, or such percentage as agreed to in writing by the parties, shall be set aside each year for services to be funded by the Department of Public Health (DPH), as required by G.L. c. 23K, §58.
7. As trustee of the Fund, the Secretary of EOHHS agrees to expend monies in the Fund, in accordance with G.L. c.23K, §58, consistent with the established budget, rules, policies, and other related direction provided by the committee.

8. In anticipation of the expanded problem gambling program to be overseen by EOHHS, via DPH as a result of the implementation of the Act, the parties recognize the need for the addition of a Director of Problem Gambling Services position within DPH. In order to offset the DPH cost arising out such full-time employment, MGC agrees to pay DPH an agreed upon sum, as reflected in an Interagency Service Agreement (ISA) executed by both parties. This amount reflects the actual cost to DPH of the Director's salary, fringe expenses, indirect costs, and travel.

For FY 2015:

- a. Half of the agreed upon sum relative to salary reimbursement on July 1, 2014, and
- b. Half of the agreed upon sum relative to salary reimbursement by January 1, 2015.

For subsequent years or until monies are available in the Fund to pay for the position ongoing:

- a. Half of the agreed upon sum relative to salary reimbursement, on July 1 of each new fiscal year, and
- b. Half of the agreed upon sum relative to salary reimbursement by January 1 of the following year.

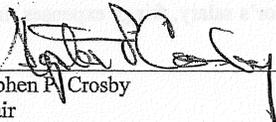
These figures shall be reviewed as needed, but at least once per year, and may be adjusted, by mutual agreement of the parties, to the extent necessary to account for any salary increase. Such adjustment shall be made in writing and incorporated into the ISA.

9. Any expenditures made by EOHHS or MGC to (1) further the research agenda (G.L. c.23K, §71), or (2) assist social service or public health programs to prepare for gaming expansion, made prior to monies being in the Fund for such purposes, may be paid back to the respective agency from the Fund once monies are available, with approval of the Executive Committee.
10. The Director of Problem Gambling Services at DPH and the Director of Research and Problem Gambling at MGC shall work cooperatively to ensure that there are no inconsistencies, redundancies, or conflicts in their respective duties and responsibilities.
11. This agreement, upon execution by both MGC and EOHHS, shall remain in effect unless amended by mutual written consent or until terminated by the MGC or EOHHS upon 90 days written notice, and shall remain in effect regardless of whether either or both of the undersigned is/are no longer authorized to represent their respective offices.

12. This Agreement may not be amended or modified, except by a writing signed by both parties.

Massachusetts Gaming Commission

By:

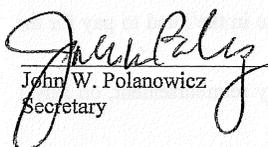


Stephen P. Crosby
Chair

7/29/14
Date

Executive Office of Health and Human Services

By:



John W. Polanowicz
Secretary

7/29/14
Date