



# COMMUNITY HEALTH WORKERS AND INTERVENTIONS FOR PROBLEM GAMBLING

NEEDS ASSESSMENT FOR EASTERN REGION

MAY 2020



Massachusetts Department of Public Health  
Office of Problem Gambling Services



**COMMUNITY HEALTH WORKERS AND INTERVENTIONS  
FOR PROBLEM GAMBLING: NEEDS ASSESSMENT  
EASTERN REGION (Everett, Malden, Chelsea, Revere area)**

**Massachusetts Department of Public Health  
Office of Problem Gambling Services**

**May 2020**



# TABLE OF CONTENTS

Acknowledgments.....	3
Executive Summary.....	4
Overview.....	4
Why Community Health Workers? .....	4
Massachusetts Department of Public Health (MDPH) Definition of a Community Health Worker (CHW).....	5
Core Questions and Design of Assessment.....	5
Findings.....	6
Observations About Local Problem Gambling.....	6
Perceptions of the Nature of Problem Gambling.....	6
Perceptions about the Opening of the Encore Casino in Everett.....	7
Perceptions about Risks of Residents Developing Problem Gambling.....	7
Suggested Approaches to Prevention and Intervention for Problem Gambling.....	8
Roles Community Health Workers Could Play.....	8
Overview of Report.....	10
The Strategic Plan: Services to Mitigate the Harms Associated With Gambling in Massachusetts...11	
Why Community Health Workers? .....	11
Massachusetts Department of Public Health (MDPH) Definition of a Community Health Worker (CHW) .....	12
Core Questions and Design of Assessment.....	14
Interview and Focus Group Participants.....	14
Table 1: Key Informant Interviews, Affiliations, and Positions.....	14
Table 2: Key Informant Interviews, Affiliations, and Positions.....	14
Table 3: Key Informant Interviews, Affiliations, and Positions.....	14
Table 4: Focus Group By City and Organizational Type.....	16
Findings.....	16
Setting the Stage.....	16
Local Context.....	17
Observations About Local Problem Gambling.....	17
Gambling Common but Not Salient Compared to Other Challenges.....	17
Perceptions of the Nature of Problem Gambling.....	18
Problem Gambling Involves Excessive Time, Stressed Budget.....	18
Strong Connections Between Addiction and Gambling.....	19
Perceptions About the Opening of the Encore Casino in Everett.....	20
Mixed Emotions About Anticipated Opening.....	20
Perceptions About Risks of Residents Developing Problem Gambling.....	20
Financial Vulnerability a Risk Factor for Gambling Problems.....	20
Mental Health and Addiction Issues Pervasive.....	22
Ease of Access to New Casino Enhances Risks.....	22
Suggested Approaches to Prevention and Intervention for Problem Gambling.....	24
Perception That Local Cities are Unprepared.....	24
Education About Gambling Needed.....	24
Community-wide Risk Education to Balance Positive Messages.....	25
Possible Citywide and Regional Collaborations Suggested.....	26
Alternative Entertainment Sources and Social Centers Needed.....	28
Roles for Community Health Workers.....	29
Community Health Workers Well Positioned to Raise Awareness.....	29
Community Health Workers Provide Support and Resources.....	30
Adding Linguistic and Cultural Diversity to Services.....	31
Outreach and Support Staff Play “CHW-like” Roles.....	32
Training Needs.....	33
General Issues.....	35
Suggestions for Additional Training for CHWs and Others.....	35
Conclusion and Recommendations.....	37

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Thanks are due to the individuals and organizations that helped to organize and/or hosted the focus groups: in Chelsea, the Community Action Program Inter-City; in Everett, the Family Resource Center; the Adjustment Counselor Office at Malden High School; and Revere's Neighborhood Developers.

Thanks are also due to Ms. Anastacia Marx de Salcedo for professional editing of this report.

# EXECUTIVE SUMMARY

## Overview

In 2011, the Massachusetts legislature passed and the governor signed into law the Expanded Gaming Act, which expanded legal gambling to include a limited number of casinos and formed a state Gaming Commission to oversee legal gaming in the Commonwealth. It also established the Public Health Trust Fund (PHTF) to prevent and treat problem gambling and related issues by allocating significant resources to research, prevention, intervention, treatment, and recovery support services.

This report presents the findings and recommendations from a Regional Needs Assessment of the roles that community health workers (CHWs) could effectively play in future systems of prevention, identification, assessment, support, and referrals to treatment services to mitigate problem gambling. Also included are expert perspectives concerning the nature and content of the training needed to properly prepare CHWs for their roles.

The assessment was conducted in the four municipalities immediately north of downtown Boston, in the cities of Everett, Chelsea, Revere, and Malden. In September 2014, Everett was approved to be the site of the sole full-resort casino for the northeastern region, one of three allowed statewide. Everett, the four cities adjacent to it, and others nearby, called “surrounding communities,” thus qualify for additional state assistance to reduce the negative impacts of a new gambling casino through community agreements. These agreements are separate from the Public Health Trust Fund, which funds public health interventions related to casino impacts. This Regional Needs Assessment is part of the implementation of recommendations outlined in the “Strategic Plan for Massachusetts to Mitigate the Harms Associated with Gambling.”

The plan was guided by the two key principles of sustainability and cultural competence of messaging and services; it identified community health workers as part of multiple strategies. The Public Health Trust Fund Executive Committee adopted the strategic plan on April 16, 2016.

## Why Community Health Workers?

The community health worker (CHW) workforce brings cultural, socio-economic class and racial diversity to public health and healthcare organizations as part of who they are and what they are trained to do. They directly address inequities in health and in access to prevention and care through the building of bridges among marginalized communities and systems of care.

**Massachusetts Department of Public Health (MDPH)**  
**Definition of a Community Health Worker (CHW)**

*A community health worker is a public health professional who applies his or her unique understanding of the experience, language, and/or culture of the populations he or she serves in order to carry out at least one of the following roles:*

- Bridging/culturally mediating among individuals, communities, and health and human services, including actively building individual and community capacity
- Providing culturally appropriate health education and information
- Assisting people to get the services they need
- Providing direct services, including informal counseling and social support
- Advocating for individual and community needs

CHWs are distinguished from other health professionals because they: 1) are hired primarily for their understanding of the populations they serve, 2) conduct outreach a significant portion of their time; and 3) have experience providing services in community settings.

## **CORE QUESTIONS AND DESIGN OF ASSESSMENT**

The core questions explored in the assessment are:

1. What are the perceptions concerning roles community health workers could effectively play in prevention of, screening for, and interventions with problem gambling in the north of Boston/Everett area?
2. What are the views about best approaches to integrate such work by CHWs into both existing behavioral health (i.e., substance use and mental health) services and/or other interventions related to problem gambling in the region?
3. What are the views concerning key content and skills needed to prepare CHWs for these roles, and what local training or educational organizations could best provide such training?

The needs assessment was conducted from October 2018 through May 2019. Key informant interviews were conducted with a total of 21 healthcare, behavioral health, and community providers and leaders. Additionally, four focus groups were held in Everett, Chelsea, Revere, and Malden, with a total of 33 participants. Participants included multiple community health workers and others who could be expected to work with any future programs to mitigate gambling-related harms.



## FINDINGS

### Observations about Local Problem Gambling

- There was awareness of gambling happening locally. However, the salience among providers of problem gambling was minimal compared to other challenges faced by their constituents, including rising housing costs, low wages, trauma and other mental health issues, substance addictions, and pressures from changing federal immigration policies.
- Perceptions that low-income residents purchase scratch tickets more than they can afford and regular out-of-state casino visits by seniors on fixed incomes were highlighted most often as concerning.
- Revere is seen by some there to have a culture of gambling, due in part to its history of dog and horse racing.

### Perceptions of the Nature of Problem Gambling

- Perceptions are that problem gambling is when people constantly spend and lose more money than their budget for basic necessities such as food and housing and care for family can support.
- Descriptions of connections between gambling and substance use addictions included a shared sensation or “rush,” the substitution of the one for the other during recovery, and pursuit of gambling with the goal of supporting a substance use addiction.

### Perceptions about the Opening of the Encore Casino in Everett

- Speculation about the local effects of the imminent opening of a multi-billion dollar resort casino on 33 acres of property in Everett within months dominated most of the discussions.
- Excitement about new economic, job, and entertainment possibilities were mixed with concerns that the new casino could contribute to rising housing costs; worsened traffic; increases in prostitution, robbery, drug and alcohol addiction; and the uncertain effects of an influx of strangers into the cities.

### Perceptions about Risks of Residents Developing Problem Gambling

- The dramatic rise in costs of housing was seen as partly due to the upward pressures on the local market by people seeking alternatives to Boston’s high cost housing. Still, providers believe the construction of the Everett casino and related development has already driven a number of residents from their homes, contributed to rising costs, and increased their financial vulnerability.
- The belief that people with limited incomes tend to look to gambling as a way to improve their finances and the conviction that casino entertainment will be very compelling in light of limited local alternatives lead many providers to worry about residents who might be at high risk.

- Additional stresses on resident families include social isolation for seniors and immigrants without local family supports and children and teenagers who experience cultural gaps between their lives in the U.S. and their parents' background.
- The ease of access to gambling that the new casino will bring led providers to highlight several categories of residents for whom they have particular concerns: 1) people recently in substance use recovery; 2) seniors on fixed incomes; 3) young adults with jobs and some independence who aren't ready for it; and 4) those who habitually use alcohol and/or drugs.
- Some expressed concerns that financial losses from gambling may contribute to increased homelessness in the area.

## Suggested Approaches to Prevention and Intervention for Problem Gambling

- There is a belief that most providers and residents of the region are unprepared for the influence of a new large resort casino. The highest priority for all was widespread education about problem gambling, its risks, signs, effects, and how to support and treat it.
- Education about the risks and impacts of problem and addictive gambling is doubly needed to counter the incomplete impression of gambling as "just having a good time," and to balance the constant positive marketing of the business to attract customers.
- Citywide collaborations among a variety of health, mental health, substance use, community and police service organizations was envisioned by some as an effective approach to coordinating services. Such collaborations and coalitions exist in these cities, built primarily to address substance use addictions and related health issues.
- Regional multi-city service coordination and information sharing was suggested to match the scope of the likely impact of the casino and in order to assure services access across cities.
- Notions that social isolation and a need for community as well as local entertainment contribute to excessive gambling led people to recommend funding and organizing alternative forms of entertainment to the casino.

## Roles Community Health Workers Could Play

- Providers viewed the coming of the casino as a holistic "all hands on deck" need for preparing and engaging a variety of colleagues to meet problem gambling needs.
- Participants stressed the importance of funding for additional CHW, psychiatric and counseling staff in order to meet the needs that accompany increased access to gambling for at-risk community residents.
- Community health worker roles were envisioned
- as important in the wide range of organizations and initiatives where they work. Key roles in community education, screening, identifying people who need support, and connecting and accompanying them to groups, counseling, and other kinds of services were stressed.
- Providers in healthcare organizations, compared to those in other community organizations, were most familiar with the community health worker label and reported the highest concentration of CHW staff. Some saw CHWs as important sources of awareness in their capacity as community leaders even beyond their professional

positions and roles.

- Some suggested CHWs could support those struggling with problem or addictive gambling in ways similar to how they work with those in recovery from substance addictions. This included offering alternative activities and accompanying people to meetings.
- Numerous employees or volunteers at community organizations play similar “CHW-like” roles by embedding in their communities, conducting outreach education, and supporting those in need.
- CHWs and “CHW-like” employees and volunteers offer cultural competence and linguistic and racial/ethnic diversity. They can assure that those in the region are educated and supported by those who speak their language and understand their circumstances.

## Community Health Worker Training Needs, Conclusion and Recommendation

- The content needed for a basic curriculum for CHWs untrained in behavioral health peer support should be geared to what is most helpful to someone who works in a non-clinical role. Still, the training should include information about the nature of and approaches to recovery from addiction. This section captures ideas offered by respondents for at least one and generally all three of the regional assessments of CHWs and problem gambling service needs.
- A similar non-clinical “essentials of problem gambling training” should be adapted and provided for behavioral health peers, who are sometimes categorized as community health workers but have tended to work in mental health and substance-use program settings.
- Trainings should also highlight the role and impact of CHWs and related interventions in reducing inequities in access to care for communities at higher risk for gambling problems.
- The MDPH Office of Problem Gambling Services should use this report to facilitate discussions and collaboration among relevant organizations to implement its findings:
  1. Organizations such as Educational Development Center (EDC) that are piloting and implementing elements of the Strategic Plan to Mitigate Harms Associated with Gambling in Massachusetts;
  2. CHW specialized training programs;
  3. MDPH’s Bureau of Substance Addiction Services staff or its behavioral health contractors (the latter often work in settings funded by the Department of Mental Health (DMH)); the Office of Community Health Workers and their designated partners, including the Massachusetts Association of Community Health Workers (MACHW).

## OVERVIEW OF REPORT

In 2011, the Massachusetts legislature passed and the governor signed into law the Expanded Gaming Act, which expanded the domains of legal gambling to include a limited number of casinos. The law formed a state Gaming Commission to oversee legal gaming in the Commonwealth.<sup>1</sup> It also established the Public Health Trust Fund (PHTF) to prevent and treat problem-gambling-related issues by allocating significant resources to research, prevention, intervention, treatment, and recovery support services.

The fund will be financed from annual fees charged to gaming licensees and five percent of the taxes on gross gaming revenues by licensees for resort casinos.

This report presents the findings and recommendations from a Community Health Worker (CHW) and Problem Gambling Needs Assessment in Everett, Massachusetts—the location of the single resort casino allowed by law in the northeastern area—and surrounding municipalities, primarily Chelsea, Malden, and Revere. The main goal was to get the perspectives of local service providers, including those of CHWs, on the roles community health workers could effectively play in future systems of prevention, identification, assessment, support, and referrals for problem gambling.

This is the third and final report on this topic and with interviews from local community service providers, including CHWs. The other two reports were based on assessments conducted in 2017, in the Plainville/southeastern region of Massachusetts where the first Massachusetts casino opened in 2015, and in the Springfield/Holyoke area in 2018, just prior to the opening of the Springfield MGM resort casino.

The Expanded Gaming Act passed in Massachusetts in 2011 and permitted a total of three resort casinos in the state. Only one could be located in the Eastern Region, which includes Greater Boston. A number of gaming corporations competed for the award, and the city of Revere voted on whether to allow a casino there.

The casino proposed for Everett was the only one approved by the Gaming Commission. Local residents voted in 2015 to allow its construction, which began the following year and was completed by the time of this assessment (November 2018—May 2019). However, its opening was delayed by litigation and additional reviews by the Gaming Commission, a situation that was still unresolved during the period in which the key informant interviews were conducted and focus groups held. The Encore Boston Harbor Casino finally opened on June 23, 2019.

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<sup>1</sup> The law can be accessed on the website of the 189th General Court of the Commonwealth of Massachusetts (<https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter194>). The Gaming Commission does not oversee the state lottery and instant games, although the director of the Massachusetts Lottery is a member of the Public Health Trust Fund Executive Committee.

## The Strategic Plan: Services to Mitigate the Harms Associated with Gambling in Massachusetts<sup>2</sup>

The Strategic Plan for Massachusetts was informed by existing studies and original research supported with funds associated with the Trust. The authors prioritized a continuum of services, from prevention to recovery support, based on evidence of the need, community support for, and effectiveness of the interventions. They also considered the balance between the services' costs and benefits. The plan was guided by the two key principles of sustainability and cultural competence; it identified community health workers as part of multiple strategies for assuring cultural competence of messaging and services.

Research cited in the plan acknowledges that the meanings, practices, and attitudes towards gambling vary across communities, including groups defined by ethnic and socio-economic class identities. While anyone can be vulnerable to gambling-related problems, members of some social categories and groups are at higher risk compared to others. For example, people with incomes below \$15,000 and those with a high school degree or less are at higher risk for developing a problem with gambling. So are those in special circumstances, such as unemployment, incarceration, and former military service.<sup>3</sup>

The report was presented by the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) of the Education Development Center, Inc. (EDC). The Public Health Trust Fund Executive Committee voted to adopt the strategic plan on April 16, 2016.

## Why Community Health Workers?

The community health worker workforce brings cultural, socio-economic class, and racial diversity to public health and healthcare organizations as part of who they are and what they are trained to do. They directly address inequities in health and in access to prevention and care through the building of bridges among marginalized communities and systems of care.<sup>4</sup> There is growing evidence that intervention models that include CHWs help people access the resources they need to improve their health care and their health. In many cases, CHWs provide basic education on health-related issues pertinent to the communities and programs with which they work.<sup>5</sup>

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<sup>2</sup> The plan is supported by the Massachusetts Department of Public Health and the Massachusetts Gaming Commission. The plan's text can be accessed at <http://www.mass.gov/eohhs/docs/dph/com-health/problem-gambling-strategic-plan.pdf>.

<sup>3</sup> Williams, R.J.; Zorn, M.; Volberg, R.A.; Stanek, E.J.; Freeman, J.; Maziya, N.; Naveed, M.; Zhang, Y.; and Pekow, P.S. (2017). *Gambling and Problem Gambling in Massachusetts: In-Depth Analysis of Predictors*. Amherst, MA: School of Public Health and Health Sciences, University of Massachusetts Amherst. [www.umass.edu/seigma](http://www.umass.edu/seigma)

<sup>4</sup> National Center for Chronic Disease Prevention and Health Promotion: Division of Community Health. *Collaborating with Community Health Workers to Enhance the Coordination of Care and Advance Health Equity*. Issue Brief. <https://www.cdc.gov/nccdpdp/dch/pdfs/dch-chw-issue-brief.pdf>. Accessed June 27, 2017.

<sup>5</sup> Institute for Clinical and Economic Review. *Community Health Workers: A Review of Program Evolution, Evidence of Effectiveness and Value, and Status of Workforce Development in New England*. The New England Comparative Effectiveness Advisory Council. Boston, Massachusetts: July 2013.

**Massachusetts Department of Public Health (MDPH)  
Definition of a Community Health Worker (CHW)<sup>6</sup>**

*A community health worker is a public health professional who applies his or her unique understanding of the experience, language, and/or culture of the populations he or she serves in order to carry out at least one of the following roles:*

- Bridging/culturally mediating among individuals, communities, and health and human services, including actively building individual and community capacity
- Providing culturally appropriate health education and information
- Assisting people to get the services they need
- Providing direct services, including informal counseling and social support
- Advocating for individual and community needs

CHWs are distinguished from other health professionals because they: 1) are hired primarily for their understanding of the communities and populations they serve, 2) conduct outreach a significant portion of their time at work; and 3) have experience providing services in community settings.

## **CORE QUESTIONS AND DESIGN OF ASSESSMENT**

The core questions explored in the assessment are:

1. What are perceptions concerning the roles community health workers that could effectively play in prevention of, screening for, and interventions to assist problem gamblers in Everett and the surrounding area?
2. What are views about best approaches to integrate such work by CHWs into both existing behavioral health (i.e., substance use and mental health) services and/or other interventions related to problem gambling in the region?
3. What are views concerning key content and skills needed to prepare CHWs for these roles, and what local training or educational organizations could best conduct such training?

As noted earlier, this needs assessment was conducted from November 2018 to May 2019. The local and community service providers' perspectives captured in this report will be shared both with the director of the Office of Problem Gambling Services and the Public Health Fund Executive Committee; it will be made public at their discretion. The research strategy, adapted slightly from that used in the two regional needs assessments was as follows:

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<sup>6</sup> For the definition, see <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/comm-health-wkrs/chw-definitions.html>.

Two distinct types of qualitative interviewing were conducted during an overlapping time period: 1) relatively open-ended and semi-structured key informant interviews and 2) focus groups.

- **Key informant interviews** were conducted with public health leaders and providers in Everett and surrounding cities, primarily Chelsea, Malden, and Revere, who worked with CHWs and/or included addiction recovery services in their programs; or who worked with seniors; and/or who provided a variety of community-based supports and services.
- **Focus groups** were conducted in these same cities with similar kinds of providers, including multiple CHWs and others who could be expected to work with any future programs to prevent or mitigate gambling-related harms.

Potential focus group participants were recruited from among the following organizational types:

1. Providers that employ CHWs and others who do community outreach;
2. Providers serving ethnically diverse and low-income communities; and
3. Providers serving people who are at risk for developing gambling-related problems, including:
  - a. Behavioral health treatment organizations, including substance use treatment and recovery
  - b. Veterans organizations
  - c. Elder services organizations
  - d. Healthcare and community-based programs serving people with low incomes

Recruitment built on the author's and the DPH Office of Community Health Workers' contacts among CHWs, CHW employers, and public health leaders, as well as those of a local focus group coordinator. Additionally, in each key informant interview, the author asked for suggestions for other organizations or individuals who should be included, a strategy known as 'snowball sampling.'

Focus group turnout varied, from six in Everett, twelve in Chelsea, and ten and five in Malden and Revere respectively. Key informant interviews were conducted with providers in each of these four cities, along with several others in health and public health organizations in nearby Somerville and Lynn and one in the Charlestown neighborhood of Boston.

Both the facilitator and the focus group coordinator took thorough notes on their laptops during the focus groups. The coordinator made audio recordings of the discussions with permission of all participants and checked her notes against them to produce transcripts. The recordings were deleted once the notes were corrected and refined by the coordinator. The author took notes on a laptop during all of the key informant interviews, which she also led. Resulting notes and transcripts were analyzed for content and themes by the author.

## INTERVIEW AND FOCUS GROUP PARTICIPANTS

Key informant interviews were conducted with 21 individuals, located mainly in the four target cities of Everett, Chelsea, Malden, and Revere.<sup>7</sup> Questions asked of these respondents were the same as those asked of the participants in focus groups.

**Tables 1-3: KEY INFORMANT INTERVIEWS,  
AFFILIATIONS AND POSITIONS**

Table 1: EVERETT, N = 5 (ALPHABETICAL ORDER)
<p><b>AFFILIATIONS</b></p> <p>Cambridge Health Alliance, Elder Service Plan (Everett); La Comunidad; The Eliot Center at Everett; Everett Public Schools, Parent Information Center; Family Resource Center</p>
<p><b>POSITIONS</b></p> <p>Director of Outpatient Clinic, Director, Executive Director, Outreach Educator, Program Director</p>

Table 2: CHELSEA, N = 8 (ALPHABETICAL ORDER)
<p><b>AFFILIATIONS</b></p> <p>City of Chelsea; Community Action Programs Inter-City, Inc.; GreenRoots; Massachusetts General Hospital, Center for Community Health Improvement, Chelsea</p>

<sup>7</sup> Four of the interviews were conducted with respondents in organizations based outside these four cities: one in Somerville, one in Charlestown, and two in Lynn.



**POSITIONS**

CHW Manager, CHW Supervisor, Director, Director of Elder Services, Executive Director, Youth Coordinator, Senior Director, Substance Use Services Director

**Table 3: OTHER NEARBY CITIES, N = 7 (ALPHABETICAL ORDER)****AFFILIATIONS**

Cambridge Health Alliance, Community Health Improvement, Malden, and Somerville sites; Charlestown Coalition; Lahey Health Behavioral Services, Healthy Streets Outreach Program; Lynn Community Health Center; Mystic Valley Elder Services, Malden; Revere Office of Elder Affairs

**POSITIONS**

Director, Director of Community Health Outreach, Manager of Ambulatory Care Management, Program Director

The ultimate composition of each focus group resulted from the interplay of the categories of providers, the connections best known to the local organizer, and the availability of possible participants on the designated dates. They varied by locale.

The table below represents a summary of the types of organizations and professionals who participated in the focus groups, displayed by city. In each group, most of the participants had experience with gambling problems, either personally and/or professionally.

**Table 4: FOCUS GROUP PARTICIPANTS BY CITY/TOWN AND ORGANIZATIONAL TYPE**

									TOTAL N=33: 14
City	Health Care	Addic-tions/ Substance Use (not standalone program)	Mental Health or Public school MH Service	Community Advocacy, Support	Municipal Office	Police Depart-ment	Public Health Program or Prevention Collaborative	Senior Services	Ratio of Total to Peer/ CHW Participants
Chelsea N=12	2	(4)		6	(Veterans services) 1	1		2	Total N= 12; Peer/ CHW= 5
Everett N=6	1	(2)		3			2		Total N=6: Peer/ CHW= 5
Malden N=10	2	(3)	3	1	3			1	Total N= 10; Peer/ CHW= 2
Revere N=5	1	(1)			2	1	1		Total N=: 5; Peer/ CHW= 2

## FINDINGS

The broader questions explored with key informants were largely the same as those explored with focus group participants in all four cities. Therefore, this report combines the resulting themes and insights into a single analysis.

### Setting the Stage

At the time the interviews and focus groups were held, from November 2018 through April 2019, the Encore casino slated for the region still hadn't opened its doors, so the topic of potential roles for community health workers in problem gambling prevention and intervention remained a hypothetical one. As the Strategic Plan for Massachusetts documented, and the current assessment confirms, services focused on gambling are currently limited in type and availability. Community health workers are not yet working with people for whom gambling is an acknowledged challenge in their lives. Therefore, interviews and focus groups began by exploring:

- How participants view problem gambling and related health and socio-economic issues in their city
- If and how problem gambling manifests in their locales
- What support or services exist now for people struggling with problem gambling and related risk conditions, such as substance use

- And what services are needed

The first questions focused on the dominant health, social, and economic concerns experienced by populations served by providers and organizations locally, then probed about people's perceptions of local gambling and problem gambling. This allowed participants to contextualize a challenge they were not yet experiencing as a salient one. This grounding also made it easier for them to speak more meaningfully about what role community health workers could play as part of new programming that might be developed.

## Local Context

The cities included in this assessment—Everett and its neighbors Chelsea, Malden and Revere—are considered by the Metropolitan Area Planning Council to be part of the Boston “inner core,” both for their proximity (ranging from two to nine miles from Boston city limits) and for their urban character. “As some of the most urban and populous communities within the MAPC planning area, ICC cities and towns deal with a host of unique challenges, such as finite developable land, issues of neighborhood change and gentrification, limited affordability, congestion, and public transit capacity limitations, to name a few.”<sup>8</sup>

In addition to these similarities, all the cities share boundaries with Everett and with one another (Malden and Chelsea are the exception, each located on opposite sides of Everett) and are interconnected by highways and thruways. Many respondents reported that their organization's service catchment areas cover multiple cities and towns, including these four cities. Both the Massachusetts General Hospital health system and the Cambridge Health Alliance are major presences, with health centers and clinics located throughout the region.

## Observations About Local Problem Gambling

### Gambling Common but Not Salient Compared to Other Challenges

Many respondents said problem gambling was not a dominant concern about patients/clients, given that most are struggling with a range of day-to-day challenges, including housing affordability, food insecurity, transportation, limited decently paying jobs, and mental health and substance use troubles. They reported many immigrants, both documented and undocumented, among their constituencies who fear deportation and other potential restrictions imposed by rapidly changing policies at the federal level.

Respondents varied in their level of awareness of gambling by residents in their communities, but a number of participants in all cities observed that residents participated in a variety of types of gambling, both locally or in casinos outside the region.

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<sup>8</sup> <https://www.mapc.org/get-involved/subregions/icc/>

Regular purchase of scratch tickets and the lottery were the most commonly mentioned local practices of concern to some of these health and community providers. In addition, they identified keno (also offered by the Massachusetts lottery); card playing and mahjong, mentioned as particularly popular among Asians; and sports betting brokerage, or as one person put it, “exploitation” by “bookies.” Card games took place in Chinatown as well as in homes.

Casino gambling came up most often in association with seniors. Many observed that buses filled with seniors shuttle from local sites to out-of-state casinos, mainly Connecticut’s Foxwoods and Mohegan Sun.

Some interviewees and focus group participants in Revere described their city as having a “culture of gambling,” in part because both dog and horse racing were historically located in their city and adjacent East Boston.

*I think Revere has a history as a community that’s had gambling. We’ve had the horse track and dog track. My husband’s from East Boston; they all gamble. They’re always going to Foxwoods. It’s not just people from here, it’s also people from East Boston.*

Law enforcement staff, focus group, Revere

## Perceptions of the Nature of Problem Gambling

### Problem Gambling Involves Excessive Time, Stressed Budget

Most respondents were clear about the difference between occasional gambling and problem gambling, which was generally seen as when players invest a lot of time (plays “constantly”) and loses more money than they can afford, impacting their ability to care for their basic needs and their families. The latter situation was seen to lead to domestic conflict and even violence.

**L:** *As a mental health provider, I know that it [gambling] can become an addiction, and can affect all areas of one’s personal function, family dynamics, economic status—pretty much can destroy your life, like any other addiction.*

**V:** *I think much more about people who frequently purchase scratch tickets or tend to be watching the lottery, following the lottery a lot—who are constantly spending money on it.*

**E:** *Some people go constantly to the casino to play, including playing dominoes, those type of games for money.*

Some were quick to note that purchasing scratch tickets is not usually seen as gambling. Rather, it is often viewed as a legitimate strategy for acquiring much-needed cash, particularly among the poor. Still, the stories told in focus groups to illustrate the pitfalls of excessive gambling for those with low incomes often featured these readily available games. Below is an exchange among three focus group participants about scratch ticket and keno purchasers:

**R1 (recovery coach):** *I'm a person in recovery. It's the same rush. I've got some tickets in my car right now. I was convinced! I'm going to win! (laughs)... But a lot of the people I work with, honestly, it's the scratch tickets. It's right there. At the liquor store, buy a few "scratchies," they think they're going to win, they don't, they go right back in. And they spend all their money.*

**R2:** *You can go to any establishment, you'll see mostly older Hispanics, there for hours.*

**R1:** *Keno, too.*

**R3 (manages finances for low income clients):** *My clients, and they're not mostly Hispanic, they're pretty diverse. The scratch tickets, hanging out at the Little Peach or White Hen, any of those stores where they can sit and play Keno all day. And their Social Security checks disappear.*

**R4 (substance use program director):** *Some have come in to ask for food vouchers before they get their next Social Security check. You'll sit and have a conversation with them and they will tell you "Well I bought some scratch tickets, I bought a few more." They don't have the money to buy food for the rest of the month.*

Participants in focus group, Chelsea

### Strong Connections Between Addiction and Gambling

Mental health and substance use specialists, including recovery coaches, also viewed gambling through an addictions lens. More than one such respondent expressed concern that most people don't understand the potential for gambling to become an addiction and as a result, underestimate the pervasiveness of such problems.

The association of gambling with addiction observed by respondents included similar physiological sensations—the “rush” experienced by some with drugs and with the excitement of gambling. Some in recovery said that gambling can be a kind of substitute for drugs. One harm reduction program director in Lynn noted that she often sees that when people “stop ‘using’ [drugs], they start gambling—on sports, with scratch tickets—we have observed. . . and keno is another one.” A focus group participant in Chelsea, himself in recovery, expressed the view that when he was actively addicted to drugs, his gambling and other “negative ” activities got out of hand partly because he saw them as a way to get money.

The respondent from the harm reduction program cited above also observed that, "It's kind of a little secret among people that gambling is a really bad addiction and they would rather [not talk about it until they are in treatment]." Several other providers spoke about gambling as a "quiet" or "hidden" addiction that may not be brought up easily by clients.

## **Perceptions About the Opening of the Encore Casino in Everett**

### Mixed Emotions About Anticipated Opening

Issues related to the imminent opening of a multi-billion dollar luxury resort and casino on 33 acres of land in Everett, scheduled for just months after this assessment, dominated most of the discussions and interviews.

Interview and focus group subjects expressed mixed feelings about the casino and its potential impact. They said residents were excited about the number and type of new jobs and about the glamour and entertainment. A number planned to visit the casino themselves once it opened, and few knew people who had already gotten jobs there. But they also had numerous concerns about the negative repercussions of the casino on Everett and surrounding municipalities. Participants spoke of fears about rising housing costs; worsened traffic; increases in prostitution, robbery, drug and alcohol addiction; and an influx of strangers into the cities.

## **Perceptions About Risks of Residents Developing Problem Gambling**

### Financial Vulnerability a Risk Factor for Gambling Problems

Respondents universally agreed that their biggest concerns were about the impact of the casino on residents with low incomes. Most shared the perception that the poor are vulnerable because they are more likely to gamble to gain much-needed cash. One person in the Chelsea focus group quoted a friend as saying, "Gambling is the hope of the poor!" Others pointed to the limited local entertainment options for families, which they feel will enhance the casino's draw for those who live nearby.

Many observed that their patients and clients have little to no disposable income; often residents are struggling to meet basic needs. As noted above, multiple participants identified elders on fixed incomes with a lot of free time as particularly at risk for developing problem gambling issues. People repeatedly discussed casino marketing directed to seniors and the common sight of seniors boarding buses destined for out-of-state casinos.

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*I know the casinos target older people. I have no reason to believe the Encore Casino is going to be any different. I am not of a mind that the casino is innately evil; if people can go and enjoy it, that's not a problem. But the group that we are worried about are those with addictive behaviors and who cannot afford to be there and lose their money. Those are the people I worry about.*

Senior center staff member, Malden

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A number of respondents in interviews and focus groups were certain that the resort casino's presence had already negatively affected many low-income residents by sparking new construction and helping to drive up the cost of housing. An additional factor described as driving up housing prices in all four municipalities is that rising costs in Boston lead people to move to smaller cities on the outskirts. New hotels and market-rate housing in these cities is a response to that demand, some said.

*A lot of people are going to be hired who are looking for a job. That is definitely a positive [result of the new casino]. At the same time, what we have seen is the displacement. So many families in that area are affected by the construction. Even three years ago I used to be a home visitor, I remember when the process was starting people were selling their houses. They were asked to move, and they couldn't find anything for that price. The cost of rents has tripled. We've seen a huge amount of families sharing expenses in the household. Families with 2-3 children sharing an apartment with another family to survive. Due to the changes in housing prices, the amount of stress that families are dealing with has increased.*

Program director, family support program, Everett

*I am interested in its [the new casino's] relationship to the displacement of housing. People don't have food! These past few years I have seen the most disturbing problems of people being unable to put food on their table. And they can't because of what they are paying for housing.*

Administrator, community action program, Chelsea

### Mental Health and Addiction Issues Pervasive

Respondents in all four cities highlighted their large immigrant populations and the challenges such families face when they also have limited financial resources. Participants in the focus groups also spoke about how common addiction struggles—with alcohol, opiates, and gambling—are among the residents they serve, as well as in other parts of the state. They

mentioned as sources of additional stress rapidly rising housing costs, immigrant fears about or the actual familial disruption of deportation, and the need to hold multiple jobs to survive.

*When I was a clinician based in one of the schools in Everett, a lot of the families we were working with had experienced trauma and addictions in multiple layers; alcohol is the biggest addiction. It's the one we don't talk about. It's part of the culture, it's normalized. We see a lot of our clients and family members struggling with the results of alcoholism. Some are homeless, and the children are dealing with the trauma due to the addictions of family members.*

Manager, family support program, Everett

Social isolation was mentioned in multiple interviews as a factor contributing to the vulnerability of clients to behavioral health issues.

*The biggest concern I see with youth in Chelsea is their mental health. A lot of young people were born here, but their parents were not. So there is a disconnect on their issues at school or in their social life. They feel they can't connect with their parents. So they experience a lot of isolation. Quite a few have a social worker through their schools. But each social worker at the school has about 400 students.*

Youth coordinator, healthy food program, Chelsea

*A lot people we work with here don't have the safety net of a family. They're isolated. A lot of times that's a factor [in mental health]. You can't talk to family and often have nobody to talk to. The majority of the patients we work with, especially if they are undocumented, they are just here by themselves. They are hiding and just going to work and school, and that's it. They don't have any support.*

Manager of CHWs, community health center, Chelsea

### Ease of Access to New Casino Enhances Risks

Service providers and community leaders included in the focus groups and interviews were uncertain of the effect of the imminent opening of the Encore Casino in Everett on clients and some community residents, but expressed concern. At the time of this assessment, the casino was slated to open in a matter of months, although sufficient barriers remained to make the exact timing unclear. Many providers were beginning to prepare mentally and, in the case of some organizations, to plan for how their clients or patients might be affected.

Below are some examples of the worries expressed, including fears about recovery relapses for some, and ease of access to the casino for elders and others.

*One of the things that the providers at CHA have been talking about: the patients in a Suboxone group, or those who are recently clean, off of drugs for a very short amount of time. Because they still have that addiction very much*



*present in their day-to-day life. They kind of like, know, in the back of their mind that they can't "use" [drugs], but there's another opportunity to relieve that by getting into gambling. So they're afraid that those people who are recently clean will fall into a different type of pattern of addiction.*

Focus group, Revere

***[Q: Is there gambling among your clients?]*** *It's not super common to hear of major gambling at casinos where someone is significantly in debt, but I would not be surprised to see a rise in it based on our populations, who suffer from significant trauma, PTSD. We work with a lot of homeless folks, a lot of drug use, alcohol-substance use issues. I worry some of [the] people we serve will develop problems [gambling at the casino].*

Director, mental health clinic, Everett

*[I worry about] the elderly. That's a huge population. My parents love going to Foxwoods, but it's really difficult to get there. But now there's something so close. Most are on a fixed income. They'll be struggling with this as well.*

Recovery and addiction specialist, focus group, Malden

*We work with those that are homeless and those with substance and alcohol use, and we are surrounded by this casino now. We have talked, my staff and I, about what do we think is going to happen in the next few months. The addiction to gambling brings substance use, alcohol use, and prostitution, so we are already starting to talk about that. Are we going to see an increase, and how are we going to be prepared for it?*

Substance use director, community action organization, Chelsea

*I'm concerned about young adults. Not necessarily high school age, but post high school. They have some income, they have their own schedule in life that might not include the structure and support that they get from the adjustment counselors. They don't yet have that regulatory ability to say what's healthy and what isn't. Especially when there are so many young people who are already experiencing addiction and mental health issues that haven't been addressed. Or that have been addressed, and now they're sort of on their own.*

Substance use prevention specialist, focus group, Malden

*I worry about folks going and spending all their money that they don't have. In a state where it is really expensive to live what happens when people can't pay the rent? Are we going to have more homeless folks? We really don't have enough space for people who are homeless.*

Director, community outreach program, Lynn

## Suggested Approaches to Prevention and Intervention for Problem Gambling

### Perception That Local Cities are Unprepared

Most respondents—with some notable exceptions—said that until recently they had given limited thought to the implications of the coming casino for their work. Four or more years had elapsed since the public debates and vote to approve casinos, both statewide and locally. In addition, as one service program leader in Chelsea observed, “The development of the casino here has been so uncertain”; the Encore Casino in Everett was beset by challenges and lawsuits related to its ownership, and the delays associated with them. Even at the time of these interviews and discussions (winter to early spring 2019), the possibility of additional delays was still making news.

Whatever the reasons, numerous individuals expressed the view that their city and the community as a whole is not prepared to deal with problem gambling once the casino opens.

*I don't know if Everett and towns around Everett are prepared to deal with gambling addiction.... There has not been enough opportunity to prepare the city or prepare residents.*

Director, community services organization, Everett

*We are not ready and not really conscious about gambling—the entire city. We have looked mainly at the positive side [of the coming casino]: employment, investment in infrastructure, the roads, traffic lights, a lot of money to increase police action. What's missing is increased social services and programs in the schools.*

Public health leader, Chelsea

### Education About Gambling Needed

Most felt that widespread education is needed about the risks, definitions, manifestations, and ways to help people (including their families) at any stages of gambling-related problems, from incipience to addiction.

Interviewees and focus group participants consistently acknowledged their ignorance about the risks and signs of gambling problems, including addictive gambling. Most were unaware of local gambling intervention resources, including the location of the closest Gamblers Anonymous support groups. Education was the top priority for all respondents. They agreed that community residents of all ages and backgrounds need educating. Education is also needed

for clinical and other service providers and community organizations of all kinds, including community health workers and other outreach staff.

### Community-wide Risk Education to Balance Positive Messages

As many pointed out, casino gambling, as well as lottery and other legal forms of gambling, is viewed as just “having a good time” in many communities in the region. Numerous respondents said it will be important to make up for the general lack of understanding of the risks of problematic or addictive gambling.

The potential negative effects are not likely to be advertised by the casino business itself, as some noted. One recovery coach and street worker in the Chelsea focus group wryly observed, “My concern is: Their billboards won’t show someone sleeping in their car!” Quite a few people said it was important to provide a counterbalance to the feel-good campaigns deployed to persuade residents to approve the casino and, once it opened, to drive customers into the facility. For example:

*I see a lot of excitement. I see a lot of people who can’t wait for this to come. I see a lot of messages about jobs being created. But I don’t hear a lot about crime, devastation, addiction, losing their homes. I’m not hearing that end, but I’m seeing a lot of excitement, because let’s face it, it’s great for the community. It’ll bring jobs, the economy.*

Substance use and addictions specialist, focus group, Malden

*It [the casino] is good for the community, but there are going to be negative effects. We have to be able to relay that and not take away from the positive. But we want to make sure you’re aware that there’s going to be some negative effects. Make sure we’re having those conversations.*

Substance use prevention manager, Malden

*[Q: What services or approaches are needed?] Education is the biggest tool we can use. We need to educate parents and families on what gambling can mean.... Once you understand more what an addiction is, you can do something about it. I don’t think a lot of families we work with in this community really understand the implications of having a casino so near.*

Director, family support program, Everett

Most respondents observed that neither they nor many of their colleagues, whose skills will be needed by those who struggle with gambling problems, are sufficiently informed.

*People will visit [the casino] and gamble for entertainment and some people will be going for the windfall—and the addiction that is related to that. I think we will see a huge number in Chelsea and Revere and Everett, but nothing is being*

*done that really truly addresses this. I don't think we have the expertise to know what to do. I don't know much about the problem of gambling and what resources might be available to help people.*

Director, community action program, Chelsea

*[There is a] need for training in our organizations. We have amazing workers but I don't think many are trained on behavioral health in general, like gambling or substance abuse or trauma. We need more clinicians and more access to mental health support, but also more training overall for community agencies—we are serving the same families and their same kids are attending the local schools.*

Family support program director, Everett

*[Our mental health center] is getting in place folks who need to be trained in gambling disorders. It's definitely high on our list to get a few clinicians trained in gambling disorders so we can address them right away with clients. In addition to clinicians getting training in therapeutic modalities appropriate for gambling, we are getting our case managers to be trained as well to help people in the community. Our recovery coach helps people get into treatment and detox, but those don't exist for gambling. We need more education for the case managers to help connect clients.*

Director, mental health clinic, Everett

### Possible Citywide and Regional Collaborations Suggested

Participants often talked about services in terms of a citywide scope.<sup>9</sup> Multiple participants in each focus group provide services through their city government, and a number were members of local service and prevention coalitions. When asked to describe the protections their cities and communities offer vulnerable residents, many emphasized the range of local services and community organizations. Participants in Chelsea and Malden described strong collaborations among organizations focused on shared concerns; those from Everett and Revere also mentioned public health coalitions in their cities as helpful for education and outreach.

In recent years a number of local healthcare and other organizations developed programs and collaborations to respond to the opiate epidemic. Numerous people drew on this experience as they envisioned how prevention and interventions concerning problem and addictive gambling might be implemented. For example, Chelsea participants described as very helpful the "HUB" model funded in part by the city: a wide variety of healthcare, mental health, substance use prevention, and community organizations and police representatives meet regularly to discuss cases and coordinate resources for substance-use and other patients. A key

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<sup>9</sup> All four of the cities in this assessment have small population sizes: Malden, 61,036; Revere, 53,821; Everett, 46,880; and Chelsea 40,160. Figures are U.S. Census Bureau estimates for 2018. Data from <http://www.donahue.umassp.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-city-and-town>.

representative to the HUB described it as a “robust system of care.”

Another HUB member worried that the response to gambling problems would be too slow and fail to draw lessons about the provision of services from the opiate epidemic:

*We'll wait until we're in the thick of it instead of coming at it early on, knowing what we're going to be in for. There was a time when they [drug users] were wheeled back out the door.... We now have recovery coaches working in the hospital. The HUB has a great relationship. We have coaches in several hospitals now, we have the team.*

Recovery coach, street worker, community mental health program, Chelsea

Collaborative models of working across a municipality were described as active in other cities as well.

*[At a mental health] organization, many clinicians were actually offered to be trained on gambling addiction. We have a lot of substance use committees in the community. We have mental health clinicians in all the schools in Everett. Yes, the community is definitely working together. What can we do in order to be ready? Just in case we see things getting out of proportion so we can actually work on it. It's not a problem for one specific community; we see it as a whole community.*

Director, family support program, Everett

The observation that these small, contiguous cities would share the behavioral health and social service challenges posed by the casino's presence in Everett led some to call for a regional sharing of approaches, models, and connections, too. In one focus group in particular respondents stressed the variability in levels of services across cities and the possibility that some could wind up bearing a disproportionate burden of clients related to problem gambling. This was cited as another reason for communication across locales.

*One thing the casino could do—they're trying to create a cluster of citywide, unified effort[s].... So we're all fighting the same battle together. It's all very siloed. Chelsea does its own thing, Revere does its own thing. It would be nice if there's a centralized effort that connected all the cities that are impacted by this.*

Service coalition coordinator, focus group, Chelsea

### Alternative Entertainment Sources and Social Centers Needed

Social isolation, the need for community, and insufficient local meeting places and entertainment facilities were all raised in focus groups as factors that can contribute to excessive gambling. One approach was offering activities and ways to connect socially that

could serve as alternatives to regular casino visits. This social approach, several respondents theorized, was needed because gambling, among other pursuits, often offers people companionship and a social identity.

*I'd also throw in social isolation. Even just finding a community room for this focus group was hard. Our community really suffers from not really having a centralized community center. That's been brought up at [a] recent master plan visioning process.*

Community organizer for health initiative, Revere

*R1: Another thing that we've been doing in the past couple of years is a lot of social activities. Recovery BBQ, recovery movie night, Healthy Chelsea works with us, but there's only so much funding. If we could put up some more of those activities, on a Friday afternoon, people can go to a pro-social gathering with other community members. There's no gambling there. They're having fun. They leave there and they're content with the community.*

Recovery coach, health center, focus group, Chelsea

A moment later in the same focus group the following exchange picked up on the point:

***R2 (CHW at youth program):*** *That's also helpful in the winter. In the winter, there's nothing going on. It becomes a place that people will go because there's nothing happening.*

***R3 (Senior center program coordinator):*** *I think this is true of all age groups. People bond around gambling. The ones who sit in the bus shelter and scratch, they become a tribe. They become a community.*

Focus group, Chelsea

Another respondent in a different focus group stressed the importance of relationships and a sense of connection to preventing problems with addictive behaviors as well as helping people to recover from them.

*A sense of community connection goes a long way when you have someone you feel like you can talk to, or someone to go to when you're having a hard day; when you're struggling with something so you don't turn to negative coping skills. Then you don't need to turn to harmful/destructive behaviors.*

Substance use prevention outreach manager, focus group, Malden

Finally, a community health worker participant in Revere captured the challenge of trying to develop compelling problem gambling prevention messages without acknowledging the real appeal of the casino, including gambling, as a source of entertainment.

*With gambling, they get in because they want to have fun. The city doesn't have anything to offer. So if they're not gambling, we can talk to them about how*

*their financial life will get better, you won't get in trouble with your family. What other options do they have? ... There's nothing to replace the fun part of it. They might be low income, tired of working so hard, and they want to do something and go to the casino! What other options do they have?*

CHW, health system, focus group, Revere

## Roles for Community Health Workers

The sense from most participants and interviewees in the four cities was that the opening of the new local casino resort was an “all-hands-on-deck”-sized event for their colleagues. Those with the CHW title and others, whom some called “CHW-like” staff,<sup>10</sup> were anticipated to be important in the variety of roles they play in all types of organizations. Among the organizations represented in the assessment discussions, healthcare organizations reported the largest numbers of staff referred to explicitly as community health workers.

### Community Health Workers Well Positioned to Raise Awareness

Community health workers often play generalist roles by working holistically with patients or clients to help them self-manage various chronic health conditions, as well as to help them address basic needs for shelter, transportation, or access to other services. One health center program manager saw the role of CHWs in informing their communities as going beyond their strictly professional staff roles:

*CHWs are leaders in the community. If the leaders understand what it [problem gambling] is, what are the risks for developing it, how to talk about it, where to refer people to get help, that would be very helpful.*

Their influence as community leaders would be in addition to their role in the variety of departments at the health center where they worked, she continued. Among the 15 CHWs at their center...

*A number are working with complex care patients on social determinants of health and some with substance use issues. CHWs are working on different initiatives with youth and they work in the community, in schools, and in the clinic here.*

Manager of CHWs, health center, Chelsea

Despite the variety of organizational settings or the differences in ages and health conditions of their clients, CHWs usually provide some formal or informal assessments of clients'

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<sup>10</sup> Community health worker is an occupational category, but it is not always part of the organizational title for people doing CHW work, so it's not unusual for people to be uncertain if a colleague is a CHW. Often those with titles such as navigators, family advocates, community resource specialists, community organizers, and community care managers also fit the definition and scope of work for a CHW. Outreach worker is a very common title for CHWs. In addition, CHWs and recovery coaches are increasingly cross-trained, so in some cases staff are both CHWs and recovery coaches. See page 12 in this report for the Massachusetts Department of Public Health (MDPH) definition of community health workers.

needs and barriers to help. As some respondents pointed out, such assessments offer opportunities to talk to people about the risks of gambling and to help reduce the stigma of discussing gambling problems.

*If [the CHW] is located in the clinic, these are the conversations we have with patients when we assess their needs. We would provide a lot of education in trainings for CHWS on how to talk about it—problem gambling—and how to educate the patients we see here.*

Manager of CHWs, health center, Chelsea

### Community Health Workers Provide Support and Resources

One of the central roles of CHWs, wherever they work, is to help identify and share information about resources for those in need. Often this includes how to get basic necessities such as food, housing, and transportation, in addition to accessing direct services for physical and mental health. Those who work in community settings, including visiting people in their homes, can provide information about patients' circumstances and needs back to their organizations to help plan and adjust interventions.

One interviewee who was knowledgeable about the strengths of the CHW workforce highlighted this aspect of their role as helpful in program planning:

*CHWs are well placed to help distribute resources or provide trainings and they can help to make meaning of the numbers of people [who need help] in particular communities. [They can help with] figuring out where resources need to go and make sure people who need them are able to use those resources. They also offer translation into the variety of local languages and can work at places where targeted folks gather. CHWs would have great deal of potential to help mitigate some of the risks [of problem gambling].*

Director, community health team, health center Malden

The CHW workforce works with people who have behavioral health issues such as substance use addictions. Increasingly, in health care, they work within integrated systems of behavioral health and physical health care. In one such system, a program director referenced their work in actively supporting people in recovery, including offering to join them in alternate activities.

***Q: What would CHWs' role be in addressing problem gambling? It would be similar to the way they support folks with other addictions: educating those we are working with about the concerns, services, and supports. Some of my team members, when a patient says they are ready to start making changes, my CHWs have gone to NA or AA meeting with them. They could do that with gambling too. They are working with behavioral health providers to reinforce***



*treatment messages. Now, we could say [to a patient], "Every Friday you meet with the CHW rather than go to gamble." The CHW can do other stuff with them.*

*CHWs can have a huge role in spreading awareness to their community and to providers about what services there are—and working side by side with individuals to support them in their recovery.*

Director, outreach program, health center, Lynn

The role of community health workers in getting clients and community members the help they need was summed up succinctly by a CHW in a focus group discussion.

*I think this is where we come in. When they do come in and they see their provider, they share that information of their issue. Then they come to us, and we "bridge" them to the resources to help them in the community. This is one of our main roles. If they share the concern, and they want help, they will get the help.*

CHW, health center, focus group, Malden

### Adding Linguistic and Cultural Diversity to Services

The tremendous cultural and linguistic diversity among populations of the four target cities and the region was a theme in all discussions for this assessment. Respondents pointed to the large numbers of immigrants from all around the world who live in each of these cities and surrounding locales. For example, some mentioned that Malden High School, where one focus group took place, is among the most linguistically diverse in the state, with over seventy languages spoken by its students. Their point was the need for any public health services, including those addressing problem gambling, to be available in the languages common in the area.

Many called for more mental health and other clinicians in the region who reflect the linguistic and cultural diversity of residents. Several also said that it is challenging to find such clinicians. Still, they insisted, this is an important priority for behavioral health work and all work in the area.

Community health workers, by definition, are hired, in part, for their shared background and even residency in the communities they serve. As a result, this workforce tends to be as diverse as their patient and client populations in their cultural, linguistic, ethnic, socioeconomic, and health condition backgrounds. As one manager of a CHW program at a health care organization in Chelsea put it:

*Our patient community is [culturally, socially, medically] complex, so it is difficult for providers to work without community health workers and translators; so we have a robust CHW department. It consists of medical interpreters, community*

*health workers, patient navigators, home visitors. All of them are essentially CHWS—but each works with a certain population or disease management program.*

A number of people pointed to the distinctive challenges immigrant families face, given the gap that often emerges between the experience of parents and their children, as young people quickly adopt the ways of the new country. Community health workers who share the cultural and ethnic background of the parents, one participant observed, can help to bridge that gap when discussing difficult behaviors such as addiction or gambling.

*Being able to bring culturally competent conversations and messaging and approaches and outreach [is key]. Being able to go to the Islamic Center and have a conversation. A CHW who is Arabic and a part of their community and able to have that conversation in a non-stigmatizing way.... People respond better to people who look like them. If you can bring in CHWs who look like our population, we need at least people of 10 different backgrounds to hit the main languages spoken in the home. That sort of outreach and comfort level is helpful.*

Substance use prevention outreach manager, focus group, Chelsea

### Outreach and Support Staff Play “CHW-like” Roles

Many of the people who participated in assessment discussions did not work in healthcare organizations. They worked in community action programs, ethnic or immigrant non-profits or volunteer programs, community mental health organizations, and municipal government. While the term community health worker is most frequently associated with healthcare, in recent years, other kinds of programs often provide similar services. Their staff works in the community, conducting outreach and educating and supporting residents in health-related issues, including behavioral health. It is thus reasonable to categorize this function as similar to that of community health workers<sup>11</sup>.

As one interviewee described it:

*A lot of places have cultural workers and street workers. Having women that look like the women in the community is important. It's important in Chelsea that they speak Spanish. We don't have CHWs. We have organizers, but we don't have any health workers. We have three of them. They are organizing the community around issues affecting the community ... around environmental justice or health issues.*

*Youth program director, food justice organization, Chelsea*

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<sup>11</sup> Those knowledgeable about the history and core competencies of the CHW profession would call such staff community health workers. Here they are referred to as “community health worker-like” staff to reflect the distinctions made by local community organizations.

The above positions may not have community health worker in their job title, but they fit the definition of what a community health worker is and does. As are CHWs, these staff are hired for their community connections and work in the community to address health-related issues, including educating and building capacity to improve the conditions that affect health locally. Community outreach positions were described at councils on the elderly, senior programs, and in public housing. Mental health organizations and programs mentioned similar kinds of roles with different titles, including enhanced outreach and case managers. In one Latinx-oriented community organization, the receptionist and a community organizer worked to engage the community on a variety of issues that affect them.

All of the organizations represented in the assessment discussions share an emphasis on service to the community by those who are from the community. They are focused on improving the engagement and well-being of residents. In short, the community health worker role that is a familiar component of comprehensive healthcare is also common in community organizations, but may be called something else. The role of community health workers in problem gambling interventions applies equally to these workers.

## **TRAINING NEEDS FOR COMMUNITY HEALTH WORKERS AND OTHERS**

This report is the final regional of three similar assessment of the cities and surrounding communities for Massachusetts' three casinos. The first took place in the Plainview/southeastern region in 2017. The second was in the Springfield/Holyoke western region in 2018. The three assessments aimed to include the same types of organizations and providers, but the balance, which included CHW staff and/or to staff expected to work with those at risk of problem gambling, varied slightly from site to site and region to region. Likewise, emphases varied across assessment sites depending on a range of local features, including proximity to additional out-of-state casinos (the southeast is closer to casinos in Connecticut and Rhode Island and had a smaller, more geographically isolated Massachusetts casino); timing of the opening of the new casino (western and northeastern Mass casinos were both close to their initial opening at the time of the assessment); and features of the local environment (the northeastern sites in the current report were experiencing drastically rising housing costs due in part to close proximity to the Boston market).

Compared to the assessments for the two other Massachusetts casinos, the interview subjects and focus group participants for northeastern Massachusetts were less concerned with what training CHWs in particular need to be prepared for their roles related to problem

gambling prevention and treatment. Rather, as described in the Findings section, the emphasis was on the need for greater education about problem gambling across all providers and community residents, especially around the issues of identification, community resources, and ongoing support and care for those affected by it.

Based in part on the findings and recommendations from the first report, a first-of-its-kind curriculum was designed to train CHWs for work in problem gambling. *Recognizing the Signs of Problem Gambling* was piloted in a one-day, six-hour training in May 2018.<sup>12</sup> It was funded by the MDPH Office of Problem Gambling Services, as was the Lowell Community Health Center's CHEC CHW training program, which offers additional free trainings to CHWs from around the state and includes a travel stipend. There have been multiple offerings of this training in different regions of the state since then.

Predictably, there is a great deal of overlap in the training suggestions from each region. Participants in all three regions asserted the need for widespread training in the signs and symptoms and other features of problem gambling. Their suggestions about who should be trained included healthcare professionals, behavioral health clinicians and peer support specialists, recovery coaches, and those who work in faith-based organizations and other community-based organizations, in particular those serving low-income residents.

Participants in all three regions agreed that CHWs and other peer workers, such as recovery coaches and peer support specialists, would be well-suited to expand problem-gambling education throughout targeted communities and among their clients/patients. In the current assessment in Everett and surrounding cities, this observation included a number of outreach and community support staff who, while they may not be seen as community health workers, are similarly grounded in local cultures and communities.

## General Issues

There were a number of general issues around training of community health workers that were highlighted in the western Massachusetts assessment that did not emerge in discussions in the current assessment. Nonetheless, they are worth including in this report due to their broad relevance. They are listed below.

### **1. Any new trainings should be accessible both geographically and financially to**

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<sup>12</sup> An announcement for one of these trainings offered in May 2018 highlighted the following as learning objectives for the training: 1) Define gambling disorder, 2) Identify gambling activities, 3) Identify similarities and differences between problem gambling and substance abuse/addiction, 4) Explain the prevalence of gambling in the U.S. and Massachusetts, 5) Explain the difference between gambling and problem gambling, 6) Recognize signs and symptoms of problem gambling, and 7) Identify sources for further assessment, referral, and resources.

<sup>13</sup> Due to ongoing innovations in health care and behavioral health integration, there is a trend in cross-training of CHWs and recovery coaches, as well as other behavioral health peer providers.

**CHWs and to the peer support and recovery specialists most often located in behavioral health organizations.** In the northeast region, community health worker training centers are located primarily in Boston and in Lowell. However, given the range of providers in Everett and surrounding cities who are interested in learning about problem gambling prevention and treatment, MDPH or other trainers should offer some trainings nearby.

**2. The problem gambling curriculum should be offered both as part of addiction courses, as well as independently.** Such classes should qualify for the “special health topics” credits that are required to meet the new state certification requirements for CHWs and also qualify as continuing education credits (CEUs).

**3. Trainings on problem gambling for CHWs should differ from addictions trainings for recovery coaches and other behavioral health peer staff.** While behavioral health peers have usually received training on addictions in general, CHWs often have not. Additionally, as one substance use counselor pointed out, recovery coaches differ from CHWs in the kind of psychological boundaries they are expected to sustain: Coaches are required to have a personal background in addiction and recovery experiences as a way to support recovery for their clients. Recovery coaches, like CHWs, have a core program of defined content areas. One respondent argued that a module on problem gambling should also be added to the recovery coach core trainings.<sup>13</sup>

## Suggestions for Additional Training for CHWs and Others

Training for CHWs and others who do similar outreach and community work should prepare them for the kinds of roles described in the Findings section above, that is, for non-clinical work to help educate and support people around problems related to gambling. Several respondents in the assessment conducted in 2017 in southeastern Massachusetts said they had received training from the Massachusetts Council on Compulsive Gambling; they felt a less clinical version should be adapted for community health workers.

In the southeastern and western Massachusetts regional assessments, respondents generally agreed that it would be appropriate for generalist CHWs to incorporate gambling trainings into their repertoire of topics. Some pointed out that gambling and other addictions could be an area of specialization for some CHWs, just as other health topics such as diabetes are. *However, numerous respondents in western Massachusetts stressed that as the need for gambling-related work grows, it’s crucial to provide funding for new CHW positions.* It would be counterproductive, they insisted, if the current CHW workforce were to be burdened with an additional responsibility with no supportive increase in staffing. This latter point very much applies to the needs in the Everett area; many there emphasized that their staff and services are already overstretched. They asserted that new functions related to problem gambling, an issue that is likely to expand greatly during the local casino era, require funding to cover the costs of additional CHWs, behavioral health clinicians, and other staff.

The following content areas were suggested for CHWs in previous assessments. They are consistent with findings from the current assessment, even if they were not explicitly

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<sup>13</sup> Due to ongoing innovations in health care and behavioral health integration, there is a trend in cross-training of CHWs and recovery coaches, as well as other behavioral health peer providers.

discussed. Most of these topics would also be appropriate for peer recovery or other behavioral health peer worker trainings and others who do outreach and support work in community settings.

**1. Compulsive gambling disorder should be taught as part of a CHW overview**

**understanding of addictions.** CHWs are not usually trained in the nature and manifestations of addictions. This may be changing, given the increased integration of behavioral and physical health services in the healthcare system and the consequent greater attention to co-occurrence of these aspects of illness.

**2. CHWs and other peer staff should also receive a separate training or module on problem gambling.**

Suggestions were to include an understanding of how to speak with people before they've developed a problem and how to help them recognize when they're developing or have developed a problem.

**3. CHWs want to learn how best to informally identify or screen people for problem gambling in community and home settings, as well as in healthcare or program contexts.**

Topics that arose in multiple discussions in the western region were how to ask the right questions in a conversational way, when to probe for more information, and how to share or work with simple two to five-question screening tests. Lie-Bet Tool (from the National Council on Problem Gambling) is one such screening tool that was mentioned as having been validated.

**4. Screening, brief intervention, and referral to (substance use) treatment (SBIRT) is already taught by MDPH's Bureau of Substance Addiction Services; it could be included in CHW trainings related to addiction, including compulsive gambling.**

**5. CRUCIAL: Train CHWs about the range of resources available locally for problem gambling.**

These should include both the usual resources in which CHWs are expert and those that are specific to addictions and gambling problems. Housing, food security, transportation, domestic violence, and other needs commonly referred to as 'social determinants of health' are likely to be as essential to helping those with gambling problems as they are for other people with whom CHWs work.

**6. Educating people about how to manage their money so that monthly expenditures don't regularly exceed income**

was mentioned multiple times in all regional assessment discussions. **Similarly, participants believed the public should be informed about how casinos, the lottery, and other gambling businesses depend on odds that are stacked against the gambler.** Whether these topics are appropriate or needed for CHW trainings or whether these should be more widely available for free to help people control their own unrealistic dreams about winning should be discussed. At the very least, respondents insisted, there should be sufficient access to counseling or training on these topics so that CHWs and others could refer people to them as needed.

**7. Help CHWs understand the variety of ways people avoid getting more deeply involved in gambling and the multiple pathways to recovery.**

This need was pointed out by two respondents in western Massachusetts, including one of the CHW training program directors there. Strategies include techniques for responsible gambling for those who have not yet developed problems, as well as suggestions for alternative activities such as bingo games

which offer prizes rather than cash winnings. The Everett area discussions were even more emphatic than those in Springfield/Holyoke about the importance of offering alternatives to casinos for socializing and entertainment.

**8. Teach CHWs how to raise community awareness and organize educational events on the topic of problem gambling** was a suggestion by one of the CHW training program directors in western Massachusetts. This could involve discussions of the strategy and logistics of organizing community events in one's own community and serve as a possible field practice aspect of a course on problem gambling. Some community health workers and community organizers have experience with this and could help to teach workshops or classes grounded in understanding of local cultures and communities.

## CONCLUSION AND RECOMMENDATIONS

The purpose of this Regional CHWs and Gambling Needs Assessment is to provide insights and guidance to the Massachusetts Department of Public Health (MDPH) Office of Problem Gambling Services as it plans for expansion of infrastructure, services, and programming throughout the state. Its focus has been to explore what might be learned from appropriate community and other service providers in regions of the Commonwealth most directly impacted through close proximity to a casino about how to engage community health workers as part of these services.

Given the focus on community health workers, this assessment was developed collaboratively with guidance from both the MDPH Office of Problem Gambling Services and the MDPH Office of Community Health Workers. The implications of the findings from the interviews presented here should be discussed within this collaborative context as well as with the Public Health Trust Fund Executive Committee.

Just as in there was in the Springfield/Holyoke western region, there is a heightened awareness among service provider respondents in Everett and its environs about the potential downsides of hosting a large resort casino in the city. When the interviews and groups discussed in this report were conducted, in fall and winter 2018 and early 2019, the Encore Casino was scheduled to open in June 2019, which it in fact did—to great fanfare and large crowds. Given the populations the participants in these interviews serve—low-income, communities of color, many of whom are struggling with substance addictions and other life and health challenges, it makes sense that they expressed serious concerns about the risks of the casino's presence. Some displacement of low-income residents has already occurred in Everett and nearby municipalities, according to focus group participants. The focus of the discussions was how to keep people from developing, and then to intervene in, gambling-related problems.

Several clear implications emerged from analysis of the recent focus groups and interviews, consistent with the findings and conclusions from the two previous assessments.

- Prevention of and intervention in problem gambling are closely related in most respondents' minds. They see a need for raising awareness and understanding among all staff and volunteers of the organizations that come into regular contact with community members, rather than solely among outreach workers or staff specialized in the issue.
- Assuming sufficient new funding for CHW staff as well as for training, CHWs are well suited for roles in prevention education, particularly by expanding understanding of problem gambling into communities through outreach, home visits, and community events.
- CHWs are also well positioned to play their usual role of connecting people to the resources they need, whether these are specific to problem gambling or for health and basic needs. A key aspect of their training, as always, will be learning all the different kinds of resources and types of treatment and recovery support available in their communities.
- Confirming a strong finding from the assessments in the southeastern and western Massachusetts regions, respondents emphasized that CHWs could play a crucial role in helping people reluctant to talk about gambling problems to consider seeking help.
- Informal screening by CHWs in community or home settings using sensitive questions developed to help people self-identify as having a problem with gambling was promoted consistently in the western region assessment. The possibility of CHWs or other staff providing screenings that would encourage a candid response by patients/clients in institutional settings was supported, as long as the questions were asked by staff who already have a relationship with the person.
- Screening tools to be used to identify gambling-related problems should be brief and culturally sensitive. CHWs should review such tools under consideration at organizations where they work.

There are a few actions that could be facilitated by MDPH's Office of Problem Gambling Services to explore the feasibility of pursuing ideas presented in this report. The Office of Problem Gambling Services should use this report to facilitate discussions of its findings among other contractors who are piloting and implementing elements of the Strategic Plan to Mitigate Harms Associated with Gambling in Massachusetts. The findings can inform collaborative shaping of programs and initiatives.

**1. MDPH's Offices of Problem Gambling Services and of Community Health Workers should share this report** with and solicit responses to these findings and recommendations from CHW training programs to develop new, gambling-focused training units.



**2. The Office of Problem Gambling Services should solicit input on planning for CHW and other behavioral health peer workforces' role in gambling prevention and support** from MDPH's Bureau of Substance Addiction Services and with staff or contractors for peers in Department of Mental Health-funded mental health settings.

**3. The Office of Problem Gambling should require that the training content ideas here inform the existing and in-depth training for community health workers in this topic area.** Such curricula should be developed collaboratively with the Office of Community Health Workers and their designated partners, including the Massachusetts Association of Community Health Workers.

**4. The Office of Problem Gambling should assure that this and any subsequent initiatives involving CHWs highlight the importance of addressing and tracking the effects of gambling-related services on reducing inequities** in prevalence and care among low-income, ethnic/racial minority, and other disenfranchised communities.