



COMMUNITY HEALTH WORKERS AND INTERVENTIONS FOR PROBLEM GAMBLING:

NEEDS ASSESSMENT FOR PLAINVILLE/REGION C

JULY 2017



Massachusetts Department of Public Health
Office of Problem Gambling Services

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(SOUTHEASTERN MASSACHUSETTS)**

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

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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 Plainville/southeast region of Massachusetts, including what is commonly known as the South Coast, the Cape and Islands, and the area adjacent to or near Plainridge Park Casino, located in Plainville, that qualifies for extra state assistance in mitigating negative impacts of a new gambling casino. 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 one 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 are:

1. What roles could community health workers effectively play in preventing, screening for, and intervening in problem gambling in the Plainville/southeast region?
2. What are the best ways 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 appropriate curricula to prepare CHWs for these roles, what kind of training might be needed, and who can best prepare and conduct the training?

The needs assessment was conducted from mid-March through May 2017 and informed the development of a curriculum for CHWs on the subject of problem gambling; this was piloted in May and June 2017. Eleven background interviews with targeted gambling experts and service providers in the Plainville/southeast Massachusetts region were conducted. They were followed by four focus groups with a total of 44 service providers, including multiple CHWs and others who could be expected

to work in any future programs to mitigate gambling-related harms. The focus groups were held in Attleboro, Brockton, Fall River/New Bedford, and Hyannis.

FINDINGS

Observations about Local Problem Gambling

- Healthcare and community service provider respondents were aware of casinos, but an additional common concern was low-income clients losing money for basic needs by playing scratch tickets (lottery).
- People are increasingly exposed to and engaged in a variety of gaming types, including sports betting, online gambling, and social gambling in homes.
- Seniors were highlighted for extra risk of gambling problems in casinos, due partly to marketing and incentives that target them.

Perceptions of the Nature of Problem Gambling

- Gambling can develop into an addiction and shares features with other addictions.
- There is a lack of awareness and understanding of problem gambling.
- People often do not perceive playing the lottery and other non-casino gaming as gambling.
- Gambling is widely accepted and very often legal, yet it's shameful for those who've lost control over it.
- Consequently, people rarely open up about or seek assistance for gambling-related problems.
- It is common for people to seek help for other conditions, such as mental health or addictions, with the role of gambling emerging only after in-depth assessment.

Roles Community Health Workers Could Play

- A key role for community health workers is to identify people who need help and support for varying levels of gambling-related problems.
- Identification could occur during screenings and/or outreach in a variety of healthcare, public health, or community settings. Referrals could take place on the spot.

- CHWs, peer recovery specialists, and/or other mental health and addiction services peers could improve access to and retention in treatment and recovery.
- In healthcare or community-based social services settings, CHWs could inform people about, accompany them to, and advocate for them with a variety of specialized resources and services.
- CHWs can also provide health education, support, and assistance by assessing barriers to care and obstacles to retention in it. Home visits are common as part of this work.
- CHWs contribute to reducing inequities in access to health care, health-related information, and other services because they share cultural, socio-economic class, and/or ethnic characteristics with the underserved and have a commitment to improving the health of their communities.
- CHWs can review problem-gambling campaign messaging and materials for cultural appropriateness and relevance.
- CHWs can educate individual clients, their families, and communities at events and as part of their ongoing education about public health issues and related services in widely culturally diverse neighborhoods.

Community Health Worker Training Needs

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.

- 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 tend to work in mental health and substance-use program settings.

Findings from this report should inform subsequent needs assessments in Regions A and B. They 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 legal gambling to include a limited number of casinos. The law formed a state Gaming Commission to oversee legal gaming in the Commonwealth.¹ 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.

The fund is to 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 related recommendations from a Community Health Worker (CHW) and Gambling Needs Assessment Plainville/Region C of the roles that CHWs could effectively play in future systems of prevention, identification, assessment, support, and referrals to treatment services for mitigating problem gambling. Also included are perspectives of those interviewed concerning the nature and content of the training needed to properly prepare CHWs for their roles.

The Strategic Plan: Services to Mitigate the Harms Associated with Gambling in Massachusetts²

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

¹ 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.

² 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>.

others. For example, people with incomes below \$15,000 and those with a high school degree or less are at higher risk than others for developing a problem with gambling. So are those in special circumstances, such as unemployment, incarceration, and former military service.³

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 and adopted 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.⁴ 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.⁵

Massachusetts Department of Public Health (MDPH) Definition of a Community Health Worker (CHW)⁶

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

³ 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

⁴ 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/nccdphp/dch/pdfs/dch-chw-issue-brief.pdf>. Accessed June 27, 2017.

⁵ 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.

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

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.

The assessment of potential CHW roles and training needs was conducted in the Plainville/southeast region of Massachusetts, including what is commonly known as the South Coast, the Cape and Islands, and the area adjacent to or near Plainridge Park Casino located in Plainville. This latter area qualifies for extra state assistance in mitigating potential negative impacts of a new gambling casino.⁷ Plainridge Park was the sole operating casino in the Commonwealth as of the date of this report. Penn National Gaming received a license to open up to 1,250 slot machines at the Plainridge Park Casino in June 2015, three years before resort-style casinos were scheduled to open in other regions of the state. This casino is not a resort casino, but rather offers a variety of gambling in addition to slot machines, including KENO, electronic blackjack, and the Massachusetts Lottery. Pari-mutuel betting is available at the adjoining racetrack.

Because it is the region where the first state-approved gambling slot parlor is located, the broader southeastern Massachusetts area is also the target region for the pilot primary prevention campaign for the state's Problem Gambling Initiative.

CORE QUESTIONS AND DESIGN OF ASSESSMENT

The main questions explored in the assessment are:

1. What are perceptions concerning roles community health workers could effectively play in prevention of, screening for, and interventions to assist problem gamblers in the Plainville/southeast region?
2. What are views about how best 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 appropriate curricula to prepare CHWs for these roles, what kind of training might be needed, and who can best prepare and conduct the training?

⁷ "A Surrounding Community is a municipality in proximity to a host community that the [Massachusetts Gambling] Commission determines experiences or is likely to experience impacts from the development or operation of a gaming establishment." Agreements must be signed between these municipalities and the entity licensed for a casino. Further information may be accessed at <http://massgaming.com/about/2017-community-mitigation-fund/host-surrounding-communities/>

The needs assessment project was conducted from mid March through May 2017 and informed the development of a curriculum for CHWs on problem gambling, which was piloted from May to June 2017. The following design was developed:

Two phases of qualitative, relatively open-ended and semi-structured interviews and focus groups:

- **Initial background interviews** with gambling experts and providers in the targeted region who either worked with CHWs and/or included addiction recovery services in their programs;
- **Subsequent focus groups** with relevant providers in four locations in the Plainville/southeastern region, including multiple CHWs and others who could be expected to work in any future programs to mitigate gambling-related harms.

A local focus group organizer was identified in each of the four cities where groups were to be held. Focus group participants were selected from among the following organizational types, with an emphasis on those serving communities at relatively higher risk for developing gambling-related problems:

- Provider participant categories included CHWs in each focus group;
- Providers serving ethnically diverse communities; and
- Providers who serve people who research has indicated 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;
 - d Probation and parole organizations;
 - e Healthcare and community-based programs serving people with low incomes.

A consultant was hired to take notes during the focus groups, and the lead consultant took notes on a laptop during background key informant interviews. Transcripts were analyzed for content and themes.

INTERVIEW AND FOCUS GROUP PARTICIPANTS

Formal background key informant interviews were conducted with eleven individuals, primarily in the target region of southeast Massachusetts. Questions asked of these respondents were the same as those asked of the participants in subsequent focus groups. However, an additional purpose of these initial interviews was to do a rapid assessment of where risk factors associated with problem gambling were

concentrated in the region and, therefore, where to hold the limited number of focus groups.

Among the background interview respondents were four gambling experts based in the Boston area. The remaining seven respondents worked and lived in the Plainville/southeast Massachusetts region, from Wellfleet, Hyannis, Attleboro, and Fall River/New Bedford to Brockton. Below is a display of respondents' professional positions and organizational affiliations.

**Table 1: BACKGROUND KEY INFORMANTS:
ORGANIZATIONAL AFFILIATIONS AND POSITIONS**

Problem gambling experts, Boston area	Brockton Neighborhood Health Center	Southcoast Health System, New Bedford office	Immigrant Service Center, Greater New Bedford area	Episcopal Church and Inter-church Anti-Gambling Coalition, New Bedford	Southcoast CHW Collaborative, Fall River/New Bedford	Stanley Street Treatment and Resources, Fall River	Outer Cape Health Services, Wellfleet/Harwich, Cape Cod
Three interviews; one call included two experts	Community health manager, CHW supervisor	Community benefits manager	Executive director	Pastor	Director	Program director	Director of program management and resources

The ultimate composition of each focus group resulted from the interplay of the categories of providers recommended, 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 2: FOCUS GROUP PARTICIPANTS BY CITY/TOWN AND ORGANIZATIONAL TYPE

								TOTAL N=4: 17
City	Health Care	Addic- tions/ Substance Use	Mental Health	Criminal Justice	Commun- ity-Based Service	Church	Public Health	Ratio of Total to Peer/ CHW Partici- pants
Attleboro	1	4	1	3	4		2	Total N=15: Peer/ CHW=0 ⁸
Brockton	1	7	1		2	1		Total N=12: Peer/ CHW=8
Fall River/ New Bedford		2	1		3	1	2	Total N=9: Peer/ CHW=3
Hyannis	1	4	2		1			Total N=8: Peer/ CHW=6

SELECTION OF FOCUS GROUP SITES

Given the focus of the assessment, one priority was capturing the current roles and geographic and institutional concentrations of CHWs in the region. In part this was to assure that focus groups included community health workers.

CHW Workforce in Plainville/Southeast Massachusetts

The background key informant interviews offered the following main points concerning where CHWs tend to be employed in the region:

- CHWs work in a wide variety of settings in Brockton, Fall River, and New Bedford and in less concentrated numbers in towns and rural areas.
- Employing organizations include healthcare organizations, such as hospitals and health centers; public housing developments; immigrant service organizations; a

⁸ Focus group organizers were unable to identify community health workers employed in Attleboro.

volunteer veterans' outreach non-profit; local health departments; YMCAS; Fishing Partnership; and other community-based organizations.

- CHW roles vary but commonly include engaging people in care and helping them access resources and services.
- Increasing numbers of CHWs are working in behavioral-health-related roles. For example, at the New Bedford-based Southcoast Health System, there is a formal position with the title "community health worker," and 15 CHWs work in the behavioral health department.
- The CHWs in this example are staff of the behavioral health department and work as part of care teams supporting people with recent histories of very high use of hospital emergency room and inpatient services who need both physical and/or behavioral health-related assistance.
- Another behavioral health role for CHWs in rural areas is "community navigator," exemplified at Outer Cape Health Services. These positions fall under the CHW umbrella, as they help people in the community struggling with behavioral health, substance use disorders, criminal justice involvement, and other challenges. Navigators connect people with services and treatment by working closely with a multitude of social and human services agencies.

Selection of Sites for Focus Groups

As noted above, presence of CHWs in local organizations was one factor that influenced selection of focus group sites. Additionally, the presence of local addiction services was a criterion, given the evidence that gambling addictions are commonly associated with other addictions. Other factors considered for the limited number of focus groups feasible were:

- Assure geographic spread (**Hyannis in Cape Cod region**),
- Target low-income populations near multiple out-of-state casinos (**Fall River/New Bedford area**),
- Proximity to current Plainview Park Casino in Plainville, MA (**Attleboro**), and
- Include an additional city with a disproportionately low-income population in the northern part of the region (**Brockton**).

FINDINGS

As noted above, the broader questions explored with key informants in background interviews 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 of the discussions reported on here, new resort-style casinos in Massachusetts still hadn't opened their doors. Thus, the topic of potential roles for CHWs in problem-gambling prevention and intervention was hypothetical. As the Strategic Plan for Massachusetts documented, and this assessment confirms, services focused on gambling are currently limited in type and availability. CHWs are not yet working with people for whom gambling is an identified challenge in their lives. Therefore, interviews and focus groups began by exploring:

- How participants view problem gambling,
- How it manifests in their areas,
- What support or services now exist for those struggling with it, and what is needed.

These introductory questions helped participants define a challenge they had not yet experienced and allowed them to speak more meaningfully about the role CHWS can play in new programming.

The topic of problem gambling in their locales and how best to respond to it generated thoughtful and sometimes passionate discussion.

Observations About Local Problem Gambling

Concerns About Lottery Use Among Low-Income People

All participants were keenly aware of casinos located not only in Plainville, MA, but also multiple casinos in Rhode Island and Connecticut not far from their cities and towns. At least three had actively opposed casinos coming to their communities, including one that is now slated to open in Tiverton, RI, very near Fall River.

Still, almost all began their discussion with their concerns about the pervasive use of scratch tickets, having observed their sale in convenience and other stores and noted the discarded tickets everywhere in the streets.

Participants in all focus groups asserted that problem gambling occurs among individuals and families at all socio-economic levels. They concurred, however, that the cases they saw most often in their social services work were people with limited resources, for whom small or regular financial losses can have serious consequences.

People unable to live on fixed or low-income budgets who return often for assistance with basic needs were described by a number of providers. Participants noted that frequently clients' financial struggles are exacerbated by the purchase of scratch tickets.

"I work with patients who have difficulties with mental health; a lot of them have dual diagnoses and a lot of them are doing scratch tickets. You look into why they are having financial issues and it turns out they are spending hundreds of dollars a month on scratch tickets. I do see that quite a bit--they aren't so forthcoming but it's there. A lot of them don't even see it as gambling."
Therapist, mental health facility, Cape Cod

Discussions in all four focus groups pointed to a variety of types of gambling that are increasingly accessible to ordinary people, in addition to casino gambling and scratch tickets, sports betting, Powerball, online gambling, and even private in-home gambling nights.

Worries About Seniors and Casino Gambling

Participants varied in the amount of professional contact they had with people who regularly gamble at casinos. As one person pointed out, Plainridge Park Casino, in the small town of Plainville, MA, is somewhat inaccessible for those without cars. It also lacks the range of gaming options that casinos over the state line in Rhode Island or Connecticut have. This may explain why some have not noticed much impact from Plainridge Park on their clients or others. Additionally, as noted earlier, most do not screen for gambling problems.

Other participants—among them, a pastor from the Salvation Army, an addictions counselor, and a mental health clinician—reported having clients who regularly visit Plainridge, and some have financial troubles related to gambling.

In addition to people with other addiction issues, seniors were most often mentioned across all focus groups as being at risk for casino gambling problems. Seniors were highlighted in part because free bus transportation and other incentives are offered to them by casinos, reportedly including by some senior services organizations.

The Challenges of Helping People

Gambling Often Not Seen as Having Addictive Potential

Some focus group participants had training and/or significant experience with problem gambling, including their own, a friend's, or a family member's. Most participants believed that gambling can become an addiction. In addition to the potential for loss of control/compulsiveness and related shame and diminished self-esteem, all agreed that financial losses, stresses, and family problems are the most common negative outcomes.

The main distinction participants made between drug and alcohol addictions and gambling is the relative lack of understanding of gambling dysfunctions compared to other conditions. One aspect of this lack is that many people who are struggling with the effects of excessive gambling do not identify it as a problem. In the case of scratch tickets or other non-casino gambling, people often do not even define the activity as gambling.

Shame Associated with Loss of Control over Gambling

Two common, seemingly contradictory, themes identified across the focus groups and interviews are: a) These gambling forms are legal, common, and even promoted, so most people don't see them as a bad thing, at least not like illegal drugs—it's just "having fun;" and yet b) Gambling problems are shameful and often hidden, and hence people don't want to discuss them or seek help.

"A lot of people are ashamed of it and don't want to talk about it or even admit to it. We could put it on the membership form and ask them point blank but they may still say no. Gamblers, even amongst recovering addicts, will still a lot of times feel ashamed and deny it." Addictions counselor, substance addiction treatment organization, Brockton

One of the most challenging aspects of offering help is getting people to open up or seek out assistance for gambling struggles, participants stressed. This is made more difficult by the fact that gambling is socially acceptable, very often legal, and, to date, lacks public education about the possibility of addictive/compulsive behavior and its consequences.

"By the time I get people calling me they are usually pretty far into the hole. Could be sports betting, slot machines at Twin River. Those are generally people that call me up when they are in \$50,000-\$100,000 behind, and they are in deep trouble. I have to agree about the scratch tickets, because it targets low-income people. Because of the fear and anxiety about paying bills, they get caught up in that cycle. It's a very embarrassing situation for people to be in." Clinician and certified gambling specialist, mental health and addictions organization, Attleboro

Participants asserted that it is unusual for people to, in one provider's words, present with a primary diagnosis of gambling. As one psychologist and public health advocate put it:

"Typically people don't come into counseling situations saying 'I have problem gambling.' They come in with other issues, and it becomes clear that the underlying issue is gambling. Most people don't present with only one issue." Prevention coalition, New Bedford

Lack of Understanding or Recognition of Problem Gambling, Including by Insurers

There was an emphasis in all the group discussions and in some of the key informant interviews on the lack of understanding of the signs of problem gambling. Additionally, the discussions highlighted the tension between the general acceptance of gambling as a legitimate form of recreation with the problem gambler's shame about his or her loss of control despite the negative consequences. Hence, it's not surprising that most also agreed that one of the biggest challenges to helping people is identifying those who need assistance.

Participants in multiple groups mentioned that the lack of public or private health insurance coverage for a primary gambling problem diagnosis may, in part, account for the rarity of such a diagnosis. This appears to present a barrier to treatment on a broader policy scale.

CHWS Can Identify People Who Need Help

Respondents were unanimous that currently there are few services geared specifically for those with gambling-related problems. And what services there are, they agreed, are not widely promoted or known by even those who work in social services. For instance, it was common during focus group discussions for participant providers to do internet searches on their smart phones to learn if there were any gambling-oriented programs in their area. Gamblers Anonymous 12-Step model groups were the most recognized service by the range of providers in the focus groups. Even some of those trained in compulsive gambling treatment (most often by the Boston-based Massachusetts Council on Compulsive Gambling), who were working in general health care or recovery facilities, reported seldom receiving referrals of people with this problem.

- Assuming there is funding in the future, respondents asserted that the most crucial element to help people struggling with gambling problems is **widespread public education about the nature of problem gambling, the signs, and where to find help.**
- However, even with an expansion of services and awareness, participants in focus groups and interviews felt **having people seek out help for their gambling problems would remain a challenge.**

- In such a context, **the importance of having trusted community members, such as CHWs, help people open up emerged as a major theme.**

“They [CHWs] could be part of the outreach team, provide peer support, and help to engage skeptical people, talk to families.” Director of community programs to prevent addiction, Fall River/New Bedford

“One of the major roles of CHWs is to make people feel comfortable so that they can talk about this stuff with somebody, feel like they can finally tell someone. And then to supply them with resources and connect them with safe places and good places they can go and get assistance. We are missing that last piece. Where are CHWs going to send these people?” Community health worker, community health center, Cape Cod

“They [CHWs] know the culture—addiction has a culture, and they are going to make a critical difference in whether people will engage or be afraid.” Wellness coalition leader and private therapist for addictions, including gambling, Fall River/New Bedford

“They [CHWs] can play a role in prevention. Veterans are afraid to talk, or get services. But they will trust another vet.” Veteran and CHW/navigator with a volunteer veteran support non-profit, Fall River/New Bedford

CHWs Can Initiate Contact and Engage People in Services

Screening

The need to include questions about gambling, along with other behavioral health questions, in a wide variety of screening instruments and situations was mentioned often. As one person put it, “[T]here’s no questions on the assessments about gambling, so how would you know?”

- CHWs are accustomed to assessing clients/patients for basic and service needs in public health, medical, and social service settings and could be trained to assess for behavioral health concerns and needs, including gambling problems.
- CHWs have more time to talk to patients in depth than most other providers, so their conversations are likelier to allow a variety of topics to emerge.

Community Outreach

CHWs commonly work beyond the walls of healthcare or other service programs. In these more comfortable environments and while other issues are being discussed, opportunities may naturally arise to explore what role, if any, excessive gambling losses play in the lives of clients and their families.

CHWs Can Give Peer Support for Addiction Services, Including Gambling

Peer support is key for helping people access and maintain treatment and recovery from various behavioral health conditions, affirmed multiple discussions in this assessment. As quotes in the above section illustrate, the sense of someone having “been through” what the client or patient has experienced is often critical to encouraging people to build trust and accept help. Likewise, a shared cultural background, as with immigrant communities or military veterans, can make it easier for people who are struggling with behavioral health issues to accept help. CHWs and other peers are also trained to educate clients about the nature of their condition and support them in self-care.

Co-Occurrence with Other Addictions Points to Key Role for Behavioral Health Peers

Given the common co-occurrence of mental health and other addiction concerns among people who have developed a gambling problem, it is important to acknowledge that the established peer support roles in these fields—peer support specialists, recovery coaches, and peer specialists—are likely to play essential roles in future gambling treatment access and support.

Gambling experts interviewed observed that most people with gambling-related concerns who are in treatment are in substance-use addiction treatment programs or mental health programs. The relationship between gambling addiction and other addictions and its co-occurrence with other mental health problems is well established in the research literature.⁹ As one provider quoted above noted, it’s rare that people present in treatment programs with a single issue, and gambling addiction is seldom the primary condition reported.

Respondents in this assessment did not always draw clear distinctions between CHWs and behavioral health peer workers (*see sidebar for a comparison*). Community health workers are most often employed in the frontline of healthcare, public health, and community-based social services settings. As such, they are well positioned to help people connect and continue with problem-gambling support groups and other forms of treatment and recovery.

CHWs’ Community Relationships Key to Value of Their Work

Community health workers develop relationships with people in a variety of organizations, including many community-based organizations. Their reputation as providers who help people access resources makes them potentially valuable allies of behavioral health treatment staff and patients, especially in extending treatment and recovery support work to community settings.

⁹ Williams, R.J. et al. *Gambling and Problem Gambling in Massachusetts: In-Depth Analysis of Predictors*. University of Massachusetts Amherst School of Public Health and Health Sciences. Amherst, MA. March 23, 2017.

- A main strategy to help mitigate the negative impacts of legalized gambling proposed in the Strategic Plan for Massachusetts is to build the capacity of existing organizations to prevent and treat problem gambling. The Plan report recommends a community-wide environmental approach to raise awareness and understanding of problem gambling and how to find help.
- Respondents observed that CHWs often work in trusted organizations where many people already go for services. For instance, an immigrant services organization or a community health center attracts many people in need of information and assistance. CHWs offer accessibility of support, community presence, and, if sustainably funded, stability of relationships.

Prevention and Support in Community Settings

Were CHWs to be trained to understand addiction, the common circumstances that lead to problems with gambling, and the signs that someone may be in trouble, they could offer education and support in addition to providing connections to appropriate groups or interventions.

Their ethnic, socio-economic class, and linguistic diversity could expand the reach of prevention and treatment into currently underserved communities.

“CHWs are there with people, they are a person who is there, people aren't left by themselves. There is a huge amount of trauma in this area. They often overreact or shut down, so having someone who is there who can help modulate the response [would be helpful].” Private psychologist specializing in addictions, Fall River/New Bedford

“It could be like the CHW role in primary care. They aren't just going to work with them in the office, it's going to be in the grocery store, in their homes.” Community health worker, large addictions service and recovery agency, Fall River

Peer Support: Differences and Overlap Between Community Health Workers and Behavioral Health Peer Workers

As more attention is paid within physical health and behavioral health care systems to the role of peer education, support, and care coordination, it is important to clarify differences and similarities among related workforces. In the area of problem-gambling prevention, this means understanding how community health workers and peer support specialists and other behavioral health specialized peer positions both converge and diverge. This is complicated by the fact that increasingly (but inconsistently) community health worker is used as a cover term for both types of workforce, despite historically distinct institutional and training orientations.

Community health workers are an established profession defined by the peer relationship that a shared cultural/socio-economic class, community, and often shared health condition background with clients establishes. The profession developed in the context of community-based public health work, including health promotion, education, and helping with

access to both basic and service needs. Healthcare reform has contributed to an expansion of their roles supporting people managing chronic health conditions and linking health care and community organizations. Motivational interviewing is a skill that is part of the training both for CHWs and peer support staff.

Healthcare reform has also driven increased integration of physical and behavioral health services through co-location, care coordination, and other forms of system integration. As a result, some community health workers in healthcare settings are receiving training in behavioral health topics—including recovery coaching. In some programs interviewed for this assessment, the term ‘behavioral community health worker’ is used.

The historical distinctions between peer workers, who have “lived experience” of and are also trained in behavioral health issues, and community health workers, trained primarily in public health, is partly based on these distinct emphases in their respective fields’ core competencies. Additionally, the CHW ‘peer’ status is most often defined by cultural/ethnic/class and community background. This contrasts with the behavioral health peers’ requirement of having been diagnosed with mental health and/or addiction conditions. However, it is not uncommon for CHWs to have a shared health condition with those they serve. One example is CHWs with a history of substance misuse doing education and outreach for those at risk for HIV. Another example is the successful diabetic patient CHW who is trained to share their skills with other chronic disease patients. Neither CHWs nor behavioral health peers are required to bring post-secondary formal educational credentials to their work; both rely on experiential expertise shared with clients and patients together with specialized competency-based training.

Another distinction among behavioral health peer workers and CHWs is that, to date, the former support clients in behavioral health institutional settings. CHWs, on the other hand, often work in community settings outside their employing organization. As health care reform and integration proceeds, it may be that boundaries between these workforces blur, and hiring criteria and training expectations may have significant overlap.

CHWS: The Bridge between Providers and Communities

As noted in this assessment’s overview section, the crucial topic of cultural appropriateness to all gambling education and services was highlighted in the *Strategic Plan: Services to Address the Harms Associated with Gambling in Massachusetts*. Respondents in this assessment spoke about the greater trust one has in someone from one’s own community, whether that be military veterans, an immigrant group, or a geographical area.

Culturally Competent Communication

Community health workers highlighted the importance of their role in assuring that communication with people from distinct communities would be sensitive to local taboos and norms. This includes reviewing screening tools to make sure they meet this test and suggesting how to approach people in a variety of settings.

“Being able to give input on the wording of the screening and the way it should be phrased. One of the big issues we have in the clinic is making sure you are looking at religious or cultural barriers that might exist when talking about addiction, if it’s okay to even talk about and ask for help from anywhere other than the church. Sometimes they can’t even go there [to the church for help] because it would ruin everything. They can’t be seen there. . .” Community health worker, community health center, Cape Cod

“Some people may need a different approach to getting help. Outreach to specific communities is important; in some cultures it’s not acceptable to ask for help.” CHW harm reduction specialist, community health center, Brockton

Community-Based Education

Community health workers as community educators can be part of a broad-based effort to enhance understanding of the risks of gambling. The importance of community-wide education via numerous forms of media regarding the nature, signs, and support available for problem gambling was a major theme uniting the interviews and focus groups. Suggested media included ethnic radio for immigrant communities, church bulletins (for assistance information), school curricula, and widely distributed flyers and information sheets. Community-wide and other prevention efforts should, of course, be built around evidence-based and best-practices approaches and principles.

- When asked to describe community assets that help protect residents from the negative effects of increased gambling opportunities, participants pointed to the presence of numerous community organizations, recovery programs, and groups. A psychologist who works with people with gambling problems stressed the importance of a diversity of groups so that different kinds of people can find one where they feel comfortable. Equally important, several participants pointed out, is that people *know about and understand* the variety of educational and support groups available in a town.

“The more normative it is for people to access help, the more people will look for help.” Prevention and addictions specialist, addictions program, New Bedford

COMMUNITY HEALTH WORKER TRAINING NEEDS

The topic of education about problem gambling was both a focus and a theme of the interviews and discussions of this assessment. Many of the service providers

expressed a desire to receive basic training in gambling problems and approaches to helping people who have them. This included the behavioral health peer support staff, who primarily work with people who are addicted, but none of whom had received training about gambling.

A number of people suggested that a range of providers who work directly with clients or patients, including in healthcare facilities, could benefit from greater awareness of the signs or situations that can indicate possible gambling troubles.

Pastors who were interviewed all expressed a desire to receive training on prevention and ways to help people in these situations. In one group, police officers who often respond to domestic violence calls suggested that the advocate who works with families experiencing domestic violence would benefit from such a training, given the possibility of links between conflicts over financial losses and gambling.

Asked to describe what kinds of training community health workers should receive to serve in the roles identified as appropriate for them, respondents consistently identified a number of topics. Additionally, there were several issues raised and explored concerning CHW training and education in this area.

General Issues

The Strategic Plan: Services to Mitigate Harms Associated with Gambling in Massachusetts aims initially to build capacity to recognize and support a gambling-addiction component among current addiction and mental health organizations, as well as in other health and human services. Consistent with that idea, there was widespread agreement in interviews and focus groups that training about problem gambling should be part of addiction trainings in general. The following points were made:

- CHWs tend to be generalists, and in the case of problem gambling training, that makes sense as well. Perhaps some might develop specialized expertise in addictions and problem gambling, but most wouldn't need to.
- The question of whether CHWs, to be helpful as peers, must have personal experience with gambling problems was raised but not resolved. The general view was that this would depend on what kind of role they were playing with people in treatment or recovering from such challenges. But for most CHW functions—screening, referrals for support and services, education, and in-person advocacy with organizations not specialized in addictions, shared experience of the behavior is unnecessary.
- Trainings for CHWs are often best held in community-based settings for accessibility and comfort. However, community colleges or other kinds of educational settings are also common.
- A similar “essentials of problem gambling training” should be adapted and provided for behavioral health peers.

Training Content for CHWs: Recommendations

The content needed in a basic training for CHWs who are not in behavioral health peer support positions should be geared to what is most helpful to someone who works in a non-clinical role. Some in the focus groups had received training from the Massachusetts Council on Compulsive Gambling and felt it should be adapted for community health workers by making it less clinical. The following captures the content suggestions:

- **Acquire basic knowledge.** "They don't have to be a counselor, they just have to have some basic knowledge of addiction and trauma. What does it look like when someone is having a trauma response?" *Psychologist in focus group*
- **Learn motivational interviewing.** This is already part of the CHW core competency trainings, but needs to be adapted for addictions and gambling problems in particular.
- **Understand different cultures and communities, including how different kinds of gambling are viewed and why problem gambling might not be discussed.** "Communities" include ethnic/socio-economic class communities, but also communities of veterans, seniors, people in recovery, and young people. It's also important to understand what types of settings for support groups might be comfortable for a particular community.
- **Gain information about the different kinds of gambling** that are prevalent in the region and some exposure to the language of gambling culture.
- **Learn how to recognize signs of where someone might be on the continuum of gambling involvement,** from just recognizing they might have a problem to confronting a serious one.
- **Understand the effect problem gambling has on families,** including its relationship to domestic violence.
- **Acquire a good understanding of local resources, locations of interventions, models, and types of support** for people in different phases or situations. Knowing where or when to send people for help is crucial.
- **Understand the types of community that peers, perhaps including CHWs, can help to promote,** such as what it takes to form a local Gamblers Anonymous support group.
- Two people suggested CHWs should **know how to find help for people in managing limited budgets.** In Attleboro, a social services organization sometimes brings free credit counseling services to work with low-income clients who spend more than they can afford on scratch tickets.

CONCLUSION AND ADDITIONAL RECOMMENDATIONS

The purpose of this Community Health Worker and Gambling Needs Assessment is to provide 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 selected regions of the Commonwealth concerning how to engage CHWs as part of these services. This assessment also solicited views on how CHWs should be trained for such roles.

The suggestions emerging from the ten background key informant interviews and focus groups in four municipalities in the southeastern part of Massachusetts should be considered and possibly incorporated into DPH's planning and design process. Given the focus on CHWs, 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.

- **As funding for prevention education and public awareness becomes available at city and community levels, CHWs are well positioned to help convey information about the addictive potential of gambling in locally meaningful terms in widely diverse communities.**
- **One of the clearest points emerging from the assessment is that CHWs may be helpful in one of the most challenging aspects of problem gambling assistance: identifying and assisting those struggling with such problems to find and engage with the services they need.**

Community health workers on the Cape, in Brockton, and in Fall River/New Bedford are already working to coordinate care and resources for patients struggling with behavioral health as well as physical health problems. It's possible that—with additional funding and training about key elements of problem gambling (see above recommendations)—this work could be extended to include assessment, community-based referrals, education, and support for those with gambling-related problems.

To explore the feasibility of the ideas presented in this report, MDPH's Office of Problem Gambling Services could take the following actions:

1. **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.

2. Working with the Office of Community Health Workers, **share this report with CHW training programs and solicit their responses to its findings and recommendations** to inform planning for additional CHW training.
3. **Solicit input on planning for CHW and other behavioral health peer workforce roles in gambling prevention and support** from MDPH's Bureau of Substance Addiction Services and from peer staff or contractors in settings funded by the Department of Mental Health.
4. **Require that these training content ideas inform any curricula developed for CHWs 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 and the Training Consortium for CHWs.
5. Working with contractors, **refine any future regional assessments for CHWs and problem gambling services** in Regions A and B based on the process and findings for this current assessment.
6. **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.