Office of Problem Gambling Services Capabilities Gap Analysis

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High quality national research studies suggest that Gambling Disorder affects less than 1% of the general population (Kessler et al., 2008; Petry, Stinson, & Grant, 2005). Consistent with this estimate, research in Massachusetts estimates that less than 1% of the general population might be considered to be "pathological gamblers"[1] (Volberg et al., 2017). Although Gambling Disorder is a low base rate problem, the public health system should be prepared to address it upon major changes in gambling accessibility. Gambling expansion in the Massachusetts might be associated with increased demands upon its health providers, generally, and its behavioral health providers, particularly. This is because gambling expansion events might be associated with temporally and geographically located increases in gambling behavior and gambling-related problems (LaPlante, Gray, Williams, & Nelson, 2018; Volberg, 2000; Welte, Tidwell, Barnes, Hoffman, & Wieczorek, 2016; Welte, Wieczorek, Barnes, Tidwell, & Hoffman, 2004). Although adaptation to gambling expansion is likely to occur (LaPlante & Shaffer, 2007), these changes also might be associated with increased treatment seeking activity at least initially and potentially in the long term.

The current Capabilities Gap Analysis compared self-reported *actual clinical provider capabilities* with *ideal clinical provider capabilities*[2] on key gambling-related domains of interest. The goal was to identify instances for which select Bureau of Substance Addiction Services (BSAS) provider capabilities align and misalign with those ideal capabilities. Through the identification of such alignment, the Office of Problem Gambling Services (OPGS) can develop plans to reinforce key areas that are well-aligned or develop actions to bring other areas into better alignment.

This summary begins with a description of the participatory research process that we used to identify (1) the current clinical domains of interest to the OPGS and (2) associated clinical capabilities for the gap analysis. Following this description, we provide results of a BSAS provider survey that indicate how well those providers report that they are meeting the expected clinical capabilities. Lastly, we provide some recommendations for domains and capabilities areas in need of improvement.

1. Identifying the Domains of Interest

First, we used a *participatory* research process to identify the domains of interest for this Capabilities Gap Analysis. Specifically, through an electronic interview process, the OPGS identified its current domains of interest related to assessing provider capabilities. For this first electronic interview, we administered a modified version of the Addiction Technology Transfer Center of New England (ATTCNE) *Index of Training Needs* survey (Hall, Shaffer, & Vander Bilt, 1997), requesting that the OPGS report, for 20 possible provider capability domains, their level of interest (i.e., No interest, Very little interest, Moderate interest, Considerable interest, Maximum interest), and an explanation for the indicated interest level.

The OPGS responses (see Table 5-1 in Section 5) indicated that the Capabilities Gap Analysis should focus upon the following domains of interest that were of "Considerable" or "Maximum" interest:

- Providers' understanding of the relationship between gambling and other mental health problems (e.g., suicide, substance abuse)
- Screening for gambling
- Assessment for gambling
- Diagnosis for gambling
- Treatment process skills
- Intervention skills

[1] Volberg et al. provide a weighted estimate of 2.0% for combined problem and "pathological" gambling in the body of their report, but the Appendix to this report includes unweighted N's of 75 (problem) and 54 (pathological) out of 9,523 total, which suggests the pathological gambling rate is less than 1%.

[2] Throughout this report, we use the terms "clinical capabilities," "provider capabilities," and "gambling-treatment capabilities" interchangeably.

- Treatment techniques
- Ability to make referrals for gambling
- Special populations
- Treatment administration skills
- Current training history for gambling
- Anticipated training for gambling
- Perceived organizational support for addressing gambling
- Other gambling-related certification

Domains not selected at this time (i.e., of "Very Little" or "Moderate" interest) included:

- Providers' interest in treating gambling-related problems
- Providers' understanding of: (a) Addiction to gambling, (b) Theoretical models of Gambling Disorder, and (c) Signs and symptoms of Gambling Disorder
- Interpersonal process skills
- Therapy organization and movement skills
- Perceived BSAS support for addressing gambling
- Perceived DPH support for addressing gambling
- Massachusetts Problem Gambling Specialist certification

Although we focused upon those domains the OPGS indicated as having "Considerable" or "Maximum" interest in the current Capabilities Gap Analysis, it is important to note that the OPGS does not necessarily consider the other domains to be unimportant. These domains might be the subject of future investigation.

2. Identifying the Capabilities of Interest

Second, we identified appropriate clinical capabilities for treating Gambling Disorder for each of the selected domains of interest. As with identifying the domains of interest, we used a *participatory* research process to identify appropriate clinical capabilities. To do so required us to propose ideal provider capabilities for the above domains. We therefore developed sets of possible ideals for clinical capabilities within these domains. Then, we asked the OPGS to complete a second electronic interview. More specifically, we requested that the OPGS indicate whether a given clinical capability was "Not Important," "Important," or "Most Important," and to do so for "All BSAS Providers" and for "BSAS Providers Who Treat Gambling." We asked the OPGS to indicate specific capabilities for these groups because the expectations and requirements reasonably might vary according to whether the provider is considered to have a gambling-related specialization (i.e., specialists), or not (i.e., non-specialists). To capture such variance, it would be reasonable, for example, to have a set of basic capabilities expected for "All BSAS Providers" regardless of specialization and a specialized set of capabilities appropriate for "BSAS Providers Who Treat Gambling" that includes more comprehensive standards.

The OPGS responses (see Tables 5-2 – 5-15 in Section 5) indicated that the Capabilities Gap Analysis should focus upon the following clinical capabilities that the OPGS endorsed as "Most important":

Screening for gambling

All BSAS Providers

- Providers should be able to list at least one specific brief screen for gambling-related problems
- Providers should report that they at least occasionally screen their clients for gambling-related problems
- Providers should report that they always screen their clients for gambling-related problems

BSAS Providers who treat gambling

- Providers should be able to identify specific brief screens for gambling-related problems from a list
- Providers should be able to generate a list of specific screens for gambling-related problems

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

Assessment for gambling

BSAS Providers who treat gambling

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

Diagnosis for gambling

All BSAS Providers

- Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making

BSAS Providers who treat gambling

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

Treatment process skills

All BSAS Providers

- Providers should be aware of cultural factors that could influence the gambling treatment process
- Providers should adapt their treatment for cultural factors that could influence the gambling treatment process

Intervention skills

All BSAS Providers

- Providers should know when and how to intervene in life crisis situations

BSAS Providers who treat gambling

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

Treatment techniques

All BSAS Providers

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

Ability to make referrals for gambling

All BSAS Providers

- Providers should be able to refer clients to the Gambling Helpline
- Providers should know who within their organization (if anyone) is a gambling specialist

Special populations

All BSAS Providers

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

BSAS Providers who treat gambling

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

Treatment administration skills

All BSAS Providers

- Providers should keep records, as required
- Providers should protect the privacy of patients, as required
- Providers should understand HIPAA, such that patients are protected accordingly

Current training history for gambling

BSAS Providers who treat gambling

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

Perceived organizational support for addressing gambling

All BSAS Providers

- Providers should indicate that their organization provides them time to participate in gambling-related training
- Providers should indicate that their organization provides time to complete gambling-related screening
- Providers should indicate that their organization provides time to treat clients' gambling-related problems

BSAS Providers who treat gambling

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

The OPGS did not endorse any of the proposed capabilities as "most important" for the following domains: (1) Providers' understanding of the relationship between gambling and other mental health problems; (2) Anticipated training for gambling; and (3) Other gambling-related certification. As with the domains of interest, it is important to note these endorsement decisions do not mean that the OPGS considers the other capabilities unimportant. These capabilities might be the subject of future investigation.

3. BSAS Provider Capabilities Gap Analysis Survey Summary

Recall that the provider survey was intended to help the OPGS identify areas for which ideal provider capabilities and actual provider capabilities align well and areas for which these are mis-aligned. The identification of such gaps, in turn, can inform stakeholders about areas that require targeted workforce development efforts. In the sections below, we describe the survey implementation procedures and findings. Subsequently, we use this information to (a) highlight gaps between ideal and actual BSAS provider capabilities for gambling-related treatment, and (b) make recommendations for bridging identified gaps.

Capabilities Gap Analysis Survey Procedure Summary

To gain insight into how well BSAS-affiliated providers' actual capabilities meet target ideals for treating gambling-related problems, we administered an e-survey (see Section 6) to a convenience sample of 226 providers associated

with 27 organizations[3] contracted to provide gambling treatment services for the DPH. We targeted BSAS-affiliated providers at the request of the OPGS and because the BSAS providers were a primary target for the state's gambling-related capacity building during the past 20 years. With the cooperation of BSAS, the OPGS defined the sample of organizations and providers, and accordingly provided the Division with names, email addresses, and telephone contact information for potential survey respondents. The OPGS revised and contributed to the design and content of the e-survey, and specifically requested that it address two primary groups of providers: (1) BSAS Providers Who Treat Gambling and (2) All Other BSAS Providers.

The e-survey took place during two waves of data collection. More specifically, during the summer of 2018 following an announcement to providers at the 27 organizations regarding the e-survey from the Director of BSAS, the Division emailed eligible providers a survey invitation, which included a link to the survey. Following these initial invitations, the Division sent reminders to complete the survey. Following these recruitment efforts, only 46 providers completed the survey. After discussion with the OPGS[4], we decided to hold further e-survey recruitment until fall 2018. The second wave of recruitment followed a new announcement regarding the e-survey from the Director of BSAS to program directors of the 27 organizations and additional recruitment from the Division of the program directors of the 27 organizations. After 9 weeks[5], the Division closed the survey to responses and analyzed the data.

This procedure yielded a sample of 161 (71%) providers who opened the e-survey, 153 (68%) who consented to participate, and 135 (60%) who completed more than one or two questions in the survey. Analyses focused upon characterizing providers' perceived gambling-treatment capabilities, especially with respect to the OPGS's stated ideal gambling-treatment capabilities.

Capabilities Gap Analysis Survey Results

In the following sections, we report the e-survey results. A comprehensive list of our data cleaning procedures is available in Section 7. After cleaning the data, we generated descriptive statistics for all survey items. In our tables and text descriptions, we provide percentages with missing values excluded (i.e., valid percentages).

Respondent Characteristics

On average, respondents indicated they started working as a BSAS-affiliated treatment provider 8.2 (SD=7.7) years ago, and that they started working as a BSAS-affiliated treatment provider at their current job 5.5 (SD=5.5) years ago. Most indicated that their highest level of education complete was Master's Degree (84.4%). Following this, respondents endorsed Advanced Graduate Degree (7.4%), Bachelor's Degree (4.4%), and Associates Degree (1.5%).

We observed that 80% said that they had special professional certifications or licenses related to their current job. Table 8-1 in Section 8 shows opens responses for this question. When asked about a list of professional gambling treatment experience options, 68.9% of respondents endorsed that they had attained at least one of those listed in Table 3-1. The remainder of respondents either endorsed *none of the above* or did not answer the question. In the following sections, we examine separately individuals who endorsed at least one of those listed in Table 3-1

[3] To protect privacy, this list of organizations is not included in this summary report.

[4] Around the same time, the Division and the OPGS also were completing a state of services survey, which we suspect might have limited participation.

[5] Acting Director of BSAS, Jim Cremer sent out an e-mail to program directors on November 15th. The second wave of data collection began the following day on November 16th, when we emailed program directors providing them a word document with individualized emails addressed to each of their staff members inviting them to complete the survey, as well as a table of all the providers we have in our database and their contact information. We sent a follow-up message to providers approximately 2 weeks later at the end of November (11/28). We sent a final reminder to program directors approximately two weeks later in the middle of December (December 15th). One week later we sent a final reminder e-mail directly to providers (December 19th). The final survey response was entered in Qualtrics on January 8th, 2019. We closed the survey on January 16th, 2019.

(i.e., BSAS Providers who Treat Gambling; n = 93) and individuals who endorsed *none of the above* or those who did not answer the question (i.e., All Other BSAS Providers; n = 42).

Table 3-1 Do any of the following options describe you?

Description (N=135)	n	%
Massachusetts-Problem Gambling Specialist (MA-PGS) certified	32	23.7%
International Certified Gambling Counselor (ICGC) certified	2	1.5%
Certified Addiction Specialist (CAS) w/ gambling specialization	2	1.5%
Have treated a client for gambling at current job	69	51.1%
Client with gambling problems might be assigned to me at current job	42	31.1%
Have treated a client for gambling in private practice	9	6.7%
None of the above	42	31.1%
Missing	0	0.0%

OPGS Ideals for:

Screening for gambling

All BSAS Providers

Providers should be able to list at least one specific brief screen for gambling-related problems

Providers should report that they at least occasionally screen their clients for gambling-related problems

Providers should report that they always screen their clients for gambling-related problems

BSAS Providers who treat gambling

Providers should be able to identify specific brief screens for gambling-related problems from a list

Providers should be able to generate a list of specific screens for gambling-related problems

Providers should be able to identify specific screens for gambling-related problems from a list

Providers should consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening

Assessment for gambling

BSAS Providers who treat gambling

Providers should consistently complete an assessment of those clients who screen positive for gambling-related problems

Providers should consistently screen clients for other disorders if they screen positive for gambling-related problems

Providers should consistently assess clients who screen positive for gambling-related problems for readiness to change

Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery

Diagnosis for gambling

All BSAS Providers

Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making

BSAS Providers who treat gambling

Providers should use gambling history information as part of diagnostic decision-making related to gambling

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

Capabilities of BSAS Providers Who Treat Gambling

The results that follow pertain to the 77 respondents who compose the group of BSAS Providers Who Treat Gambling and completed more than a few survey questions (see Section 7).

Screening, Assessment, & Diagnosis

The OPGS provided capability expectations for screening, assessment, and diagnosis. This section reports upon key survey items that addressed these capabilities. In all, 50.6% of BSAS Providers Who Treat Gambling reported that they could list one *brief* screen (i.e., one that includes 5 or fewer items) for gambling-related problems. Table 8-2 in Section 8 shows open responses for this question. Examination of the open responses showed that 24.6% of BSAS Providers Who Treat Gambling listed an actual brief screen. We also asked BSAS Providers Who Treat Gambling to indicate brief screens from a list of options. The list included four actual brief screens and three faux brief screens, as well as the options *none of the above* and *I don't know*. We observed that 51.2% of BSAS Providers Who Treat Gambling correctly endorsed at least one of the actual brief screens and 72.1% of BSAS Providers Who Treat Gambling incorrectly endorsed at least one of the faux brief screens or indicated *none of the above* or *I don't know*.

In all, 41.9% of BSAS Providers Who Treat Gambling indicated that they could list one specific screen (i.e., a screen *other than* a brief screen) for gambling-related problems. Table 8-3 in Section 8 shows open responses for this question. Examination of the open responses showed that 23.4% listed an actual specific screen. We also asked BSAS Providers Who Treat Gambling to indicate specific screens from a list of options. The list included five actual

specific screens and two faux specific screens, as well as the options *none of the above* and *I don't know*. We observed that 59.7% of BSAS Providers Who Treat Gambling correctly endorsed at least one of the actual specific screens and 53.3% of BSAS Providers Who Treat Gambling incorrectly endorsed at least one of the faux specific screens or indicated *none of the above* or *I don't know*.

We asked BSAS Providers Who Treat Gambling to indicate the extent to which they agreed with a number of statements related to screening, assessment, and diagnosis. Table 3-2 displays the extent to which BSAS Providers Who Treat Gambling agreed or disagreed with specific screening, assessment, and diagnosis situations.

Table 3-2 BSAS Providers Who Treat Gambling responses to screening, assessment, and diagnosis items

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
I screen my clients for gambling-related problems at least occasionally	77	3.9%	18.2%	13.0%	45.5%	19.5%
I screen my clients for gambling-related problems always	77	10.4%	22.1%	19.5%	31.2%	16.9%
It is important to consider the importance of other brief screening for high risk behavior related to mental health concerns in conjunction with gambling screening	77	1.3%	1.3%	6.5%	51.9%	39.0%
I consistently complete a more detailed assessment of those clients who screen positive for gambling-related problems	77	1.3%	19.5%	20.8%	33.8%	24.7%
I consistently assess clients who screen positive for gambling-related problems for readiness to change	77	3.9%	15.6%	13.0%	40.3%	27.3%
I consistently assess clients who screen positive for gambling-related problems for other disorders	77	1.3%	11.7%	13.0%	44.2%	29.9%
I consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery	77	1.3%	11.7%	14.3%	46.8%	26.0%
I always use DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling	77	3.9%	11.7%	16.9%	35.1%	32.5%
I always use gambling history information as part of diagnostic decision-making related to gambling	77	1.3%	6.5%	10.4%	45.5%	36.4%
I always use current physiological and mental state, in conjunction with DSM-5, as part of diagnostic decision-making related to gambling	77	1.3%	3.9%	11.7%	45.5%	37.7%

Treatment Process Skills

The OPGS provided capability expectations for treatment process skills, such as attending to cultural factors that might impact treatment. This section reports upon key survey items that addressed these capabilities. BSAS Providers Who Treat Gambling reported the extent to which they believe certain cultural factors have the potential to influence the gambling treatment process. Table 3-3 displays providers' impressions of the degree to which various factors might affect treatment.

OPGS Ideals for:
Treatment process skills
All BSAS Providers
Providers should be aware of cultural factors that could influence the gambling treatment process
Providers should adapt their treatment for cultural factors that could influence the gambling treatment process

Table 3-3 BSAS Providers Who Treat Gambling responses to factors that have the potential to influence the gambling treatment process

Factor	n	Not at all	A little bit	Moderately	Quite a bit	Very much
Primary language	74	17.6%	4.1%	20.3%	33.8%	24.3%
Level of acculturation to local majority culture	75	5.3%	6.7%	25.3%	46.7%	16.0%
Age	75	8.0%	6.7%	33.3%	40.0%	12.0%
Gender	76	13.2%	2.6%	31.6%	42.1%	10.5%
Occupational issues (such as, undocumented workers or highly skilled workers without local licensing)	76	17.1%	3.9%	22.4%	44.7%	11.8%
Family structure (such as paternalistic, or primary caregivers, or family makeup)	75	9.3%	5.3%	25.3%	52.0%	8.0%
Intergenerational interaction patters (such as deference to elders)	74	9.5%	6.8%	25.7%	47.3%	10.8%
Religious beliefs (such as membership in an organized religion	74	6.8%	14.9%	23.0%	44.6%	10.8%
Spirituality (such as belief in a divinity)	74	9.5%	6.8%	37.8%	37.8%	8.1%
Health beliefs (such as, Eastern versus Western medicine)	75	13.3%	12.0%	33.3%	32.0%	9.3%
Emotional expression	75	8.0%	9.3%	28.0%	38.7%	16.0%
Coping styles	75	6.7%	8.0%	14.7%	42.7%	28.0%
Communication styles	75	10.7%	1.3%	26.7%	42.7%	18.7%
Tendency toward help-seeking	75	5.3%	10.7%	20.0%	42.7%	21.3%
Individualism/collectivism	75	5.3%	13.3%	30.7%	37.3%	13.3%
Trust in authority	75	5.3%	10.7%	28.0%	42.7%	13.3%
Historical stigma and discrimination	75	6.7%	6.7%	26.7%	44.0%	16.0%
Contemporary stigma and discrimination	75	5.3%	6.7%	26.7%	48.0%	13.3%
Purpose and understanding of gambling	75	6.7%	5.3%	17.3%	48.0%	22.7%

Table 3-4 shows that a majority (79.2%) of BSAS Providers Who Treat Gambling reported that they adapt their treatment by considering the client's psychosocial environment. Other popular adaptations included actively monitoring their own biases and stigma (67.5%) and examining how social status might impact the client-provider relationship (53.2%). The least popular adaptation was completing a formal cultural assessment for diagnosis and care (20.8%). On average, BSAS Providers Who Treat Gambling report making 5.8 (SD = 3.8) adaptations to their treatment to account for cultural factors that could influence the gambling treatment process. Table 8-4 in Section 8 shows open responses for this question.

Table 3-4 BSAS Providers Who Treat Gambling endorsements of ways you have adapted your treatment plan

Adaptation	n	%
Incorporated non-Western approaches into my treatment plan	22	28.6%
Changed how I communicate (such as, reducing or increasing my expressed emotion)	39	50.6%
Used a translator	18	23.4%
Used gender-specific treatment strategies	25	32.5%
Used age-specific treatment strategies	25	32.5%
Actively monitored my own biases and stigma	52	67.5%
Changed an evidence-based practice to suit a client's religious or spiritual orientation	27	35.1%
Included family in the treatment process	38	49.4%
Inquired about cultural identity to inform my diagnosis	40	51.9%
Explored the possibility that I am misinterpreting cultural expressions as psychopathology	39	50.6%
Examined how social status might impact the client-provider relationship	41	53.2%
Considered the client's psychosocial environment	61	79.2%
Completed a formal cultural assessment for diagnosis and care	16	20.8%
Other	4	5.2%
I have not adapted my treatment for cultural factors that could influence the gambling treatment process	1	1.3%
Not applicable	9	11.7%

Intervention Skills

The OPGS provided capability expectations for intervening during life crisis situations. This section reports upon key survey items that addressed these capabilities. We asked BSAS Providers Who Treat Gambling to identify common experiences associated with Gambling Disorder. Table 3-5 reports endorsement rates for a variety of common experiences. Notably, 58.4% indicated that experience of self-harm was a common experience associated with Gambling Disorder.

OPGS Ideals for:
Intervention skills
All BSAS Providers
Providers should know when and how to intervene in life crisis situations
BSAS Providers who treat gambling
Providers should understand that Gambling Disorder is associated with experiences of self-harm

Table 3-5 BSAS Providers Who Treat Gambling endorsements of common experiences associated with Gambling Disorder

Experience	n	%
Financial trouble, such as debt	75	97.4%
Experiences of self-harm	45	58.4%
Job loss	72	93.5%
Feelings of restlessness, irritability, and/or anxiousness when trying to cut down gambling	75	97.4%
Psychiatric comorbidity	64	83.1%
Driving while impaired	31	40.3%
Drug dependence	55	71.4%
Lying about gambling	77	100%
None of the above	0	0%
I don't know	0	0%

We asked BSAS Providers Who Treat Gambling to indicate what they would do if their client was having a life crisis situation, such as considering or preparing to self-harm. All of the BSAS Providers Who Treat Gambling indicated

that they would do at least one of options provided. Table 3-6 shows endorsement rates for these options. Table 8-5 in Section 8 shows open responses for this question.

Table 3-6 BSAS Providers Who Treat Gambling endorsements of actions during life crisis

Actions	n	%
Determine the nature and persistence of the harmful thoughts	72	93.5%
Determine the likelihood of intent	70	90.9%
Determine whether the client has a plan	74	96.1%
Determine whether the client has access to a means for self-harm	74	96.1%
Determine whether the client has a history of self-harm	75	97.4%
With permission, talk with a supportive family member or friend to ascertain their understanding	62	80.5%
Call 911 for imminent risk	69	89.6%
Set up a follow-up plan if not at imminent risk	71	92.2%
Other	3	3.9%
None of the above	0	0%
I don't know	0	0%

Treatment Techniques & Referrals

The OPGS provided capability expectations for knowledge and use of treatment techniques and referrals. This section reports upon key survey items that addressed these capabilities. We asked BSAS Providers Who Treat Gambling to report one or more evidence-based treatment approaches for addressing Gambling Disorder. Roughly 66% reported one or more correct evidence-based treatment approaches for addressing Gambling Disorder, though some open responses also included non-evidence-based practices. Table 8-6 in Section 8 shows open responses for this question.

OPGS Ideals for:

Treatment techniques

All BSAS Providers

Providers should be aware of the DPH Treatment Guidelines manual

Providers should be able to list evidence-based practices for treating Gambling Disorder

Ability to make referrals for gambling

All BSAS Providers

Providers should be able to refer clients to the Gambling Helpline

Providers should know who within their organization (if anyone) is a gambling specialist

We asked BSAS Providers Who Treat Gambling to report the extent to which they agreed with the statement, *I know how to refer clients to the Department of Public Health Gambling Helpline.* In all, 1.3% indicated that they strongly disagree, 15.6% disagree, 15.6% neither agree nor disagree, 41.6% agree, and 26.0% indicated that they strongly agree.

We asked BSAS Providers Who Treat Gambling to indicate whether they knew who in their organization is a gambling specialist. In all, 67.5% indicated that they did and named an individual (open responses withheld to protect privacy). However, 15.6% indicated that although they believe their organization has a gambling specialist they are not sure who it is, 16.9% indicated that their organization does not employ a gambling specialist, and 0% indicated that they are not sure whether their organization employs a gambling specialist.

Special Populations

The OPGS provided capability expectations for knowledge of and treatment planning adaptations for special risk populations. This section reports upon key survey items that addressed these capabilities. We asked BSAS Providers Who Treat Gambling to indicate special population groups that are at increased risk for gambling-related problems. Table 3-7 shows that the most frequently endorsed special population was those with mental health problems (80.5%) and the least frequently endorsed special population was casino employees (27.3%). In all, 31.2% incorrectly endorsed that high-income earners are at increased risk, 41.6% that women are at increased risk, and 50.6% that middle-aged individuals are at increased risk relative to pertinent others.

OPGS Ideals for:
Special populations
All BSAS Providers
Providers should be able to report that Intimate Partner Violence (IPV) perpetrators are at increased risk for gambling-related problems
Providers should report that they take IPV status into account for gambling-related treatment planning
Providers should report that they take Veteran status into account for gambling-related treatment planning
BSAS Providers who treat gambling
Providers should be able to report that race and ethnicity is associated with risk for gambling-related problems
Providers should report that they take race and ethnicity into account for gambling-related treatment planning

Table 3-7 BSAS Providers Who Treat Gambling endorsements of special populations at risk

Populations	n	%
Those with mental health problems	62	80.5%
Women [a]	32	41.6%
Middle aged [a]	39	50.6
High income earners [a]	24	31.2%
Veterans	50	64.9%
Perpetrators of Intimate Partner Violence	32	41.6%
Casino employees	21	27.3%
Some racial and ethnic groups	53	68.8%
None of the above	0	0%
I don't know	7	9.1%

Note. [a] = Incorrect response option.

We asked respondents whether they take Veteran status or Intimate Partner Violence status into account in their gambling-related treatment planning. Additionally, we asked whether they take race and ethnicity into account in their gambling-related treatment planning. Table 3-8 shows the extent of agreement reported.

Table 3-8 BSAS Providers Who Treat Gambling responses to special populations & treatment planning

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
I always take Veteran status into account for gambling-related treatment planning	77	2.6%	20.8%	39.0%	26.0%	11.7%
I always take Intimate Partner Violence status into account for gambling-related treatment planning	77	1.3%	23.4%	27.3%	36.4%	11.7%
I always take race and ethnicity into account for gambling-related treatment planning	77	3.9%	19.5%	27.3%	33.8%	15.6%

Treatment Administration Skills

The OPGS provided capability expectations for administrative functions, such as privacy protections and HIPAA compliance. This section reports upon key survey items that addressed these capabilities. We asked BSAS Providers Who Treat Gambling about record keeping, patient privacy, and HIPAA. In all, 98.7% endorsed using at least one of the six listed tools for client records or reported another form of clinical documentation. We observed that 0% indicated that they did not use any of the provided options and did not report another form of clinical documentation. Also, 1.3% indicated that they did not know if they used any of the tools for client records.

OPGS Ideals for:
Treatment administration skills
All BSAS Providers
Providers should keep records, as required
Providers should protect the privacy of patients, as required
Providers should understand HIPAA, such that patients are protected accordingly

Regarding patient privacy, among those who endorsed at least one privacy action, 100% indicated that their organization had implemented privacy policies and procedures. Table 3-9 displays the privacy actions that BSAS Providers Who Treat Gambling indicate their organization has done. Table 8-7 in Section 8 shows open responses for this question.

Table 3-9 BSAS Providers Who Treat Gambling endorsements of organization privacy actions

Privacy Actions	n	%
Developed privacy policies and procedures	71	92.2%
Implemented privacy policies and procedures	76	98.7%
Designated a privacy official	40	51.9%
Implemented workforce training related to client privacy	67	87.0%
Applied sanctions for privacy policy and procedure violations	48	62.3%
Mitigated harmful effects of disclosed public health information [a]	29	37.7%
Maintained data safeguard systems for public health information (e.g., locking records, shredding, as appropriate) [a]	66	85.7%
Informed clients about ways to register privacy complaints	62	80.5%
Installed a documentation system for informing clients about privacy policies and procedures	56	72.7%
Other	7	9.1%
None of the above	0	0%
I don't know	1	1.3%

Note. [a] = An error resulted in these response options referring to "public health information" instead of "protected health information".

We asked BSAS Providers Who Treat Gambling to indicate their beliefs about required HIPAA requirements for covered entities. We observed that 42.5% correctly endorsed all five requirements; however, 100% of these individuals also endorsed at least one false requirement incorrectly. Table 3-10 displays responses related to HIPAA requirements for Covered Entities. In all, 100% incorrectly endorsed at least one of three faux requirements: 87.0% endorsed "implement training programs for you and your employees about how to protect your patients' health information," 57.1% "restrict others from accessing patients' health information, entirely," and 74.0% endorsed "use electronic records to store all personal health information."

Table 3-10 BSAS Providers Who Treat Gambling endorsements of HIPAA requirements for covered entities

Requirements	n	%
Put in place safeguards to protect patients' health information	70	90.9%
Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose	66	85.7%

Requirements	n	%
Have agreements in place with any service providers that clients use to perform functions or activity on their behalf	59	76.6%
Have procedures in place to limit who can access your patients' health information	68	88.3%
Implement training programs for you and your employees about how to protect your patients' health information [a]	67	87.0%
Restrict others from accessing patients' health information, entirely [a]	44	57.1%
Use electronic records to store all personal health information [a]	57	74.0%
Notify patients when there is a breach of unsecured personal health information	49	63.6%
None of the above	0	0%
I don't know	3	3.9%

Note. [a] = Incorrect response option.

Current Training History for Gambling

The OPGS provided capability expectations for gambling-related training history. This section reports key survey items that addressed these capabilities. When asked to describe their own training history related to problem gambling, most (66.2%) indicated their experience included attending at least one problem gambling training. In order of declining popularity, other training experiences included self-education via online resources, books, etc. (51.9%), certification as a problem gambling specialist (33.8%), attending at least one problem gambling webinar (33.8%), attending at least one problem gambling conference (33.8%), and other (3.9%). In all, 6.5% indicated they did not participate in any of these training activities and 2.6% indicated that they do not know if they participated in any of these training experiences. Table 8-8 in Section 8 shows open responses for this question.

OPGS Ideals for:
Current training history for gambling
BSAS Providers who treat gambling
Providers should have a history of attending at least one gambling training

Perceived Organizational Support for Addressing Gambling

The OPGS provided capability expectations for providers' perceptions of organizational support for addressing gambling. This section reports upon key survey items that addressed these capabilities. BSAS Providers Who Treat Gambling had the opportunity to describe their perceptions related to organizational support for addressing gambling. Table 3-11 shows that with respect to time for screening, 53.3% agreed or agreed strongly that their organization provides time. With respect to time for treating, 68.9% agreed or strongly agreed that their organization always provides time to treat clients' gambling-related problems. With respect to time for training, 75.0% agreed or strongly agreed that their organization always provides time for gambling-related training. Finally, with respect to reimbursement for training, 49.4% agreed or strongly agreed that their organization always reimburses for gambling-related training.

OPGS Ideals for:
Perceived organizational support for addressing gambling
All BSAS Providers
Providers should indicate that their organization provides them time to participate in gambling-related training
Providers should indicate that their organization provides time to complete gambling-related screening
Providers should indicate that their organization provides time to treat clients' gambling-related problems
BSAS Providers who treat gambling
Providers should indicate that their organization reimburses for participation in gambling-related training

Table 3-11 BSAS Providers Who Treat Gambling responses to perceived organization support for addressing gambling

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
My organization always provides time to complete gambling-related screening	77	5.2%	11.7%	29.9%	31.2%	22.1%

	n	Strongly disagree	Disa-gree	Neither disa-gree nor agree	Agree	Strongly agree
My organization always provides time to treat clients' gambling-related problems	77	2.6%	5.2%	23.4%	37.7%	31.2%
My organization always provides time to participate in gambling-related training	76	0.0%	9.2%	15.8%	44.7%	30.3%
My organization always reimburses for participation in gambling-related train-ing	77	14.3%	9.1%	27.3%	24.7%	24.7%

Self-perceptions

This section reports upon key survey items that addressed providers' self-perceptions of their readiness to address gambling-related problems. In describing their thoughts and feelings, generally, about their own capability to address clients' gambling-related problems, about half of BSAS Providers Who Treat Gambling indicated they were prepared to handle such issues right away (50.6%). Likewise, about half of BSAS Providers Who Treat Gambling indicated that they need more training about evidence-based practices for gambling. Table 3-12 shows endorsement rates for other important capabilities.

Table 3-12 BSAS Providers Who Treat Gambling endorsements of perceived capabilities for addressing gambling-related problems

Capabilities	n	%
I am prepared to handle such issues right away	39	50.6%
I feel most comfortable referring clients with such issues to someone else	19	24.7%
I have too many other things to consider adding gambling-related problems into the mix	1	1.3%
I need more training about screening for gambling	32	41.6%
I need more training about evidence-based practices for gambling	38	49.4%
I am concerned that I will see more gambling-related problems among my patients because of gambling expansion	25	32.5%
Gambling-related problems are rare, so I don't expect to have this be a common issue	3	3.9%
Other	0	0.0%
None of the above	0	0.0%
I don't know	1	1.3%

Capabilities of All Other BSAS Providers

The results that follow pertain to 33 respondents who compose the group of All Other BSAS Providers and completed more than a few survey questions (see Section 7).

Screening, Assessment, & Diagnosis

The OPGS provided capability expectations for screening, assessment, and diagnosis. This section reports upon key survey items that addressed these capabilities. In all, 9.4% of All Other BSAS Providers reported that they could list one brief screen (i.e., one that includes 5 or fewer items) for gambling-related problems. Table 8-9 in Section 8 shows open responses for this question. Examination of the open responses (n=3) indicated that 3% of All Other Providers listed actual brief screens.

OPGS Ideals for:
Screening for gambling
All BSAS Providers
Providers should be able to list at least one specific brief screen for gambling-related problems
Providers should report that they at least occasionally screen their clients for gambling-related problems
Providers should report that they always screen their clients for gambling-related problems
Diagnosis for gambling
All BSAS Providers
Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making

We asked All Other BSAS Providers to indicate the extent to which they agreed with a number of statements related to screening and diagnosis. Table 3-13 displays the extent to which All Other BSAS Providers agreed or disagreed with specific screening and diagnosis situations.

Table 3-13 All Other BSAS Providers responses to screening, assessment, and diagnosis items

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
I screen my clients for gambling-related problems at least occasionally	33	3.0%	12.1%	21.2%	48.5%	15.2%
I screen my clients for gambling-related problems always	33	12.1%	42.4%	18.2%	9.1%	18.2%
I always use DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling	33	12.1%	12.1%	36.4%	24.2%	15.2%

Treatment Process Skills

The OPGS provided capability expectations for treatment process skills, such as attending to cultural factors that might impact treatment. This section reports upon key survey items that addressed these capabilities. All Other BSAS Providers reported the extent to which they believe cultural factors have the potential to influence the gambling treatment process. Table 3-14 displays providers' impressions of the degree to which various factors might affect treatment.

OPGS Ideals for:
Treatment process skills
All BSAS Providers
Providers should be aware of cultural factors that could influence the gambling treatment process
Providers should adapt their treatment for cultural factors that could influence the gambling treatment process

Table 3-14 All Other BSAS Providers responses to factors that have the potential to influence the gambling treatment process

Factor	n	Not at all	A little bit	Moderately	Quite a bit	Very much
Primary language	33	12.1%	18.2%	27.3%	27.3%	15.2%
Level of acculturation to local majority culture	33	21.2%	15.2%	30.3%	27.3%	6.1%
Age	33	27.3%	15.2%	27.3%	24.2%	6.1%
Gender	33	36.4%	6.1%	18.2%	33.3%	6.1%

Factor	n	Not at all	A little bit	Moder-ately	Quite a bit	Very much
Occupational issues (such as, undocumented workers or highly skilled workers without local licensing)	33	24.2%	12.1%	27.3%	24.2%	12.1%
Family structure (such as paternalistic, or primary caregivers, or family makeup)	33	18.2%	12.1%	39.4%	21.2%	9.1%
Intergenerational interaction patters (such as deference to elders)	33	21.2%	15.2%	39.4%	12.1%	12.1%
Religious beliefs (such as membership in an organized religion	33	15.2%	18.2%	39.4%	15.2%	12.1%
Spirituality (such as belief in a divinity)	33	24.2%	21.2%	27.3%	15.2%	12.1%
Health beliefs (such as, Eastern versus Western medicine)	33	33.3%	15.2%	27.3%	12.1%	12.1%
Emotional expression	33	33.3%	12.1%	21.2%	24.2%	9.1%
Coping styles	33	30.3%	6.1%	18.2%	18.2%	27.3%
Communication styles	33	36.4%	6.1%	15.2%	27.3%	15.2%
Tendency toward help-seeking	33	24.2%	6.1%	21.2%	27.3%	21.2%
Individualism/collectivism	33	27.3%	9.1%	33.3%	18.2%	12.1%
Trust in authority	33	30.3%	12.1%	18.2%	27.3%	12.1%
Historical stigma and discrimination	33	30.3%	12.1%	21.2%	18.2%	18.2%
Contemporary stigma and discrimination	33	27.3%	9.1%	27.3%	15.2%	21.2%
Purpose and understanding of gambling	33	24.2%	6.1%	12.1%	30.3%	27.3%

Table 3-15 shows that a plurality (33.3%) of All Other BSAS Providers reported that they adapt their treatment by considering the clients' psychosocial environment. Other popular adaptations included examining how social status might impact the client-provider relationship (27.3%), inquiring about cultural identity to inform my diagnosis (27.3%), and actively monitoring my own biases and stigma. The least popular adaptation was Incorporated non-Western approaches into my treatment plan (3.0%). On average, All Other BSAS Providers report making 2.4 (SD = 3.6) adaptations to their treatment to account for cultural factors that could influence the gambling treatment process. Table 8-10 in Section 8 shows open responses for this question.

Table 3-15 All Other BSAS Providers responses to ways you have adapted your treatment plan

Adaptation	n	%
Incorporated non-Western approaches into my treatment plan	1	3.0%
Changed how I communicate (such as, reducing or increasing my expressed emotion)	5	15.2%
Used a translator	4	12.1%
Used gender-specific treatment strategies	3	9.1%
Used age-specific treatment strategies	4	12.1%
Actively monitored my own biases and stigma	9	27.3%
Changed an evidence-based practice to suit a client's religious or spiritual orientation	5	15.2%
Included family in the treatment process	6	18.2%
Inquired about cultural identity to inform my diagnosis	9	27.3%
Explored the possibility that I am misinterpreting cultural expressions as psychopathology	8	24.2%
Examined how social status might impact the client-provider relationship	9	27.3%
Considered the clients' psychosocial environment	11	33.3%
Completed a formal cultural assessment for diagnosis and care	5	15.2%
Other	1	3.0%

Adaptation	n	%
I have not adapted my treatment for cultural factors that could influence the gambling treatment process	3	9.1%
Not applicable	17	51.5%

Intervention Skills

The OPGS provided capability expectations for intervening during life crisis situations. This section reports upon key survey items that addressed these capabilities. We asked All Other BSAS Providers to indicate what they would do if their client was having a life crisis situation, such as considering or preparing to self-harm. Table 3-16 shows endorsement rates for the provided options. Table 8-11 in Section 8 shows open responses for this question.

OPGS Ideals for:
Intervention skills
All BSAS Providers
Providers should know when and how to intervene in life crisis situations

Table 3-16 All Other BSAS Providers responses to actions during life crisis

Actions	n	%
Determine the nature and persistence of the harmful thoughts	32	97.0%
Determine the likelihood of intent	31	93.9%
Determine whether the client has a plan	32	97.0%
Determine whether the client has access to a means for self-harm	32	97.0%
Determine whether the client has a history of self-harm	32	97.0%
With permission, talk with a supportive family member or friend to ascertain their understanding	21	63.6%
Call 911 for imminent risk	28	84.8%
Set up a follow-up plan if not at imminent risk	32	97.0%
Other	3	9.1%
I don't know	0	0%
None of the above	0	0%

Treatment Techniques & Referrals

The OPGS provided capability expectations for knowledge and use of treatment techniques and referrals. This section reports upon key survey items that addressed these capabilities. We asked All Other BSAS Providers to report one or more evidence-based treatment approaches for addressing Gambling Disorder. Roughly 57.6% reported one or more correct evidence-based treatment approaches for addressing Gambling Disorder, though some open responses also included non-evidence-based practices. Table 8-12 in Section 8 shows open responses for this question. All Other BSAS Providers also reported the extent to which they agree with the statement, *I am familiar with the Department of Public Health Practice Guidelines for Treating Gambling-related Problems*.[6] In all, 24.2% indicated that they strongly disagree, 39.4% disagree, 21.2% neither agree nor disagree, 12.1% agree, and 3.0% indicated that they strongly agree. Similarly, we asked All Other BSAS Providers to report the extent to which they agreed with the statement, *I know how to refer*

OPGS Ideals for:
Treatment techniques
All BSAS Providers
Providers should be aware of the DPH Treatment Guidelines manual
Providers should be able to list evidence-based practices for treating Gambling Disorder
Ability to make referrals for gambling
All BSAS Providers
Providers should be able to refer clients to the Gambling Helpline
Providers should know who within their organization (if anyone) is a gambling specialist

[6] Due to a coding error, this item was not presented to BSAS Providers who Treat Gambling.

clients to the Department of Public Health Gambling Helpline. In all, 15.2% indicated that they strongly disagree, 24.2% disagree, 21.2% neither agree nor disagree, 24.2% agree, and 15.2% indicated that they strongly agree.

We asked All Other BSAS Providers to indicate whether they knew who in their organization is a gambling specialist. In all, 39.4% indicated that they did and named an individual (open responses withheld to protect privacy). However, 9.1% indicated that although they believe their organization has a gambling specialist, they are not sure who it is, 12.1% indicated that their organization does not employ a gambling specialist, and 39.4% indicated that they are not sure whether their organization employs a gambling specialist.

Special Populations

The OPGS provided capability expectations for knowledge of and treatment planning adaptations for special risk populations. This section reports upon key survey items that addressed these capabilities. We asked All Other BSAS Providers to indicate special population groups that are at increased risk for gambling-related problems. Overall, 60.6% correctly identified at least one high risk special population. Table 3-17 shows that the most frequently endorsed special population was those with mental health problems (51.5%) and the least frequently endorsed special population was casino employees (18.2%). In all, 27.3% incorrectly endorsed that high-income earners are at increased risk, 18.2% that women are at increased risk, and 27.3% that middle-aged individuals are at increased risk relative to pertinent others.

OPGS Ideals for:
Special populations
All BSAS Providers
Providers should be able to report that Intimate Partner Violence (IPV) perpetrators are at increased risk for gambling-related problems
Providers should report that they take IPV status into account for gambling-related treatment planning
Providers should report that they take Veteran status into account for gambling-related treatment planning

Table 3-17 All Other BSAS Providers responses to special populations at risk

Populations	n	%
Those with mental health problems	17	51.5%
Women [a]	6	18.2%
Middle aged [a]	9	27.3%
High income earners [a]	9	27.3%
Veterans	12	36.4%
Perpetrators of Intimate Partner Violence	9	27.3%
Casino employees	6	18.2%
Some racial and ethnic groups	10	30.3%
I don't know	13	39.4%
None of the above	0	0%

Note. [a] = Incorrect response option.

All Other BSAS Providers reported the extent to which they agree with taking specific special populations into account during gambling treatment-related planning. Table 3-18 shows the extent of agreement reported for Veterans and Intimate Partner Violence.

Table 3-18 All Other BSAS Providers responses to special populations & treatment planning

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
I always take Veteran status into account for gambling-related treatment planning	33	18.2%	21.2%	36.4%	18.2%	6.1%

	n	Strongly disagree	Disa-gree	Neither disa-gree nor agree	Agree	Strongly agree
I always take Intimate Partner Violence status into account for gambling-related treatment planning	33	12.1%	24.2%	36.4%	18.2%	9.1%

Treatment Administration Skills

The OPGS provided capability expectations for administrative functions, such as privacy protections and HIPAA compliance. This section reports upon key survey items that addressed these capabilities. We asked All Other BSAS Providers about record keeping, patient privacy, and HIPAA. In all, 81.3% endorsed using at least one of the six listed tools for client records or reported another form of clinical documentation. Table 8-13 in Section 8 shows open responses for this question. We observed that 9.4% indicated that they did not use any of the provided options and did not report another form of clinical documentation. Also, 9.4% indicated that they did not know if they used any of the tools for client records.

OPGS Ideals for:
Treatment administration skills
All BSAS Providers
Providers should keep records, as required
Providers should protect the privacy of patients, as required
Providers should understand HIPAA, such that patients are protected accordingly

Regarding patient privacy, among those who endorsed at least one privacy action (n=32), 100% indicated their organization had developed privacy policies and procedures. Table 3-19 displays the privacy actions that All Other BSAS Providers indicate their organization has done.

Table 3-19 All Other BSAS Providers responses to organization privacy actions

Privacy Actions	n	%
Developed privacy policies and procedures	32	97.0%
Implemented privacy policies and procedures	31	93.9%
Designated a privacy official	7	21.2%
Implemented workforce training related to client privacy	26	78.8%
Applied sanctions for privacy policy and procedure violations	13	39.4%
Mitigated harmful effects of disclosed public health information [a]	10	30.3%
Maintained data safeguard systems for public health information (e.g., locking records, shredding, as appropriate) [a]	25	75.8%
Informed clients about ways to register privacy complaints	24	72.7%
Installed a documentation system for informing clients about privacy policies and procedures	17	51.5%
Other	1	3.0%
None of the above	0	0%
I don't know	1	3.0%

Note. [a] = An error resulted in these responses referring to "public health information" instead of "protected health information".

We asked All Other BSAS Providers to indicate their beliefs about HIPAA requirements for covered entities. We observed that 57.6% of All Other BSAS Providers endorsed all five correct requirements; however, 100% of these individuals also endorsed at least one faux requirement. Table 3-20 displays responses related to HIPAA requirements for Covered Entities. In all, 100% incorrectly endorsed at least one of three faux requirements: 84.8% endorsed implement training programs for you and your employees about how to protect your patients' health information, 69.7% endorsed restrict other from accessing patients' health information, entirely, and 66.7% endorsed use electronic records to store all personal health information.

Table 3-20 All Other BSAS Providers responses to HIPAA requirements for covered entities

Requirements	N	%
Put in place safeguards to protect patients' health information	31	93.9%
Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose	31	93.9%
Have agreements in place with any service providers that clients use to perform functions or activity on their behalf	27	81.8%
Have procedures in place to limit who can access your patients' health information	29	87.9%
Implement training programs for you and your employees about how to protect your patients' health information [a]	28	84.8%
Restrict others from accessing patients' health information, entirely [a]	23	69.7%
Use electronic records to store all personal health information [a]	22	66.7%
Notify patients when there is a breach of unsecured personal health information	21	63.6%
None of the above	0	0%
I don't know	0	0%

Note. [a] = Incorrect response option.

Perceived Organizational Support for Addressing Gambling

The OPGS provided capability expectations for providers' perceptions of organizational support for addressing gambling. This section reports upon key survey items that addressed these capabilities. Table 3-21 shows that with respect to time for screening 34.4% agreed or strongly agreed that their organization always provided time, with respect to time for treating 60.4% agreed or strongly agreed that their organization always provided time to treat gambling-related problems, and with respect to time for training 48.5% agreed or strongly agreed that their organization always provides time for gambling-related training.

OPGS Ideals for:
Perceived organizational support for addressing gambling
All BSAS Providers
Providers should indicate that their organization provides them time to participate in gambling-related training
Providers should indicate that their organization provides time to complete gambling-related screening
Providers should indicate that their organization provides time to treat clients' gambling-related problems

Table 3-21 All Other BSAS Providers responses to perceived organization support for addressing gambling

	n	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
My organization always provides time to complete gambling-related screening	32	9.4%	18.8%	37.5%	25.0%	9.4%
My organization always provides time to treat clients' gambling-related problems	33	6.1%	9.1%	24.2%	42.4%	18.2%
My organization always provides time to participate in gambling-related training	33	3.0%	18.2%	30.3%	39.4%	9.1%

Self-perceptions

This section reports upon key survey items that addressed providers' self-perceptions of their readiness to address gambling-related problems. In describing their thoughts and feelings, generally, about their own capability to address clients' gambling-related problems, outside of those who endorsed none of the above (0%), most of All Other BSAS Providers indicated I need more training about screening for gambling (78.8%). Table 3-22 shows endorsement rates for other important capabilities. Table 8-14 in Section 8 shows open responses for this question.

Table 3-22 All Other BSAS Providers responses to perceived capabilities for addressing gambling

Capabilities	n	%
I am prepared to handle such issues right away	1	3.0%
I feel most comfortable referring clients with such issues to someone else	16	48.5%
I have too many other things to consider adding gambling-related problems into the mix	4	12.1%
I need more training about screening for gambling	26	78.8%
I need more training about evidence-based practices for gambling	23	69.7%
I am concerned that I will see more gambling-related problems among my patients because of gambling expansion	7	21.2%
Gambling-related problems are rare, so I don't expect to have this be a common issue	1	3.0%
Other	3	9.1%
None of the above	0	0%
I don't know	1	3.0%

Exploratory Comparisons for Key Provider Groups

The OPGS did not indicate to us any specific preferences or questions for direct provider group comparisons. However, in this section, we present *select* exploratory results related to gambling-specific clinical experiences for two specific comparisons: (1) BSAS Providers Who Treat Gambling vs. All Other BSAS Providers; and (2) MA-PGS Certified BSAS Providers Who Treat Gambling vs. Other BSAS Providers who Treat Gambling. Although these comparisons are exploratory in nature, it might be reasonable to expect that because of training and experience, in the first set of comparisons, BSAS Providers Who Treat Gambling might show more expertise and, in the second set of comparisons, MA-PGS Certified BSAS Providers Who Treat Gambling might show more expertise. Table 9-1 in Section 9 shows values for these comparisons.

<u>BSAS Providers Who Treat Gambling vs. All Other BSAS Providers</u>

With respect the gambling-related screening and diagnostic assessment, we observed that BSAS Providers Who Treat Gambling were statistically significantly more likely than All Other BSAS Providers to (1) report they can list a brief gambling screen, (2) report that they screen their clients for gambling-related problems always, and (3) report that they always use DSM-5 for their gambling-related diagnostic decision-making. However, these groups of providers were not statistically distinguishable with respect to their (4) reported likelihood of screening clients at least occasionally.

Relating to gambling treatment, we detected that BSAS Providers Who Treat Gambling were statistically significantly more likely than All Other BSAS Providers to (1) know how to refer their clients to the DPH Gambling helpline and (2) know a gambling specialist in their organization. BSAS Providers Who Treat Gambling were statistically significantly less likely than All Other BSAS Providers to (3) fail to be able to list an evidence-based approach to gambling treatment.

Concerning their perceptions of their organization's support for gambling-related work, BSAS Providers Who Treat Gambling were statistically significantly more likely than All Other BSAS Providers to indicate their organization always provides time to (1) complete gambling-related screening, (2) treat clients' gambling-related problems, and (3) participate in gambling-related training.

Finally, pertaining to self-perceived readiness, BSAS Providers Who Treat Gambling were statistically significantly more likely than All Other BSAS Providers to indicate that they felt prepared to handle such issues immediately; however, All Other BSAS Providers were more likely to endorse that they (1) feel most comfortable referring clients with such issues to someone else, (2) have too many other things to consider adding gambling to their mix, (3) need more training about screening for gambling, and (4) need more training about evidence-based practices for treating

gambling. These groups did not differ with respect to their concerns about gambling expansion or the low base rate of gambling-related problems. Providers did not express strong concerns about either of these issues.

MA-PGS Certified BSAS Providers Who Treat Gambling vs. All Other Providers Who Treat Gambling

As might be expected, MA-PGS Certified BSAS Providers Who Treat Gambling (MA-PGS) and All Other Providers Who Treat Gambling (Others) differed in a number of ways. Being MA-PGS certified was associated with a statistically significant increased likelihood of (1) reporting that one can list a brief gambling screen, (2) always screening clients for gambling-related problems, and (3) always using DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling. However, we could not statistically distinguish these groups in terms of whether they (4) screen their clients for gambling-related problems at least occasionally.

In addition to these differences, we also observed that MA-PGS providers were more likely than Others to report that they (1) know how to refer clients to the DPH Gambling Helpline and (2) know a gambling specialist in their organization. MA-PGS providers were statistically significantly less likely than Others to (3) fail to be able to list an evidence-based approach to gambling treatment.

These groups also differed with respect to their perceptions of their organizations' supportiveness for addressing gambling. Specifically, we noted that MA-PGS were more likely to report than Others that their organization always provides time to (1) complete gambling-related screening, (2) treat clients' gambling-related problems, and (3) participate in gambling-related training.

Finally, we observed no statistically discernable differences for any self-perceived readiness items.

4. Capabilities Gap Analysis Recommendations and Future Directions

This summary report provides the OPGS with new information related to the professional capabilities of BSAS providers from organizations contracted to provide gambling treatment services for the DPH, with respect to the treatment of gambling-related problems. As indicated above, this report focuses upon BSAS providers at the request of the OPGS and because the BSAS providers were a primary target for the state's gambling-related capacity building during the past 20 years. The OPGS and the Division agree that in the future it will be important to assess the capabilities and identify gap areas for DPH-affiliated providers outside of BSAS.

In the following, we present ideal capabilities and actual capabilities related to the identified domains of interest. We also make data-based recommendations, when appropriate. More specifically, for each domain, we provide a high-level review of the OPGS's preferred capabilities, key observations by provider group (i.e., the BSAS Providers Who Treat Gambling and the Other BSAS providers) and related provider group comparisons, and our recommendations.

Screening, Assessment, & Diagnosis

A key area of interest to the OPGS was screening for gambling. In particular, the OPGS indicated that all providers should have basic capabilities for identifying brief screens and screening clients (i.e., at least occasionally or always). All providers also should be able to indicate that their organization provides sufficient time to complete gambling-related screening. Further, the OPGS suggested that Providers who Treat Gambling additionally should be able to identify and list both brief and specific screens and to consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening.

We determined that screening engagement, knowledge, and institutional support were limited in some ways and satisfactory in others. For example, more than 90% of BSAS Providers Who Treat Gambling indicated that it is important to consider other mental health screening in conjunction with gambling screening. However, just about half of BSAS Providers Who Treat Gambling reported that they can list a brief gambling screen, and just about a quarter

of those surveyed did so correctly when asked. Furthermore, about half of these providers were likely to identify brief screens from a list, but more than 70% also were likely to incorrectly endorse faux brief screens. Our observations related to specific screens (i.e., those other than a brief screen) were similar. Also, perceived institutional support for integrating gambling screening was not overwhelming. Just half of specialists and a third of non-specialists agreed or strongly agreed that their organization always provides time to complete gambling-related screening. BSAS Providers Who Treat Gambling represented the best-case scenario for gambling-related screening, as their non-specialist counterparts tended to report less screening-related engagement, knowledge, and institutional support. Therefore, there remains an obvious need for additional screening training and integration into standard clinical operations.

Recommendation 1: **Provide access to comprehensive screening education and materials to increase gambling specialist and non-specialist provider knowledge of and use of brief screens for gambling-related problems.**

Recommendation 2: **(a) Require BSAS-affiliated treatment sites to integrate brief gambling screening into standard intake protocols, and (b) if someone other than the primary provider administers gambling screening, routinely relay the outcomes of that screening to the primary provider for clinical purposes.**

The OPGS also was interested in the assessment capabilities of BSAS Providers who Treat Gambling, suggesting that ideally, in-depth assessment of those who screen positive for gambling-related problems would be routine and would include (1) screening for other disorders, (2) assessing readiness to change, and (3) assessing for strengths and weaknesses that might impact recovery.

Some aspects of providers' assessment capabilities were quite good. For example, nearly 75% of providers indicated that they follow up positive gambling screens with screening for other disorders and with assessing a client's strengths and weaknesses that might impact recovery. Similarly, nearly 70% indicated that they follow positive gambling screens with assessing a client's readiness to change. However, only about 60% of BSAS Providers Who Treat Gambling indicated that they follow up positive gambling screens with more in-depth assessment of gambling itself. This appears, then, to be an area in need of some reinforcement of good clinical practices. Many providers appear already to follow such practices, in which case the reinforcement will confirm those practices, and for others, it might encourage the adoption of these assessment techniques.

Recommendation 3: **Develop and provide advanced clinical training programs that promote techniques and tools for advancing from screening to assessment to develop a more complete picture of clients' gambling-related problems.**

Finally, in terms of diagnosis skills, the OPGS suggested that all providers should use DSM-5 to guide their gambling-related diagnostic decision-making. In addition, the OPGS suggested that ideally BSAS Providers Who Treat Gambling also should use client's gambling history and current physiological and mental state to inform their diagnostic decision-making.

As with assessment, providers' diagnostic capabilities were promising. We observed that more than 80% of BSAS Providers Who Treat Gambling said they take gambling history as well as clients' physiological and mental states into account when forming a diagnosis. Also, nearly 70% of such providers indicated using DSM-5 to support their diagnostic decision; however, only about 40% of non-specialist providers said the same. This could reflect that they are relying on some other system, or possibly that they do not engage in diagnostic decision-making related to gambling and therefore see this as not applicable to their experience.

Recommendation 4: **Reinforce existing good clinical practices by giving social norms feedback to providers about specialists' engagement in robust diagnostic decision-making practices while simultaneously working to advance**

non-specialist familiarity and engagement with DSM-5 Gambling Disorder diagnostic criteria, decision points, and definitions.

Treatment process skills

Treatment process skills are central to treatment outcome success. Treatment process skills include accounting for factors that might influence treatment dynamics, such as cultural factors and individual difference factors. Consequently, the OPGS indicated that all providers should both be aware of cultural factors that might influence treatment success and also adapt their treatment when necessary. To examine this, we asked providers about a list of factors that have the potential to influence the gambling treatment process. These factors included things such as primary language, gender, family structure, coping styles, historical stigma and discrimination, and purpose and understanding of gambling. Generally, providers did not appear to consider most of these factors to be influential.

We observed, for the vast majority of factors, that just 50-60% of BSAS Providers Who Treat Gambling and 30-40% of All Other BSAS Providers rated those factors as having quite a bit or very much potential to influence the gambling treatment process. Some exceptions occurred. Specifically, the large majority of BSAS Providers Who Treat Gambling indicated that a client's purpose and understanding of gambling and their coping style could influence the treatment process. Surprisingly, less than 30% of All Other Providers indicated that a client's (1) intergenerational interactions patterns (such as deference to elders), (2) religious beliefs, (3) spirituality, or (4) health beliefs (such as Eastern versus Western Medicine) have the potential to influence the gambling treatment process. Likewise, less than 50% of BSAS Providers Who Treat Gambling indicated that they believed that a client's (1) spirituality or (2) health beliefs have the potential to influence the gambling treatment process. It is unclear whether providers' lack of endorsement indicates a lack of familiarity or contact with clients who represent such factors, or disbelief among many that these factors hold the potential to influence gambling treatment dynamics.

Recommendation 5: **Complete an evaluation to ascertain the prevalence and nature of specific cultural and individual difference factors among BSAS clients as well as cultural and individual difference representation among BSAS providers and BSAS-affiliated organization administration.**

The OPGS also indicated that providers should adapt their treatment plans for cultural factors that might influence the gambling treatment process. For instance, we asked providers about whether they have made communication changes, used translators, engaged in self-monitoring of own stigma and bias, included family in the treatment process, and other adaptations. Engagement in such adaptations was moderate, at best, for BSAS Providers who Treat Gambling, and quite limited, generally, for All Other BSAS Providers. For BSAS Providers who Treat Gambling, the top two adaptations were (1) consideration of the client's psychosocial environment and (2) actively self-monitoring for one's own stigma and bias, with about 80% engaging in the former and almost 70% in the latter. These providers were least likely to say they (1) completed a formal cultural assessment or (2) used a translator, with less than 25% engaging in either practice. Among All Other BSAS Providers, about half indicated that adaptations were not applicable to their practice, probably because they are not engaged in gambling-related treatment.

Recommendation 6: **Develop and deliver culturally-informed trainings related to understanding and adapting treatment to address central cultural and individual difference factors among BSAS clients and among individuals with gambling-related problems more generally.**

Intervention skills

At times, providers must help clients manage life crisis situations, such as experiences of self-harm (e.g., non-suicidal self-jury, suicidal ideation, and suicidal self-injury). According to the OPGS, ideally all providers should know when and how to intervene in such situations. Beyond this, BSAS Providers who Treat Gambling, specifically, also should be aware that Gambling Disorder is associated with experiences of self-harm.

We observed that both BSAS Providers Who Treat Gambling and All Other BSAS Providers were highly likely to endorse relevant actions during client life crisis situations. This indicates a strong professional awareness of important life crisis management actions. However, just under 60% of BSAS Providers Who Treat Gambling endorsed experiences of self-harm as a correlate of Gambling Disorder. Although causal and temporal research on this topic is limited, research does suggest that the experience of gambling-related problems is associated with a variety of experiences of self-harm, so this observation suggests that more education about this topic is warranted.

Recommendation 7: **Support a comprehensive gambling and suicide initiative that includes research activities and referral training activities for BSAS-affiliated providers and the Suicide Prevention Program, as well as resource development to expand awareness of the link between gambling and suicide and provide basic assistance to those in need.**

Treatment techniques & Referrals

The OPGS indicated that ideally all providers should be aware of the DPH treatment guidelines manual and be able to list evidence-based practices for treating Gambling Disorder. We observed about 66% of BSAS Providers Who Treat Gambling accurately reported one or more evidence-based practices. Although we did not ask BSAS Providers Who Treat Gambling about the DPH practice guidelines, only about 15% of All Other BSAS Providers indicated familiarity with the DPH practice guidelines.

Recommendation 8: **Update and expand the state's practice guidelines website content to reflect the latest published research and thinking about evidence-based practices for gambling treatment, as well as best practices for screening, assessment, and diagnosis.**

Recommendation 9: **Continue to publicize the state's practice guidelines website and support clinical training related to evidence-based practices.**

Although providers generally might be expected to screen regularly for gambling-related problems, they still might rely upon professional referrals for gambling-related treatment. In such a case, awareness of how to refer to the DPH Gambling Helpline and who within a provider's organization might be a gambling treatment specialist remains important. Therefore, the OPGS indicates that all providers should be able to make referrals to the DPH gambling helpline and should know who within their organization (if anyone) is a gambling specialist. Awareness of both was moderately high among BSAS Providers who Treat Gambling, but relatively low among All Other Providers. This represents an important opportunity to educate providers about available resources in the state and potentially within their organization.

Recommendation 10: **Engage in ongoing promotion of the DPH gambling helpline and related resources that represent opportunities for immediate responsiveness to clients' gambling-related concerns, such as Your First Step to Change.**

Recommendation 11: **Encourage BSAS-affiliated organizations to maintain a gambling specialist on staff and to publicly identify gambling specialists within their organization, indicating specific referral protocols and procedures for gambling-related treatment.**

Special Populations

As with other expressions of addition, some special populations might require unique attention when it comes to gambling and Gambling Disorder. The OPGS suggests that all providers should be able to report that IPV perpetration is a risk factor for gambling-related problems. Providers should take this into consideration for treatment planning. Likewise, providers also should take Veteran status into account for treatment planning. Beyond this, BSAS

Providers Who Treat Gambling also should be able to report that race and ethnicity is associated with risk for gambling-related problems and requires attention during treatment planning.

With respect to Veterans, IPV perpetrators, and some racial and ethnic groups, BSAS Providers Who Treat Gambling demonstrated low to moderately good awareness of these characteristics as risk indicators. They showed least awareness regarding IPV perpetrators, as just above 40% of providers indicated these individuals to be at risk for having gambling-related problems. All Other BSAS Providers more uniformly demonstrated low awareness of special populations that are associated with risk. Furthermore, neither group of providers demonstrated an overwhelming indication of attending to these matters during gambling-related treatment planning. At most, just about half of BSAS Providers Who Treat Gambling indicated that they agree or strongly agree that they always take race and ethnicity into account for gambling-related treatment planning. Finally, although this observation was not associated with a specific capability, we noted that BSAS Providers Who Treat Gambling seemed incorrectly to consider some populations at relatively high risk for gambling-related problems, including women, the middle aged, and high-income earners. This pattern of findings potentially indicates that providers' endorsement of correct requirements is a product of propensity for endorsement, rather than a measure of special population knowledge These findings indicate that education about special populations should attend to expanding knowledge and correcting false beliefs.

Recommendation 12: **Develop a specific training agenda for understanding groups that might be at elevated risk for gambling problems, including Veterans, IPV perpetrators, and diverse voices.**

Recommendation 13: **Begin gambling-related outreach to representatives and DPH-affiliated organizations that represent and work with at-risk groups, including Veterans, IPV educators, and minority racial and ethnic groups to gain a better understanding of their resources for informing gambling-related treatment of clients from these groups and to work towards building strong linkages between BSAS-affiliated organizations and these representatives in relation to identifying and treating gambling-related problems.**

Treatment Administration Skills

Patient engagement, treatment planning, and associated activities are vital to effective treatment practices. Likewise, administrative aspects of treatment are centrally important to competent practice. Because of this, the OPGS indicated that all providers should maintain high treatment administration skills, including keeping records, protecting privacy, and understanding and abiding by HIPAA.

We observed that both provider groups were highly liked to endorse using clinical record keeping tools and that their organization has implemented privacy policies and procedures. However, according to providers, organizations were not especially likely to have designated a privacy official, with just about half of BSAS Providers Who Treat Gambling indicating their organization did so and about a fifth of All Other BSAS Providers endorsing the same. We also observed the need for meaningful improvement in knowledge of HIPAA requirements for Covered entities, as both groups indicated low to moderate rates of endorsing all correct HIPAA requirements and high rates of endorsing faux HIPAA requirements. This pattern of findings potentially indicates that providers' endorsement of correct requirements is a product of propensity for endorsement, rather than a measure of HIPAA knowledge.

Recommendation 14: **Reinforce good treatment administration practice by sharing social norms information regarding protecting privacy and providing continuing HIPAA education.**

Current Training History for Gambling

To advance gambling treatment within the DPH system, it is important that providers (1) are provided the opportunity to engage with training, (2) do not face any unnecessary barriers to accessing training, and (3) actively engage with training for treating gambling. Accordingly, the OPGS indicated that BSAS Providers Who Treat Gambling

should have a history of attending at least one gambling training. Furthermore, with respect to perceived organization support, the OPGS suggested that BSAS Providers Who Treat Gambling also should be able to indicate that their organization reimburses for such training and *all providers* should be able to indicate that their organization provides time to participate in gambling-related training.

Our training-related observations were mixed. About 66% of BSAS Providers Who Treat Gambling reported that they did have history of attending such training, which is meaningfully lower than the expectation that all such providers will have this experience. Although 75% indicated organizational support for training, only half indicated that their organization reimburses for participating in gambling treatment training, which suggests a mixed message and a potential barrier to full training participation. Notably, BSAS Providers Who Treat Gambling and MA-PGS providers were more likely than their comparative counterparts to indicate that their organizations provided time to participate in gambling-related training. This suggests that deficits observed for these key groups of treatment providers are more severe among non-specialists.

The provider survey also assessed providers' perceptions of their own training needs. Meaningful percentages of both BSAS Providers Who Treat Gambling and All Other Providers indicated self-identified need for additional training related to both screening and evidence-based practices. Non-specialist providers were more likely than gambling treatment specialists to endorse such need. Providers' willingness to identify gaps in their knowledge suggests that such introspection might be useful to guiding the development of additional training opportunities in the state.

Recommendation 15: **Conduct informational interviews with BSAS provider organization representatives to identify potential barriers to their support for giving providers time and financial support to participate in gambling-related training.**

Recommendation 16: **Develop provider engagement with gambling-related training by providing participation incentives, such as time reimbursement.**

Recommendation 17: **Address providers' current self-identified training needs by holding clinical trainings related to screening and evidence-based practices for treating gambling.**

Recommendation 18: **Conduct informational interviews with BSAS providers to gain insight into training topics of interest, need, and self-perceived knowledge gaps that might prevent individuals from engaging in gambling-related treatment.**

Perceived Organizational Support for Addressing Gambling

Organizational support for treating gambling might be key to increasing the numbers of BSAS providers who are prepared to address gambling. It is important for organizations to indicate to providers that they will give them the time that they need to treat gambling-related problems. Failing to do so could lead providers to avoid treating gambling. Recognizing this, the OPGS indicated that all providers should feel that their organization always provides time to treat clients' gambling-related problems. Just under 70% of BSAS Providers Who Treat Gambling suggested that their organization provided such time. Both BSAS Providers Who Treat Gambling and MA-PGS providers were more likely than their comparative counterparts to agree with this perception; hence, non-specialist status and non-MA-PGS status were associated with less support for the idea that their organization always provides sufficient time to treat gambling. Notably, non-specialist providers were more likely to indicate that they had too many other responsibilities to consider adding gambling to their mix.

Recommendation 19: **Promote organizational support of integrating gambling treatment and training by developing an incentive system that provides organizations with system-level gains and providers with individual-level gains.**

Provider Self-perceptions

Providers' personal impressions of their capabilities to treat gambling might influence whether they pursue training opportunities, whether they screen for gambling, whether they opt to treat their clients for gambling or refer out, and more. Non-specialist providers indicated poor confidence in treating gambling-related issues, including just 3% endorsing that they feel comfortable handling such issues right away and about half indicating that they would prefer to refer such clients to someone else. We noted that even among BSAS Providers who Treat Gambling, only about half reported that they are prepared to handle such issues right away and about a quarter indicated that they preferred to refer clients with gambling-related problems to someone else. Simultaneously, a small but meaningful number of each group indicated that they are concerned about gambling expansion appeared to anticipate that gambling might become a common issue. This pattern of findings might be interpreted to suggest that confidence for treating gambling-related problems is modest at best, but providers are concerned that they will face increased demand for gambling treatment.

Recommendation 20: **Engage in a provider awareness campaign to promote the idea that many substance use disorder tools and techniques (e.g., CBT, MI, self-help, brief screening) can be applied to gambling and highlight available resources in the state (e.g., YFSTC, helpline, practice guidelines) that can be used without formal training or specialty certification.**

MA-PGS Training

Our exploratory examination of preparedness among providers who had, versus had not, secured MA-PGS certification status indicated that providers who have secured their MA-PGS are better prepared and trained to address gambling treatment in a variety of ways. For example, we noted that MA-PGS providers were more likely than Others to do things like be able to list brief screens, screen for gambling, and know of gambling-related resources, including the DPH gambling helpline and gambling specialists within their organization. Relatedly, these providers' perceptions of organizational support for gambling treatment were greater than Others. It might be that organizational support drives the observed differences or follows MA-PGS participation.

Recommendation 21: **Promote MA-PGS certification by increasing training opportunities, awareness, and organizational support for securing MA-PGS certification, as well as by developing an incentivizing system to engage providers.**

5. Domains and Capabilities Tables

Table 5-1 Identifying the Domains of Interest

Domain of Interest	Reported Interest Level	OPGS Rationale
Providers' interest in treating gambling-related problems	Moderate	This is an area that is well understood. Providers have demonstrated a great interest to treating gambling related problems.
Providers' understanding of:		
a. Addiction to gambling (e.g., Three Cs)	Moderate	This is an area that providers receive training from the Mass Council
b. Theoretical models of Gambling Disorder (e.g., Addiction Syndrome, Pathways Model)	Moderate	Not provided
c. Signs and symptoms of Gambling Disorder (e.g., lying, borrowing, experiencing withdrawal)	Moderate	Not provided
d. Relationship between gambling and other mental health problems (e.g., suicide, substance abuse)	Considerable	Not provided
Screening for gambling (e.g., Lie/Bet, BBGS, NODS-CLiP)	Maximum	Not provided
Assessment for gambling (e.g., MAGS, SOGS)	Maximum	Not provided
Diagnosis for gambling (e.g., DSM5, obtaining a history)	Maximum	Not provided
Treatment process skills (e.g., adapting to client's background)	Maximum	Not provided
Intervention skills (e.g., life crisis situations)	Considerable	Not provided
Interpersonal process skills (e.g., empathy, genuineness)	Very little	Not provided
Therapy organization and movement skills (e.g., lead-ins, restatement)	Moderate	Not provided
Treatment techniques (e.g., working with ambivalence)	Considerable	Not provided
Ability to make referrals for gambling (e.g., long-term care)	Considerable	Not provided
Special populations (e.g., clients with special physical needs)	Considerable	Not provided
Treatment administration skills (e.g., taking case notes)	Considerable	Not provided
Current training history for gambling (e.g., recent CEU courses)	Maximum	Not provided
Anticipated training for gambling (e.g., upcoming CEU courses)	Considerable	Not provided
Perceived organizational support for addressing gambling	Maximum	Not provided
Perceived Bureau of Substance Abuse Services support for addressing gambling	Moderate	Not provided
Perceived Department of Public Health support for addressing gambling	Moderate	Not provided
Massachusetts Problem Gambling Specialist certification	Moderate	Not provided
Other gambling-related certification[7]	Considerable	Not provided

[7] After further consideration, the OPGS elected to postpone inclusion of this domain as a special interest.

Table 5-2 Identifying the Capabilities of Interest: Treatment Administration Skills

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should keep records, as required.	All BSAS Providers	Most Important
Providers should keep records, as required.	BSAS Providers who Treat Gambling	Most Important
Provides should protect the privacy of patients, as required.	All BSAS Providers	Most Important
Provides should protect the privacy of patients, as required.	BSAS Providers who Treat Gambling	Most Important
Providers should understand HIPAA, such that patient are protected accordingly.	All BSAS Providers	Most Important
Providers should understand HIPAA, such that patient are protected accordingly.	BSAS Providers who Treat Gambling	Most Important
Providers should understand how to refer patients to other care providers and share treatment records, as appropriate.	All BSAS Providers	Important
Providers should understand how to refer patients to other care providers and share treatment records, as appropriate.	BSAS Providers who Treat Gambling	Important
Providers should have some other treatment administration skills. [Please describe.]		

Table 5-3 Identifying the Capabilities of Interest: Assessment for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should consistently complete an assessment of those clients who screen positive for gambling-related problems.	All BSAS Providers	Important
Providers should consistently complete an assessment of those clients who screen positive for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should consistently screen clients for other disorders if they screen positive for gambling-related problems.	All BSAS Providers	Important
Providers should consistently screen clients for other disorders if they screen positive for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should consistently assess clients who screen positive for gambling-related problems for readiness to change.	All BSAS Providers	Important
Providers should consistently assess clients who screen positive for gambling-related problems for readiness to change.	BSAS Providers who Treat Gambling	Most Important
Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact treatment.	All BSAS Providers	Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact treatment.	BSAS Providers who Treat Gambling	Important
Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery.	All BSAS Providers	Important
Providers should consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery.	BSAS Providers who Treat Gambling	Most Important
Providers should consistently do some other task related to assessment for gambling. [Please describe.]		

Table 5-4 Identifying the Capabilities of Interest: Diagnosis for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should rely upon a specific theoretical model to gather screening and assessment information to make a diagnosis of Gambling Disorder.	All BSAS Providers	Important
Providers should rely upon a specific theoretical model to gather screening and assessment information to make a diagnosis of Gambling Disorder.	BSAS Providers who Treat Gambling	Important
Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making related to gambling.	All BSAS Providers	Most Important
Providers should always use the DSM-5 Gambling Disorder criteria as part of diagnostic decision-making related to gambling.	BSAS Providers who Treat Gambling	Most Important
Providers should use gambling history information as part of diagnostic decision-making related to gambling.	All BSAS Providers	Important
Providers should use gambling history information as part of diagnostic decision-making related to gambling.	BSAS Providers who Treat Gambling	Most Important
Providers should screen for current physiological and mental state of clients, in conjunction with the DSM-5 as part of diagnostic decision-making related to gambling.	All BSAS Providers	Important
Providers should screen for current physiological and mental state of clients, in conjunction with the DSM-5 as part of diagnostic decision-making related to gambling.	BSAS Provides who Treat Gambling	Most Important
Providers should be able to have some other capability related to diagnosis for gambling. [Please describe.]		

Table 5-5 Identifying the Capabilities of Interest: Intervention Skills

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should understand that Gambling Disorder is associated with the experience of self-harm.	All BSAS Providers	Important
Providers should understand that Gambling Disorder is associated with the experience of self-harm.	BSAS Providers who Treat Gambling	Most Important
Providers should know when and how to intervene in life crisis situations.	All BSAS Providers	Most Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should know when and how to intervene in life crisis situations.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to list techniques and strategies for managing gambling craving.	All BSAS Providers	Important
Providers should be able to list techniques and strategies for managing gambling craving.	BSAS Providers who Treat Gambling	Important
Providers should be able to apply techniques and strategies for managing gambling craving.	All BSAS Providers	Important
Providers should be able to apply techniques and strategies for managing gambling craving.	BSAS Providers who Treat Gambling	Important
Providers should be able to list techniques and strategies for managing gambling seeking behavior.	All BSAS Providers	Important
Providers should be able to list techniques and strategies for managing gambling seeking behavior.	BSAS Providers who Treat Gambling	Important
Providers should be able to apply techniques and strategies for managing gambling seeking behavior.	All BSAS Providers	Important
Providers should be able to apply techniques and strategies for managing gambling seeking behavior.	BSAS Providers who Treat Gambling	Important
Providers should have some other intervention skills for treating people with Gambling Disorder. [Please describe.]		

Table 5-6 Identifying the Capabilities of Interest: Perceived Organizational Support for Addressing Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should indicate that their organization provides them time to participate in gambling-related training.	All BSAS Providers	Most Important
Providers should indicate that their organization provides them time to participate in gambling-related training.	BSAS Providers who Treat Gambling	Most Important
Providers should indicate that their organization reimburses for participation in gambling-related training.	All BSAS Providers	Important
Providers should indicate that their organization reimburses for participation in gambling-related training.	BSAS Providers who Treat Gambling	Most Important
Providers should indicate that their organization provides time to complete gambling-related screening.	All BSAS Providers	Most Important
Providers should indicate that their organization provides time to complete gambling-related screening.	BSAS Providers who Treat Gambling	Most Important
Providers should indicate that their organization provides time to treat clients' gambling-related problems.	All BSAS Providers	Most Important
Providers should indicate that their organization provides time to treat clients' gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should indicate that their organization participates in Gambling Disorder Screening Day.	All BSAS Providers	Not Important
Providers should indicate that their organization participates in Gambling Disorder Screening Day.	BSAS Providers who Treat Gambling	Not Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should indicate that their organization is eligible for gambling blanket funds.	All BSAS Providers	Not Important
Providers should indicate that their organization is eligible for gambling blanket funds.	BSAS Providers who Treat Gambling	Important
Providers should indicate that their organization is open to integrating gambling treatment into its system.	All BSAS Providers	Important
Providers should indicate that their organization is open to integrating gambling treatment into its system.	BSAS Providers who Treat Gambling	Important
Providers should indicate some other organizational support for addressing gambling. [Please describe.]		

Table 5-7 Identifying the Capabilities of Interest: Other Gambling-related Certification

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should have a history of responsible gambling training (e.g., gaming industry training).	All BSAS Providers	Not Important
Providers should have a history of responsible gambling training (e.g., gaming industry training).	BSAS Providers who Treat Gambling	Not Important
Providers should be ICGC I (International Certified Gambling Counselor I) - All BSAS Providers	All BSAS Providers	Not Important
Providers should be ICGC I (International Certified Gambling Counselor I)	BSAS Providers who Treat Gambling	Not Important
Providers should be ICGC II (International Certified Gambling Counselor II)	All BSAS Providers	Not Important
Providers should be ICGC II (International Certified Gambling Counselor II)	BSAS Providers who Treat Gambling	Not Important
Providers should be CAS (Certified Addiction Specialist)	All BSAS Providers	Not Important
Providers should be CAS (Certified Addiction Specialist)	BSAS Providers who Treat Gambling	Not Important
Providers should have some other gambling-related certification. [Please describe.]		

Table 5-8 Identifying the Capabilities of Interest: Providers' understanding of the relationship between gambling and other mental health problems

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to report that gambling often co-occurs with other mental health problems, generally.	All BSAS Providers	Important
Providers should be able to report that gambling often co-occurs with other mental health problems, generally.	BSAS Providers who Treat Gambling	Important
Providers should be able to report the specific rate at which gambling co-occurs with specific mental health problems.	All BSAS Providers	Not Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to report the specific rate at which gambling co-occurs with specific mental health problems.	BSAS Providers who Treat Gambling	Important
Providers should know that for most people who struggle with gambling and another mental health problem, the other mental health problem most likely developed before the gambling-related problems.	All BSAS Providers	Important
Providers should know that for most people who struggle with gambling and another mental health problem, the other mental health problem most likely developed before the gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should be able to report on some other key concepts related to the relationship between gambling and other mental health problems. [Please describe.]	N/A	Providers should have a general understanding of key concepts of gambling and other mental health problems

Table 5-9 Identifying the Capabilities of Interest: Treatment Process Skill

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be aware of cultural factors that could influence the gambling treatment process.	All BSAS Providers	Most Important
Providers should be aware of cultural factors that could influence the gambling treatment process.	BSAS Providers who Treat Gambling	Most Important
Providers should adapt their treatment for cultural factors that could influence the gambling treatment process.	All BSAS Providers	Most Important
Providers should adapt their treatment for cultural factors that could influence the gambling treatment process.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to guide the gambling treatment process from beginning to end without inserting their personal feelings.	All BSAS Providers	Important
Providers should be able to guide the gambling treatment process from beginning to end without inserting their personal feelings.	BSAS Providers who Treat Gambling	Important
Providers should have some other gambling treatment process skills for addressing gambling-related problems. [Please describe.]		

Table 5-10 Identifying the Capabilities of Interest: Ability to make Referrals for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to tell clients how to access Your First Step to Change.	All BSAS Providers	Important
Providers should be able to tell clients how to access Your First Step to Change.	BSAS Providers who Treat Gambling	Important
Providers should be aware of the Mass Council on Compulsive Gambling.	All BSAS Providers	Important
Providers should be aware of the Mass Council on Compulsive Gambling.	BSAS Providers who Treat Gambling	Important
Providers should be able to refer clients to the Gambling Helpline.	All BSAS Providers	Most Important
Providers should be able to refer clients to the Gambling Helpline.	BSAS Providers who Treat Gambling	Most Important
Providers should know who within their organization (if anyone) is a gambling specialist.	All BSAS Providers	Most Important
Providers should know who within their organization (if anyone) is a gambling specialist.	BSAS Providers who Treat Gambling	Important
Providers should know what gambling self-exclusion is.	All BSAS Providers	Important
Providers should know what gambling self-exclusion is.	BSAS Providers who Treat Gambling	Important
Providers should know how to refer people to self-exclude from gambling venues.	All BSAS Providers	Important
Providers should know how to refer people to self-exclude from gambling venues.	BSAS Providers who Treat Gambling	Important
Providers should know how to refer people to Gamblers Anonymous, Smart Recovery, and other mutual help programs.	All BSAS Providers	Important
Providers should know how to refer people to Gamblers Anonymous, Smart Recovery, and other mutual help programs.	BSAS Providers who Treat Gambling	Important
Providers should have some other ability related to referral for gambling. [Please describe.]		

Table 5-11 Identifying the Capabilities of Interest: Screening for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should report that they at least occasionally screen their clients for gambling-related problems.	All BSAS Providers	Most Important
Providers should report that they at least occasionally screen their clients for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should report that they have participated in Gambling Disorder Screening Day.	All BSAS Providers	Not Important
Providers should report that they have participated in Gambling Disorder Screening Day.	BSAS Providers who Treat Gambling	Not Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to list at least one brief screen for gambling-related problems.	All BSAS Providers	Most Important
Providers should be able to list at least one brief screen for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to identify specific brief screens for gambling-related problems from a list.	All BSAS Providers	Important
Providers should be able to identify specific brief screens for gambling-related problems from a list.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to generate a list of specific screens for gambling-related problems.	All BSAS Providers	Important
Providers should be able to generate a list of specific screens for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to identify specific screens for gambling-related problems from a list.	All BSAS Providers	Important
Providers should be able to identify specific screens for gambling-related problems from a list.	BSAS Providers who Treat Gambling	Most Important
Providers should report that they always screen their clients for gambling-related problems.	All BSAS Providers	Most Important
Providers should report that they always screen their clients for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening	All BSAS Providers	Important
Providers should consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening	BSAS Providers who Treat Gambling	Most Important
Providers should have some other capability related to screening for gambling. [Please describe.]		This is another area of great importance

Table 5-12 Identifying the Capabilities of Interest: Special Populations

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to report that Intimate Partner Violence perpetrators are at increased risk for gambling-related problems.	All BSAS Providers	Most Important
Providers should be able to report that Intimate Partner Violence perpetrators are at increased risk for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should report that they take Intimate Partner Violence history into account for gambling-related treatment planning.	All BSAS Providers	Most Important
Providers should report that they take Intimate Partner Violence history into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to report that Veterans are at increased risk for gambling-related problems.	All BSAS Providers	Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to report that Veterans are at increased risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take Veteran status into account for gambling-related treatment planning.	All BSAS Providers	Most Important
Providers should report that they take Veteran status into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to report that clients with criminal history are at increased risk for gambling-related problems.	All BSAS Providers	Important
Providers should be able to report that clients with criminal history are at increased risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take criminal history status into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take criminal history status into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should be able to report that parental status can complicate treatment.	All BSAS Providers	Important
Providers should be able to report that parental status can complicate treatment.	BSAS Providers who Treat Gambling	Important
Providers should report that they take parental status into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take parental status into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should be able to report that SES is associated with risk for gambling-related problems.	All BSAS Providers	Important
Providers should be able to report that SES is associated with risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take SES into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take SES into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should be able to report that race and ethnicity is associated with risk for gambling-related problems.	All BSAS Providers	Important
Providers should be able to report that race and ethnicity is associated with risk for gambling-related problems.	BSAS Providers who Treat Gambling	Most Important
Providers should report that they take race and ethnicity into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take race and ethnicity into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to report that age is associated with risk for gambling-related problems.	All BSAS Providers	Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to report that age is associated with risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take age into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take age into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should be able to report that LGBTQ status is associated with risk for gambling-related problems.	All BSAS Providers	Important
Providers should be able to report that LGBTQ status is associated with risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take LGBTQ status into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take LGBTQ status into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should be able to report that relapse history is associated with risk for gambling-related problems.	All BSAS Providers	Important
Providers should be able to report that relapse history is associated with risk for gambling-related problems.	BSAS Providers who Treat Gambling	Important
Providers should report that they take relapse history into account for gambling-related treatment planning.	All BSAS Providers	Important
Providers should report that they take relapse history into account for gambling-related treatment planning.	BSAS Providers who Treat Gambling	Important
Providers should report that they take some other special population into account for gambling-related treatment planning. [Please describe.]		All areas are important, but Veterans is most important due to many health and risk factors.

Table 5-13 Identifying the Capabilities of Interest: Current Training History for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should have a history of attending at least one gambling conference.	All BSAS Providers	Important
Providers should have a history of attending at least one gambling conference.	BSAS Providers who Treat Gambling	Important
Providers should have a history of attending the Commonwealth's annual gambling conference hosted by the Mass Council on Compulsive Gambling.	All BSAS Providers	Not Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should have a history of attending the Commonwealth's annual gambling conference hosted by the Mass Council on Compulsive Gambling.	BSAS Providers who Treat Gambling	Important
Providers should have a history of attending at least one gambling training.	All BSAS Providers	Important
Providers should have a history of attending at least one gambling training.	BSAS Providers who Treat Gambling	Most Important
Providers should have a history of attending at least one gambling webinar.	All BSAS Providers	Important
Providers should have a history of attending at least one gambling webinar.	BSAS Providers who Treat Gambling	Important
Providers should have MA PGS (Massachusetts Problem Gambling Specialist certification).	All BSAS Providers	Not Important
Providers should have MA PGS (Massachusetts Problem Gambling Specialist certification).	BSAS Providers who Treat Gambling	Important
Providers should report that they read the Brief Addiction Science Information Source (BASIS).	All BSAS Providers	Not Important
Providers should report that they read the Brief Addiction Science Information Source (BASIS).	BSAS Providers who Treat Gambling	Important
Providers should have some other training history for gambling. [Please describe.]		

Table 5-14 Identifying the Capabilities of Interest: Anticipated Training for Gambling

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should report that they are planning to attend a gambling conference.	All BSAS Providers	Not Important
Providers should report that they are planning to attend a gambling conference.	BSAS Providers who Treat Gambling	Not Important
Providers should plan to attend the Commonwealth's annual gambling conference hosted by the Mass Council on Compulsive Gambling.	All BSAS Providers	Not Important
Providers should plan to attend the Commonwealth's annual gambling conference hosted by the Mass Council on Compulsive Gambling.	BSAS Providers who Treat Gambling	Not Important
Providers should plan to obtain 10 Continuing Education hours related to gambling each year.	All BSAS Providers	Not Important
Providers should plan to obtain 10 Continuing Education hours related to gambling each year.	BSAS Providers who Treat Gambling	Important
Providers should plan to obtain at least _____ Continuing Education hours related to gambling each year. [Fill in the blank.]	All BSAS Providers	n/a
Providers should plan to obtain at least _____ Continuing Education hours related to gambling each year. [Fill in the blank.]	BSAS Providers who Treat Gambling	n/a
Providers should plan to obtain at least _____ Continuing Education hours related to gambling each year. [Fill in the blank.] - Selected Choice		All BSAS Providers: CE hours related to

Clinical Capability	Provider Type	OPGS Importance Rating
		gambling each year, BSAS Providers who treat gambling: CE hours related to gambling each year
Providers should be aware that the Commonwealth supports Continuing Education for gambling via live trainings.	All BSAS Providers	Important
Providers should be aware that the Commonwealth supports Continuing Education for gambling via live trainings.	BSAS Providers who Treat Gambling	Important
Providers should be aware that the Commonwealth supports free Continuing Education for gambling via webinars.	All BSAS Providers	Important
Providers should be aware that the Commonwealth supports free Continuing Education for gambling via webinars.	BSAS Providers who Treat Gambling	Important
Providers should be aware that the National Center for Responsible Gaming supports free Continuing Education for gambling via webinars.	All BSAS Providers	Not Important
Providers should be aware that the National Center for Responsible Gaming supports free Continuing Education for gambling via webinars.	BSAS Providers who Treat Gambling	Important
Providers should have some other anticipated training for gambling. [Please describe.]		

Table 5-15 Identifying the Capabilities of Interest: Treatment Techniques

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be aware of the DPH Treatment Guidelines manual.	All BSAS Providers	Most Important
Providers should be aware of the DPH Treatment Guidelines manual.	BSAS Providers who Treat Gambling	Most Important
Providers should be aware of the DPH Treatment Guidelines website.	All BSAS Providers	Important
Providers should be aware of the DPH Treatment Guidelines website.	BSAS Providers who Treat Gambling	Important
Providers should be able to list evidence-based practices for treating Gambling Disorder.	All BSAS Providers	Most Important
Providers should be able to list evidence-based practices for treating Gambling Disorder.	BSAS Providers who Treat Gambling	Most Important
Providers should be able to reduce the inherent ambivalence associated with treatment.	All BSAS Providers	Important
Providers should be able to reduce the inherent ambivalence associated with treatment.	BSAS Providers who Treat Gambling	Important

Clinical Capability	Provider Type	OPGS Importance Rating
Providers should be able to increase motivation for change by enhancing motivation to change or reducing resistance to change.	All BSAS Providers	Important
Providers should be able to increase motivation for change by enhancing motivation to change or reducing resistance to change.	BSAS Providers who Treat Gambling	Important
Providers should have some other treatment techniques for addressing gambling-related problems. [Please describe.]		

6. Provider Survey

Welcome to the survey!

Researchers at the Cambridge Health Alliance, a Harvard Medical School teaching hospital are conducting a survey of Bureau of Substance Abuse Services (BSAS) affiliated providers for the Department of Public Health Office of Problem Gambling Services.

We are interested in understanding your experiences with treating gambling-related problems. You will be presented with information relevant to the treatment of gambling-related problems and asked to answer some questions about it.

Please be assured that your responses will be kept completely confidential. Your individual responses will not be linked to your identifying information, like your name. Your individual responses will not be provided to your employer.

The study includes no more than 22 questions and should take you roughly 30 minutes to complete. Your participation in this research is voluntary. You have the right to withdraw at any point during the study, for any reason.

There are no direct benefits for you to completing the survey. However, your responses will help us better understand gambling-related treatment within the BSAS system. There are no risks to completing this survey.

If you would like to contact the Principal Investigator in the study to discuss this survey, please e-mail Dr. Debi LaPlante *dlaplante@hms.harvard.edu*. If you would like to contact the survey Sponsor, please e-mail Victor Ortiz, Director of Problem Gambling Services *victor.ortiz@state.ma.us.*

By clicking the button below, you acknowledge that your participation in the survey is voluntary, you are 18 years of age, and that you are aware that you may choose to terminate your participation in the survey at any time and for any reason.

Please note that this survey will be best displayed on a laptop or desktop computer. Some features may be less compatible for use on a mobile device.

- o I consent, begin the survey
- o I do not consent, I do not wish to participate in the survey [Survey Note. Those who select this option will exit the survey, others will proceed to the next page.]

Thank you for agreeing to complete this important survey. DPH is interested in understanding the strengths and needs of Bureau of Substance Abuse Services (BSAS) affiliated providers for treating clients who have gambling-related problems. For the purposes of this survey, BSAS-affiliated treatment providers are defined as those providers who work for BSAS-licensed organizations or are individually licensed as a BSAS treatment provider. To help, please complete the following questions.

1. During what year did you start working as a BSAS-affiliated treatment provider? _____

2. During what year did you start working as a BSAS-affiliated treatment provider **at your current job**? _____

3. What is the highest level of education you have completed?
    a. High School
    b. Some College
    c. Associates Degree
    d. Bachelor's Degree
    e. Master's Degree
    f. Advanced graduate work (such as, Ph.D., Ed.D., M.D., or D.P.H.)

4. Do you have any special professional certifications or licenses related to your current job?
    a. Yes, _____ (Please list all related licenses or certifications)
    b. No

5. Do any of the following options describe you? [Survey Note. If "g" then gate into the set of questions for "All Other BSAS Providers" (page 9), otherwise gate into the set of questions for "BSAS Providers who treat gambling" (page 3). These are separated immediately below. Respondents will answer one or the other set of questions, not both sets.]
    a. Massachusetts – Problem Gambling Specialist (MA-PGS) certified
    b. International Certified Gambling Counselor (ICGC) certified
    c. Certified Addiction Specialist (CAS) with gambling specialization
    d. At my current place of employment, at least once, I have treated a client for a gambling-related problem
    e. At my current place of employment, if a client has a gambling-related problem, the client might be assigned to my caseload for gambling treatment
    f. In my private practice, at least once, I have treated a client for a gambling-related problem
    g. None of the above

[Survey Note. BSAS Providers Who Treat Gambling questions follow]

1. I can list one specific brief screen (one that includes 5 or fewer items) for gambling-related problems
    a. Yes (please list) _____
    b. No

2. Which of the following are brief screens (those that include 5 or fewer items) for gambling-related problems? (check all that apply)
    a. Brief Biosocial Gambling Screen (BBGS)
    b. Lie/Bet
    c. NODS-CLiP
    d. NODS-PERC
    e. Quick Gambling Screen
    f. Diagnostic Gambling Instrument
    g. Gambling Mini
    h. None of the above
    i. I don't know

3. I can list one specific screen (other than a brief screen) for gambling-related problems
    a. Yes (please list) _____
    b. No

4. Which of the following are screens (other than brief screens) for gambling-related problems?
    a. Massachusetts Gambling Screen (MAGS)
    b. South Oaks Gambling Screen (SOGS)
    c. Canadian Problem Gambling Index (CPGI)
    d. Gamblers Anonymous 20 Questions
    e. Gambling and Gambling Problems Screen
    f. Impulsive Gambling Screen
    g. Gambling Treatment Outcome Monitoring System
    h. None of the above
    i. I don't know

5. Name one or more evidence-based treatment approaches for addressing Gambling Disorder _____

6. To what extent do you agree or disagree with the following statements:

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
I screen my clients for gambling-related problems at least occasionally	◯	◯	◯	◯	◯
I screen my clients for gambling-related problems always	◯	◯	◯	◯	◯
It is important to consider the importance of other brief screening for high risk behaviors related to mental health concerns in conjunction with gambling screening	◯	◯	◯	◯	◯

I consistently complete a more detailed assessment of those clients who screen positive for gambling-related problems	◯	◯	◯	◯	◯
I consistently assess clients who screen positive for gambling-related problems for readiness to change	◯	◯	◯	◯	◯
I consistently assess clients who screen positive for gambling-related problems for other disorders	◯	◯	◯	◯	◯
I consistently assess clients who screen positive for gambling-related problems for strengths and weaknesses that might impact sustained recovery	◯	◯	◯	◯	◯
I always use DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling	◯	◯	◯	◯	◯
I always use gambling history information as part of diagnostic decision-making related to gambling	◯	◯	◯	◯	◯
I always use current physiological and mental state, in conjunction with DSM-5 as part of diagnostic decision-making related to gambling	◯	◯	◯	◯	◯
I am familiar with the Department of Public Health Practice Guidelines for Treating Gambling-Related Problems	◯	◯	◯	◯	◯
I know how to refer clients to the Department of Public Health Gambling Helpline	◯	◯	◯	◯	◯
I always take Veteran status into account for gambling-related treatment planning	◯	◯	◯	◯	◯
I always take Intimate Partner Violence (IPV) status into account for gambling-related treatment planning	◯	◯	◯	◯	◯
I always take race and ethnicity into account for gambling-related treatment planning	◯	◯	◯	◯	◯
My organization always provides time to complete gambling-related screening	◯	◯	◯	◯	◯
My organization always provides time to treat clients' gambling-related problems	◯	◯	◯	◯	◯
My organization always provides time to participate in gambling-related training	◯	◯	◯	◯	◯
My organization always reimburses for participation in gambling-related training	◯	◯	◯	◯	◯

7. Within your organization, do you know who is a gambling specialist?
    a. Yes, _____
    b. No, my organization has a gambling specialist, but I am not sure who it is
    c. My organization does not employ a gambling specialist
    d. I do not know if my organization employs a gambling specialist

8. To what extent do any of the following client cultural factors have the potential to influence the gambling treatment process?

Cultural Factor	Not at all	A little bit	Moderately	Quite a bit	Very much
Primary language	◯	◯	◯	◯	◯
Level of acculturation to local majority culture	◯	◯	◯	◯	◯

Age	◯	◯	◯	◯	◯
Gender	◯	◯	◯	◯	◯
Occupational issues (such as, undocumented workers or highly skilled workers without local licensing	◯	◯	◯	◯	◯
Family structure (such as, paternalistic, or primary caregivers, or family makeup)	◯	◯	◯	◯	◯
Intergenerational interaction patterns (such as, deference to elders)	◯	◯	◯	◯	◯
Religious beliefs (such as, membership in an organized religion)	◯	◯	◯	◯	◯
Spirituality (such as, belief in a divinity)	◯	◯	◯	◯	◯
Health beliefs (such as, Eastern versus Western medicine)	◯	◯	◯	◯	◯
Emotional expression	◯	◯	◯	◯	◯
Coping styles	◯	◯	◯	◯	◯
Communication styles	◯	◯	◯	◯	◯
Tendency toward help-seeking	◯	◯	◯	◯	◯
Individualism/collectivism	◯	◯	◯	◯	◯
Trust in authority	◯	◯	◯	◯	◯
Historical stigma and discrimination	◯	◯	◯	◯	◯
Contemporary stigma and discrimination	◯	◯	◯	◯	◯
Purpose and understanding of gambling	◯	◯	◯	◯	◯

9. In what ways have you adapted your treatment for cultural factors that could influence the gambling treatment process? (Check all that apply)
    a. Incorporated non-Western approaches into my treatment plan
    b. Changed how I communicate (such as, reducing or increasing my expressed emotion)
    c. Used a translator
    d. Used gender-specific treatment strategies
    e. Used age-specific treatment strategies
    f. Actively monitored my own biases and stigma
    g. Changed an evidence-based practice to suit a client's religious or spiritual orientation
    h. Included family in the treatment process
    i. Inquired about cultural identity to inform my diagnosis
    j. Explored the possibility of that I am misinterpreting cultural expressions as psychopathology
    k. Examined how social status might impact the client-provider relationship
    l. Considered the client's psychosocial environment
    m. Completed a formal cultural assessment for diagnosis and care
    n. Other _____
    o. I have not adapted my treatment for cultural factors that could influence the gambling treatment process
    p. Not applicable

10. Do you use any of the following for client records?
    a. Soap notes
    b. Sbar notes

c. Dap notes
d. Apso notes
e. Simple notes
f. Traditional health practice notes
g. Other clinical documentation _____
h. None of the above
i. I don't know

11. To protect the privacy of my clients, my organization has done the following (check all that apply)
    a. Developed privacy policies and procedures
    b. Implemented privacy policies and procedures
    c. Designated a privacy official
    d. Implemented workforce training related to client privacy
    e. Applied sanctions for privacy policy and procedure violations
    f. Mitigated harmful effects of disclosed public health information
    g. Maintained data safeguard systems for public health information (e.g., locking records, shredding, as appropriate)
    h. Informed clients about ways to register privacy complaints
    i. Installed a documentation system for informing clients about privacy policies and procedures
    j. Other privacy policy or procedure _____
    k. None of the above
    l. I don't know

12. Which of the following are HIPAA requirements for covered entities? (Check all that apply)
    a. Put in place safeguards to protect patients' health information
    b. Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose.
    c. Have agreements in place with any service providers that clients use perform functions or activities on their behalf. These agreements are to ensure that these service providers only use and disclose patients' health information properly and safeguard it appropriately.
    d. Have procedures in place to limit who can access your patients' health information
    e. Implement training programs for you and your employees about how to protect your patients' health information
    f. Restrict others from accessing patients' health information, entirely
    g. Use electronic records to store all personal health information
    h. Notify patients when there is a breach of unsecured personal health information
    i. None of the above
    j. I don't know

13. Which of the following demographic groups/special populations are at increased risk for gambling-related problems? (Check all that apply)
    a. Those with mental health problems
    b. Women
    c. Middle aged
    d. High income earners
    e. Veterans
    f. Perpetrators of Intimate Partner Violence
    g. Casino employees
    h. Some racial and ethnic groups

i. None of the above
j. I don't know

14. Some common experiences associated with Gambling Disorder include the following: (Check all that apply)
    a. Financial trouble, such as debt
    b. Experiences of self-harm
    c. Job loss
    d. Feelings of restlessness, irritability, and/or anxiousness when trying to cut down gambling
    e. Psychiatric comorbidity
    f. Driving while impaired
    g. Drug dependence
    h. Lying about gambling
    i. None of the above
    j. I don't know

15. If my client was having a life crisis situation, such as the experience of self-harm, I would do the following: (Check all that apply)
    a. Determine the nature and persistence of the harmful thoughts
    b. Determine the likelihood of intent
    c. Determine whether the client has a plan
    d. Determine whether the client as access to a means for self-harm
    e. Determine whether the client has a history of self-harm
    f. With permission, talk with a supportive family member or friend to ascertain their understanding
    g. Call 911 for imminent risk
    h. Set up a follow-up plan if not at imminent risk
    i. Other _____
    j. None of the above
    k. I don't know

16. My own training history related to problem gambling includes the following: (Check all that apply)
    a. Certification as a problem gambling specialist
    b. Attending at least one problem gambling webinar
    c. Attending at least one problem gambling training
    d. Attending at least one problem gambling conference
    e. Self-education via online resourced, books, etc.
    f. Other _____
    g. None of the above
    h. I don't know

17. My thoughts and feelings, generally, about my own capability to address clients' gambling-related problems include the following: (Check all that apply)
    a. I am prepared to handle such issues right away
    b. I feel most comfortable referring clients with such issues to someone else
    c. I have too many other things to consider adding gambling-related problems into the mix
    d. I need more training about screening for gambling
    e. I need more training about evidence-based practices for gambling
    f. I am concerned that I will see more gambling-related problems among my patients because of gambling expansion
    g. Gambling-related problems are rare, so I don't expect to have this be a common issue

h. Other _____
i. None of the above
j. I don't know

[Survey Note. End of Survey for BSAS Providers who treat gambling]

[Survey Note. "All Other BSAS Providers" questions follow]

1. I can list one specific brief screen (one that includes 5 or fewer items) for gambling-related problems
    a. Yes (please list) _____
    b. No

2. Name one or more evidence-based treatment approaches for addressing Gambling Disorder _____

3. To what extent do you agree or disagree with the following statements:

	Strongly disagree	Disa-gree	Neither disa-gree nor agree	Agree	Strongly agree
I screen my clients for gambling-related problems at least occasionally	◯	◯	◯	◯	◯
I screen my clients for gambling-related problems always	◯	◯	◯	◯	◯
I always use DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling	◯	◯	◯	◯	◯
I am familiar with the Department of Public Health Practice Guidelines for Treating Gambling-Related Problems	◯	◯	◯	◯	◯
I know how to refer clients to the Department of Public Health Gambling Helpline	◯	◯	◯	◯	◯
I always take Veteran status into account for gam-bling-related treatment planning	◯	◯	◯	◯	◯
I always take Intimate Partner Violence (IPV) status into account for gambling-related treatment plan-ning	◯	◯	◯	◯	◯
My organization always provides time to complete gambling-related screening	◯	◯	◯	◯	◯
My organization always provides time to treat cli-ents' gambling-related problems	◯	◯	◯	◯	◯
My organization always provides time to partici-pate in gambling-related training	◯	◯	◯	◯	◯

4. Within your organization, do you know who is a gambling specialist?
    a. Yes (please list) _____
    b. No, my organization has a gambling specialist, but I am not sure who it is
    c. My organization does not employ a gambling specialist
    d. I do not know if my organization employs a gambling specialist

5. To what extent do any of the following client cultural factors have the potential to influence the gambling treatment process?

Cultural Factor	Not at all	A little bit	Moder-ately	Quite a bit	Very much
Primary language	◯	◯	◯	◯	◯
Level of acculturation to local majority culture	◯	◯	◯	◯	◯

Age	◯	◯	◯	◯	◯
Gender	◯	◯	◯	◯	◯
Occupational issues (such as, undocumented workers or highly skilled workers without local licensing	◯	◯	◯	◯	◯
Family structure (such as, paternalistic, or primary caregivers, or family makeup)	◯	◯	◯	◯	◯
Intergenerational interaction patterns (such as, deference to elders)	◯	◯	◯	◯	◯
Religious beliefs (such as, membership in an organized religion)	◯	◯	◯	◯	◯
Spirituality (such as, belief in a divinity)	◯	◯	◯	◯	◯
Health beliefs (such as, Eastern versus Western medicine)	◯	◯	◯	◯	◯
Emotional expression	◯	◯	◯	◯	◯
Coping styles	◯	◯	◯	◯	◯
Communication styles	◯	◯	◯	◯	◯
Tendency toward help-seeking	◯	◯	◯	◯	◯
Individualism/collectivism	◯	◯	◯	◯	◯
Trust in authority	◯	◯	◯	◯	◯
Historical stigma and discrimination	◯	◯	◯	◯	◯
Contemporary stigma and discrimination	◯	◯	◯	◯	◯
Purpose and understanding of gambling	◯	◯	◯	◯	◯

6. In what ways have you adapted your treatment for cultural factors that could influence the gambling treatment process? (Check all that apply)
    a. Incorporated non-Western approaches into my treatment plan
    b. Changed how I communicate (such as, reducing or increasing my expressed emotion)
    c. Used a translator
    d. Used gender-specific treatment strategies
    e. Used age-specific treatment strategies
    f. Actively monitored my own biases and stigma
    g. Changed an evidence-based practice to suit a client's religious or spiritual orientation
    h. Included family in the treatment process
    i. Inquired about cultural identity to inform my diagnosis
    j. Explored the possibility of that I am misinterpreting cultural expressions as psychopathology
    k. Examined how social status might impact the client-provider relationship
    l. Considered the client's psychosocial environment
    m. Completed a formal cultural assessment for diagnosis and care
    n. Other _____
    o. I have not adapted my treatment for cultural factors that could influence the gambling treatment process
    p. Not applicable

7. Which of the following demographic groups/special populations are at increased risk for gambling-related problems? (Check all that apply)
    a. Those with mental health problems

b. Women
c. Middle aged
d. High income earners
e. Veterans
f. Perpetrators of Intimate Partner Violence
g. Casino employees
h. Some racial and ethnic groups
i. None of the above
j. I don't know

8. If my client was having a life crisis situation, such as the experience of self-harm, I would do the following: (Check all that apply)
    a. Determine the nature and persistence of the harmful thoughts
    b. Determine the likelihood of intent
    c. Determine whether the client has a plan
    d. Determine whether the client as access to a means for self-harm
    e. Determine whether the client has a history of self-harm
    f. With permission, talk with a supportive family member or friend to ascertain their understanding
    g. Call 911 for imminent risk
    h. Set up a follow-up plan if not at imminent risk
    i. Other _____
    j. None of the above
    k. I don't know

9. Do you use any of the following for client records?
    a. Soap notes
    b. Sbar notes
    c. Dap notes
    d. Apso notes
    e. Simple notes
    f. Traditional health practice notes
    g. Other clinical documentation _____
    h. None of the above
    i. I don't know

10. To protect the privacy of my clients, my organization has done the following (check all that apply)
    a. Developed privacy policies and procedures
    b. Implemented privacy policies and procedures
    c. Designated a privacy official
    d. Implemented workforce training related to client privacy
    e. Applied sanctions for privacy policy and procedure violations
    f. Mitigated harmful effects of disclosed public health information
    g. Maintained data safeguard systems for public health information (e.g., locking records, shredding, as appropriate)
    h. Informed clients about ways to register privacy complaints
    i. Installed a documentation system for informing clients about privacy policies and procedures
    j. Other privacy policy or procedure _____
    k. None of the above
    l. I don't know

11. Which of the following are HIPAA requirements for covered entities? (Check all that apply)
    a. Put in place safeguards to protect patients' health information
    b. Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose.
    c. Have agreements in place with any service providers that clients use to perform functions or activities on their behalf. These agreements are to ensure that these service providers only use and disclose patients' health information properly and safeguard it appropriately.
    d. Have procedures in place to limit who can access your patients' health information
    e. Implement training programs for you and your employees about how to protect your patients' health information
    f. Restrict others from accessing patients' health information, entirely
    g. Use electronic records to store all personal health information
    h. Notify patients when there is a breach of unsecured personal health information
    i. None of the above
    j. I don't know

12. My thoughts and feelings, generally, about my own capability to address clients' gambling-related problems include the following: (Check all that apply)
    a. I am prepared to handle such issues right away
    b. I feel most comfortable referring clients with such issues to someone else
    c. I have too many other things to consider adding gambling-related problems into the mix
    d. I need more training about screening for gambling
    e. I need more training about evidence-based practices for gambling
    f. I am concerned that I will see more gambling-related problems among my patients because of gambling expansion
    g. Gambling-related problems are rare, so I don't expect to have this be a common issue
    h. Other _____
    i. None of the above
    j. I don't know

[Survey Note. End of Survey for "All Other BSAS Providers"]

7. Data Cleaning Summary

- Q1. During what year did you start working as a BSAS-affiliated treatment provider? (All Respondents)
    - Respondent R_32IJO9n6rb8Zmtr had entered "204" as year began as a BSAS-affiliated treatment provider. We recoded the response to 2004.
    - To calculate years as a BSAS-affiliated treatment provider, we took the survey year 2018 and subtracted each respondent's response to question 1 the year they started working as BSAS-affiliated treatment provider.

- Q2. During what year did you start working as a BSAS-affiliated treatment provider **at your current job**? (All Respondents)
    - Respondent R_2e3FLqvrOuuIQH7 had entered "20014" as year began in current job as BSAS-affiliated treatment provided. We recoded the response to 2014.
    - To calculate years working as a BSAS-affiliated treatment provider at your current job, we took the survey year 2018 and subtracted each respondent's response to question How many years working as a BSAS-affiliated treatment provider at your current job.

6. Q3. What is the highest level of education you have completed? (All Respondents)
    7. No cleaning was necessary.

8. Q4. Do you have any special professional certifications or licenses related to your current job? (All Respondents)
    9. No cleaning was necessary.

- Q5. Do any of the following options describe you? (Click all that apply) (All Respondents)
    - First, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Next if none of the above was selected as a response option, all other answer options were unendorsed.
    - Once these two recoding steps were completed, we recoded the question into a dichotomous variable:
    10. BSAS Providers Who Treat Gambling are all those who responded to Q5 by selecting:
        a. Massachusetts – Problem Gambling Specialist (MA-PGS) certified
        b. International Certified Gambling Counselor (ICGC) certified
        c. Certified Addiction Specialist (CAS) with gambling specialization
        d. At my current place of employment, at least once, I have treated a client for a gambling-related problem
        e. At my current place of employment, if a client has a gambling-related problem, the client might be assigned to my caseload for gambling treatment
        f. In my private practice, at least once, I have treated a client for a gambling-related problem
    11. All Other BSAS Providers are those who responded to Q5 by selecting:
        g. None of the above

Questions for BSAS Providers who treat gambling

- Q1. I can list one specific brief screen (one that includes 5 or fewer items) for gambling-related problems
    - We used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
    - No other cleaning was necessary.

- Q2. Which of the following are brief screens (those that include 5 or fewer items) for gambling-related problems? (check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Next if “none of the above” or ”I don’t know” was selected as a response option, all other answer options were set as not endorsed.
    - 21 respondents who were not gambling treatment providers (Q5, response g) and could not list a specific brief screen for gambling (Q6. Response No) were incorrectly gated into this question. There initial responses to this question were “I don’t know.” Their responses were removed and changed to blank because they were not supposed to answer this question.

  - 3 respondents who were not gambling treatment providers (Q5, response g) and could not list a specific brief screen for gambling (Q6. Response No) were incorrectly gated into this question. There initial responses to this question were to select the "Brief Biosocial Gambling Screen." Their responses were removed and changed to blank because they were not supposed to answer this question.
  - Once we adjusted for the additional response from other BSAS treatment providers, we then assessed for correct/incorrect responses to this question by creating two new variables.
  - The first variable labeled as "Identified 1 brief screen" was created if a respondent endorsed any one of the following: "Brief Biosocial Gambling Screen," "Lie/Bet," "NODS=CLiP," or "NODS-PERC."
  - The second variable labeled as "Identified 1 faux brief screen" was created if a respondent endorsed any one of the following: "Quick Gambling Screen," "Diagnostic Gambling Instrument," or "Gambling Mini".
- Q3. I can list one specific screen (other than a brief screen) for gambling-related problems
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - No other cleaning was necessary.

- Q4. Which of the following are screens (other than brief screens) for gambling-related problems?
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Next if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.
  - Once we adjusted for adjusted for "none of the above" or "I don't know" responses, we then assessed for correct/incorrect responses to this question by creating two new variables.
  - The first variable labeled as "Identified 1 screen" was created if a respondent endorsed any one of the following: "Massachusetts Gambling Screen (MAGS)," "South Oaks Gambling Screen (SOGS)," "Canadian Problem Gambling Index (CPGI)," "Gamblers Anonymous 20 Questions," or "Gambling Treatment Outcome Monitoring System (GAMTOMS)."
  - The second variable labeled as "Identified 1 faux screen" was created if a respondent endorsed either of the following: "Gambling and Gambling Problems Screen" or " Impulsive Gambling Screen."

- Q5. Name one or more evidence-based treatment approaches for addressing Gambling Disorder
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - No other cleaning was necessary.

- Q6. To what extent do you agree or disagree with the following statements:
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we identified a typo in one of the survey questions. In the survey the question was written "I am familiar with the Department of Public Health Practice Guidelines for Treating Gambling-Related Problems." When the survey was transferred to Qualtrics it was written "I am familiar with the Department of Public Health Gambling Helpline." This question was dropped for analysis because it was incorrectly written.

  - No other cleaning was necessary.

- Q7. Within your organization, do you know who is a gambling specialist?
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - No other cleaning was necessary.

- Q8. To what extent do any of the following client cultural factors have the potential to influence the gambling treatment process?
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - No other cleaning was necessary.

- Q9. In what ways have you adapted your treatment for cultural factors that could influence the gambling treatment process? (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Next, if "I have not adapted my treatment…" or "Not applicable" was selected as a response option, all other answer options were set as not endorsed.
  - Finally, we calculated an "Adaptation Count" variable to count up the total number of adaptations gambling treatment providers made for cultural factors.

- Q10 Do you use any of the following for client records?
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q11. To protect the privacy of my clients, my organization has done the following (check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q12. Which of the following are HIPAA requirements for covered entities? (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.

  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Next if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.
  - Finally, we calculated who answered the question correctly by creating a variable to identify those who correctly endorsed all five correct responses including: "Put in place safeguards to protect patients' health information;" "Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose;" "Have agreements in place with any service providers that clients use perform functions or activities on their behalf. These agreements are to ensure that these service providers only use and disclose patients' health information properly and safeguard it appropriately;" "Have procedures in place to limit who can access your patients' health information;" and "Notify patients when there is a breach of unsecured personal health information."

- Q13. Which of the following demographic groups/special populations are at increased risk for gambling-related problems? (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q14. Some common experiences associated with Gambling Disorder include the following: (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q15. If my client was having a life crisis situation, such as the experience of self-harm, I would do the following: (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q16. My own training history related to problem gambling includes the following: (Check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q17. My thoughts and feelings, generally, about my own capability to address clients' gambling-related problems include the following: (Check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only BSAS providers who treat gambling.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

Questions for All Other BSAS Providers

- Q1. I can list one specific brief screen (one that includes 5 or fewer items) for gambling-related problems
    - We used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - No other cleaning was necessary.

- Q2. Name one or more evidence-based treatment approaches for addressing Gambling Disorder
    - We used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - No other cleaning was necessary.

- Q3. To what extent do you agree or disagree with the following statements:
    - We used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - No other cleaning was necessary.

- Q4. Within your organization, do you know who is a gambling specialist?
    - We used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - No other cleaning was necessary.

- Q5. To what extent do any of the following client cultural factors have the potential to influence the gambling treatment process?
    - We used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - No other cleaning was necessary.

- Q6. In what ways have you adapted your treatment for cultural factors that could influence the gambling treatment process? (Check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Next, if "I have not adapted my treatment…" or "Not applicable" was selected as a response option, all other answer options were set as not endorsed.
    - Finally, we calculated an "Adaptation Count" variable to count up the total number of adaptations gambling treatment providers made for cultural factors.

- Q7. Which of the following demographic groups/special populations are at increased risk for gambling-related problems? (Check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q8. If my client was having a life crisis situation, such as the experience of self-harm, I would do the following: (Check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q9. Do you use any of the following for client records?
    - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
    - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
    - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q10. To protect the privacy of my clients, my organization has done the following (check all that apply)
    - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.

  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

- Q11. Which of the following are HIPAA requirements for covered entities? (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Next if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.
  - Finally, we calculated who answered the question correctly by creating a variable to identify those who correctly endorsed all five correct responses including: "Put in place safeguards to protect patients' health information;" "Reasonably limit information uses and sharing to the minimum necessary to accomplish your intended purpose;" "Have agreements in place with any service providers that clients use perform functions or activities on their behalf. These agreements are to ensure that these service providers only use and disclose patients' health information properly and safeguard it appropriately;" "Have procedures in place to limit who can access your patients' health information;" and "Notify patients when there is a breach of unsecured personal health information."

- Q12. My thoughts and feelings, generally, about my own capability to address clients' gambling-related problems include the following: (Check all that apply)
  - First, we used the treatment provider variable created with Question 5 to select only All other BSAS treatment providers.
  - Next, we checked the responses to determine missing values and not endorsed responses because it is a check all that apply question. If the respondent endorsed any of the answer options, the variable was recoded to set missing values to not endorsed. Otherwise the missing value was kept.
  - Finally, if "none of the above" or "I don't know" was selected as a response option, all other answer options were set as not endorsed.

8. Open Response Tables

Table 8-1 BSAS Providers open response to special professional certifications or licenses related to current job

Responses	n	%
LICSW	12	16%
LMHC	9	12%
LCSW	3	4%
LMHC, LADC I, CADC, MA PGS	2	3%
LMHC, LADC1, MAPGS	2	3%
LMHC, LADCI, MAPGS	2	3%

Responses	**n**	**%**
MA- PGS	2	3%
A-CRA certifcation	1	1%
board certification, addiction psychiaty. medical license	1	1%
CADC	1	1%
CADC , CCDP , MAPG	1	1%
CADCII, LADCI	1	1%
cas, ladc-1	1	1%
Certified grief facilitator	1	1%
Clinical Practioner of Psychodrama	1	1%
LADC	1	1%
LADC ! MAPGS	1	1%
LADC 1	1	1%
LADC 1 MA GPs	1	1%
LADC I, CADC II, LSWA, CDP	1	1%
LADC-1, CADC-II, MA-PGS, NCGC-1, CCS	1	1%
LADC-I	1	1%
LADC-I, CADAC II, MA-PGS, NCGC-I, Certified Clinical Supervisor	1	1%
LADC, CADC	1	1%
Ladc, Cadc, Pgs	1	1%
LADC, Problem Gambling Specialist	1	1%
LADC,CADC, RN	1	1%
LADC,RN	1	1%
LADC1; CADC; MAPGS	1	1%
LCSW, A-CRA certified	1	1%
License in clinical psychology	1	1%
Licensed clinical psychologist	1	1%
licsw, Cadac II, CGP	1	1%
LICSW, LADC 1, Problem Gambling Specialist	1	1%
LICSW, LADC I, MA PGS	1	1%
LICSW, LADC-1, MA PGS	1	1%
LICSW, LADC-I, MA PGS	1	1%
LICSW, Licsensed School SW	1	1%
LICSW,ACSW	1	1%
LMFT, LADC-1, LCSW, Clinical Fellow (AAMFT)	1	1%
LMHC certified in ARC therapy	1	1%
LMHC, CCTP, NCC	1	1%
LMHC, LADC-I	1	1%
LMHC, NCC, CCTP	1	1%
MA-PGS	1	1%
MD form Russia	1	1%
MD PhD, board certified in psychiatry	1	1%

Responses	n	%
MD, Board Certification in Psychiatry and Addiction Psychiatry, Certified Group Psychotherapist (CGP)	1	1%
No	1	1%
REAT (registered Expressive Arts Therapist)	1	1%
School Counselor I	1	1%
Total	76	

Table 8-2 BSAS Providers Who Treat Gambling open response to list one brief screen for gambling-related problems

Responses	n	%
Brief Biosocial Gambling Screen (BBGS)	18	41%
South Oak Gambling Screen (SOGS)	5	11%
NORC Diagnostic Gambling Screening	4	9%
Massachusetts Gambling Screen (MAGS)	2	5%
2 questioin screening	1	2%
4 questions	1	2%
antisipatory anxiety	1	2%
CAGE	1	2%
DSM 5	1	2%
DSMV, South Oaks	1	2%
ESM	1	2%
FINANCIAL	1	2%
Lie/Bet	1	2%
lie/gamble screen	1	2%
MCCG 4 Question Screening Tool	1	2%
NODS-SA	1	2%
quick Gamb. scr.	1	2%
TOPS	1	2%
Yes	1	2%
Total	44	100%

Table 8-3 BSAS Providers Who Treat Gambling open response to list one specific screen for gambling-related problems

Responses	n	%
South Oaks Gambling Screen (SOGS)	6	17%
NODS-SA	5	14%
Quick Gambling Screen	4	11%
NORC	3	9%
4 question screaing tool	1	3%
brief biosocial gambling screen	1	3%
Diagnostic Gambling Instrument	1	3%
EIGHT screen	1	3%

Responses	n	%
GAMBLING MINI	1	3%
Gambling Pathways Questionnaire (GPQ)	1	3%
Lie/Bet	1	3%
Massachusetts Gambling Screen (MAGS)	1	3%
no	1	3%
NODS	1	3%
NORC DIANOSTIC SCREEN FOR GAMBLING PROBLEMS-SELF ADMINISTERED	1	3%
Pathways Model	1	3%
Pathways Model Screen (Nower)	1	3%
physical withdrawal depression	1	3%
Problem Gambling Severity Index	1	3%
SASSI	1	3%
SOGS & GASS	1	3%
Total	35	100%

Table 8-4 BSAS Providers Who Treat Gambling open response to list other adaptations for cultural factors

Responses	n	%
Ask client questions about what gambling means to them to assess if there is a cultural component.	1	25%
EXPLORED HOW HEARING DISABILITY IMPACTED GAMBLING	1	25%
I don't know/ I have not treated anyone with a gambling issue	1	25%
When able, provide treatment in client's primary language	1	25%
Total	4	100%

Table 8-5 BSAS Providers Who Treat Gambling open response to list other actions during life crisis

Responses	n	%
CALL CRISIS TEAM	1	33%
Call Mobile Crisis Team; Refer to Court Clinic for s. 12 observation	1	33%
refer to Crisis Team	1	33%
Total	3	100%

Table 8-6 BSAS Providers Who Treat Gambling open response to list evidence-based treatment

Responses	n	%
Cognitive behavioral therapy (CBT)	20	30%
CBT / MI	10	15%
Motivational Interviewing (MI)	7	11%
Don't know	6	9%
CBT,DBT	3	5%

Responses	n	%
CBT and medication	1	2%
CBT Motivational Enhancement/Interviewing,	1	2%
CBT, Behavioral Therapy, Relapse Prevention	1	2%
CBT, Mindfulness	1	2%
CBT, Motivational interviewing(stages of change)	1	2%
CBT, Petty Brief Treatment, Twelve Step Facilitation	1	2%
CBT, possibly naltrexone	1	2%
cognitive behavioral therapy, 12-step recovery	1	2%
COGNITIVE BEHAVIORAL THERAPY, MINDFULNESS BASED STRESS REDUCTION	1	2%
DBT	1	2%
Gambler Annoymous	1	2%
Group treatment - CBT	1	2%
Harm reduction	1	2%
Impulsive gambling screen	1	2%
Lie bet scale	1	2%
Motivational Interviewing/Enhacement	1	2%
NCRG	1	2%
none	1	2%
not sure	1	2%
SOGS	1	2%
Total	66	

Table 8-7 BSAS Providers Who Treat Gambling open response to organization privacy actions

Responses	n	%
adapted electronic medical record to allow patient choice and consent to information sharing of substance use disorder related information, as mandated by 42 CFR Part 2	1	50%
HIPAA POLICY	1	50%
Total	2	

Table 8-8 BSAS Providers Who Treat Gambling open response to training history

Responses	n	%
Consult with PROVIDER NAME	1	33%
I participated in the Mass Council on compulsive gambling training institute; I sent in application materials for the PGS but haven't received confirmation	1	33%
Mentoring with PROVIDER NAME	1	33%
Total	3	

Note. Names removed to protect privacy.

Table 8-9 All Other BSAS Providers responses to open response to list one brief screen for gambling-related problems

Responses	n	%
Brief BioSocial Gambling Screen (BBGS)	1	33%
NODS-SA	1	33%
Obsessive behavior. Impulsivity, regret	1	33%
Total	3	

Table 8-10 All Other BSAS Providers responses to open response to list other adaptations for cultural factors

Responses	n	%
have not done any of this, not treating gambling.	1	100%
Total	1	

Table 8-11 All Other BSAS Providers responses to open response to list other actions during life crisis

Responses	n	%
contact emergency services	1	33%
contact emergency services, put on alert if needed.	1	33%
contact supervisor	1	33%
Total	3	

Table 8-12 All Other BSAS Providers responses to open response to list evidence-based treatment

Responses	n	%
CBT	7	25%
Motivational Interviewing (MI)	6	21%
I don't know	5	18%
CBT, MI	2	7%
12 step based programs	1	4%
CBT, MI, DBT	1	4%
cbt, rebt, ac	1	4%
Motivational interview, CBT	1	4%
n/a	1	4%
Relapse Prevention	1	4%
Residential inpatient recovery, Cognitive Behavioral Therapy, Group Therapy	1	4%
self-help and peer support groups; continuing care; pharmacology; treatment planning	1	4%
Total	28	

Table 8-13 All Other BSAS Providers responses to open response to client records and clinical documentation

Responses	n	%
MSDP forms	2	29%

Responses	n	%
ACA, ASUDS	1	14%
Assessments and Progress Notes	1	14%
eHana	1	14%
Electronic records system	1	14%
note specific to agency electronic record.	1	14%
Total	7	

Table 8-14 All Other BSAS Providers responses to open response to perceived capabilities

Responses	n	%
I have no training in gambling related issues.	1	33%
Not rare	1	33%
realize I may not check enough for this issue. Have not had client presenting w. this as an issue in the current job.	1	33%
Total	3	

9. Exploratory Comparisons for Key Provider Groups

Table 9-1 Gambling Specialist Providers versus Non-specialist Providers

Variable	Non-Gambling Providers (n=42)	Gambling Providers (MAPGS-Certified) (n=32)	Gambling Providers (not MAPGS-Certified) (n=61)	Gambling Providers (Total) (n=93)
% reporting that they can list a brief gambling screen[1]	9.4%***[a]	74.2%**[b]	37.9%**[b]	50.6%***[a]
I screen my clients for gambling-related problems at least occasionally[2]	3.61 (1.00)	3.72 (1.28)	3.52 (1.04)	3.58 (1.12)
I screen my clients for gambling-related problems always[2]	2.79 (1.32) **[a]	4.16 (0.85) ***[b]	2.77 (1.18) ***[b]	3.22 (1.26)**[a]
I always use DSM-5 Gambling Disorder criteria as part of diagnostic decision-making for gambling[2]	3.18 (1.21) **[a]	4.40 (0.71)**[b]	3.52 (1.20) **[b]	3.81 (1.21) **[a]
% not able to list an evidence-based approach to gambling treatment (unanswered or "I don't know")[2]	33.3%	8.0%*[b]	30.8%*[b]	23.4%
I know how to refer clients to the DPH Gambling Helpline[2]	3.00 (1.32)***[a]	4.56 (0.51) ***[b]	3.37 (1.03) ***[b]	3.75 (1.05) ***[a]
% who know a gambling specialist in their organization[2]	39.4%***[a]	100.0%***[b]	51.9%***[b]	67.5%***[a]
% who know their organization has a gambling specialist but don't know who it is[2]	9.1%***[a]	0.0%***[b]	23.1%***[b]	15.6%***[a]

Variable	Non-Gambling Providers (n=42)	Gambling Providers (MAPGS-Certified) (n=32)	Gambling Providers (not MAPGS-Certified) (n=61)	Gambling Providers (Total) (n=93)
% who don't know if their organization has a gambling specialist[2]	12.1%***[a]	0.0%***[b]	25.0%***[b]	16.9%***[a]
% reporting that their organization does not have a gambling specialist[2]	39.4%***[a]	0.0%***[b]	0.0%***[b]	0.0%***[a]
% who can identify a gambling specialist in their organization (dichotomous version of above question[2]	*39.4%**[a]*	*100.0%***[b]*	*51.9%***[b]*	*67.5%**[a]*
My organization always provides time to complete gambling-related screening[3]	3.06 (1.11)**[a]	4.32 (0.63)***[b]	3.15 (1.11)***[b]	3.53 (1.12)**[a]
My organization always provides time to treat clients' gambling-related problems[2]	3.58 (1.09)*[a]	4.60 (0.65)***[b]	3.56 (0.96)***[b]	3.90 (0.99)*[a]
My organization always provides time to participate in gambling-related training[4]	3.33 (0.99)***[a]	4.64 (0.57)***[b]	3.63 (0.87)***[b]	3.96 (0.92)***[a]
I am prepared to handle such issues right away[2]	3.0%***[a]	96.0%	28.8%	50.6%***[a]
I feel most comfortable referring clients with such issues to someone else[2]	48.5%*[a]	4.0%	34.6%	24.7%*[a]
I have too many other things to consider adding gambling-related problems into the mix[2]	12.1%*[a]	0.0%	1.9%	1.3%*[a]
I need more training about screening for gambling[2]	78.8%***[a]	20.0%	51.9%	41.6%***[a]
I need more training about evidence-based practices for gambling[2]	69.7%*[a]	20.0%	63.5%	49.4%*[a]
I am concerned that I will see more gambling-related problems among my patients because of gambling expansion[2]	21.2%	48.0%	25.0%	32.5%
Gambling-related problems are rare, so I don't expect to have this be a common issue[2]	3.0%	4.0%	3.8%	3.9%
None of the above[2]	0.0%	0.0%	0.0%	0.0%
I don't know[2]	3.0%	1.9%	0.0%	1.3%

Notes:

a=significant difference between non-gambling providers and gambling providers

b=significant difference between MA-PGS and other gambling providers

**=p<.05; **=p<.01; ***p<.001*

[1]1 MA-PGS certified provider and 3 other gambling providers did not answer this question

[2]7 MA-PGS certified providers and 9 other gambling providers did not answer this question

[3]7 MA-PGS certified providers and 9 other gambling providers did not answer this question

[4]7 MA-PGS certified providers and 10 other gambling providers did not answer this question

[¥]Significance notations apply to two chi square tests run on all four responses (i.e., 2[provider type] x 4[response option] tables) – one comparing non-gambling providers to gambling providers, the other comparing MAPGS-certified gambling providers to other gambling providers.

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