



**State Of Oregon
Oregon Health Authority
Health Systems Division
Problem Gambling Services Unit**

***GAMBLING PROGRAMS EVALUATION
UPDATE - 2019***

July 1, 2018 - June 30, 2019



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The opinions expressed in this report are those of the author and do not necessarily reflect those of the Oregon Health Authority, Health Systems Division or the Problem Gambling Services.

EXECUTIVE SUMMARY

This is the annual report of the statewide problem gambling services for Fiscal Year 2018-2019 (July 1, 2018 through June 30, 2019). Problem gambling services have been funded statewide through proceeds from Oregon Lottery since 1995 and are currently coordinated through the Problem Gambling Services (PGS) that is part of the Health Systems Division (HSD) of the Oregon Health Authority (OHA). There were a total of 50 treatment programs provided by 34 agencies funded during the fiscal year. These included traditional outpatient, residential, respite, home-based, and prison-based programs as well as a full-service help line. Additionally, extensive prevention activities were also funded to cover every county in the State.

- ❖ Total enrollments of gamblers in a variety of treatment venues continued to decline year over year for nine of the past eleven years.
 - The number of gambler enrollments across all programs was 903, down approximately 4.6% from last year.
 - 79.3% of the gambler clients were enrolled in traditional outpatient programs; 5.2% in residential care; 5.4% in non-traditional home-base care; and, 10.1% in prison based treatment interventions

- ❖ Treatment Availability and Access
 - The lag time from initial call to first available appointment for outpatient treatment was, on average, 3.6 work days and 4.0 calendar days
 - 23.5% of gamblers accessed treatment providers through the Helpline, up slightly from last year
 - 8.1% through previous clients
 - 10.1% through other community health care providers
 - 21.6% reported accessing treatment through a variety of other sources

- ❖ Treatment System Performance
 - Overall average length of stay for traditional outpatient was 176.9 days, essentially the same as last year
 - Successful program completers remained treatment 333.5 days
 - Average case cost, based on reimbursable treatment services, was \$1,743 for all outpatient programs; and, \$3,239.6 for those successfully completing their course of treatment
 - Average number of service encounters was 20.0 and for successful completers 38.4 encounters
 - Unadjusted successful completion rate from outpatient treatment was 28.2%

- ❖ Helpline
 - Calls for help to the Helpline reported was 838 with 193 web chats

- ❖ Outpatient Client Demographics
 - The distribution of married clients entering outpatient treatment was 33.5%

- The distribution of females enrolling in outpatient treatment was 44.0% down from 47.9%
 - Average age was 48.4 years with females significantly older
 - Average age of those reenrolling in the same agency was 52.4 years compared with 46.9 years of those enrolling for the first time
 - The distribution of Whites enrolling was 74.4%, down somewhat from 77.6%
- ❖ Gambling Behaviors
- Average age of first gambling experience remained stable at 24.0 years with males reporting significantly younger first experiences
 - Average age of onset of gambling problems was 36.8 years, down from 37.1 years
 - Average gambling debt was \$25,609. The debt to income ratio was approximately 1:0.9
 - Primary gambling activity remained machine based (VLT/slots) at 88.0% with females being significantly more likely to report machine-based gambling. Of these, Video Poker was slightly more popular at 38.2% than line games at 37.8%
 - Primary gambling location remained Video Lottery Retailers at 71.0% essentially unchanged and followed distantly by IGC/Casino 16.3%
 - Average number of diagnostic criteria endorsed by outpatient clients was 7.7 out of 10 possible; for residential clients the average was 8.9; and, the average for the minimal intervention program (home-based) was 8.4 – all relatively unchanged
- ❖ Outcomes
- 12-month abstinence rate for successful outpatient program completers was 33.3 down from 39.7%; and, “much less gambling” was 50.9%, up from 38.1%
 - 6-month successful completers abstinence rate was 33.8% down from 51.1% ; and, much less gambling was 44.6%, up from 37.8%
 - 6-month non-completers abstinence rate was 14.0%, down from 21.0%; and, much less gambling was 29.8%, up from 25.8%
 - Statistically significant improvement in key recovery domains was demonstrated
 - Statistically significant improvement in diagnostic criteria was also demonstrated
- ❖ Client Satisfaction
- Very strong endorsement of willingness to recommend the program to others was found with 93.6% at 12-month follow-up
- ❖ Approximately 15.0% of the males and 4.6% of the females were reported as having current or prior military experience.
- 7.5% of the males and 2.4% of the females were reported to have been deployed in a combat zone

- 2.4% of the males were disabled with combat experience and 0.5% of the females
- ❖ Coordinated statewide problem gambling prevention efforts were integrated into existing prevention programming or as stand-alone strategies with over \$1.3 million investment from OHA. Additionally, over \$3 million was invested by the Oregon Lottery ® for responsible gambling and access to treatment services.
- ❖ Over the past 10 years the reported average age of onset of problems associated with gambling for individuals enrolling for the first time in the outpatient treatment programs has not significantly changed. This strongly suggests that readily available treatment combined with PGS and Oregon Lottery ® responsible gambling and prevention activities continues to be productive.

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1. INTRODUCTION

This is an annual report of the Oregon Problem Gambling Services activities for Fiscal Year 2018-2019 (FY 18-19) that included the period July 1, 2018 through June 30, 2019. The purpose of this report is twofold: to document the critical system performance elements from a large dataset addressing critical trends to provide a historical and comparative record; and, provide empirical data which program managers and policy makers can use to make decisions regarding the efficacy and efficiency of the effort.

A note to those interested in statistical analysis: The levels of confidence identified in this report are conservative. Only in cases where the probability of error is five percent ($p < .05$) or less are reported. In some cases, the level of confidence is arguably “close.” But due to the large number of individuals collecting data at the program level (estimated in excess of 100) and the difficulties standardizing this collection, along with missing data elements, it is deemed prudent to be conservative when labeling a finding statistically significant.

2. BACKGROUND AND HISTORY

The Background and History section is included and updated annually for those readers who may not be familiar with the Oregon experience. An abbreviated list of key dates is included in the appendices.

Several pilot problem gambling treatment programs were initiated throughout the state from 1992 through the spring and early summer of 1995. On July 1, 1995, the statewide

treatment effort was consolidated through a management contract by the Department of Administrative Services (DAS) with the Association of Community Mental Health Programs (AOCMHP). In 2001, following 1999 legislative action, management of the statewide treatment and prevention effort was consolidated in-house by the State Office of Addiction and Mental Health (AMH)¹ under the direction of the Problem Gambling Services Manager.

During the current year there were 50 treatment programs funded through 37 provider agencies. Twelve of the funded programs were statewide assets including a residential program in Marion County; two respite programs in Josephine and Baker County; home-based minimal intervention program based in Lane County; three culturally specific Spanish speaking programs in Multnomah, Lane and Umatilla County; a Native American program in Multnomah County; an Asian culturally specific program in Multnomah; and, three Department of Corrections programs.

Beginning in the summer of 2001, several special project contracts were initiated with provider organizations throughout the state by AMH to enhance local outreach and prevention. Funding for prevention was formalized under a separate line item and is currently blended with substance use disorder prevention or other prevention-related program efforts at the community level. Beginning in July 2009, treatment agencies were provided the financial support to conduct outreach and case finding efforts in the local communities and in July 2012 flexible funding was allowed for services outside the standard billing codes. During recent years, there were attempts to integrate peer services personnel with limited success, as

¹ Over the life of this project there have been changes in the organizational structure of the human services and consequently name changes. The names of organizational entities in this report are those currently being utilized unless otherwise indicated for historic purposes.

discussed below, with supporting billing codes introduced to reimburse agencies employing peer service providers.

Gambling Opportunities

Oregon, like most states, has dealt with illegal and gray gambling² since statehood was achieved. In 1933 the State passed legislation that allowed for pari-mutuel wagering on horses and dogs. From the mid-1950's through 1991, various modifications and new rules were adopted covering pari-mutuel wagering and in 1987 off-track betting was legalized. Since legalization, pari-mutuel wagering has been governed by the Oregon Racing Commission, now primarily focused on off-track wagering.

Social gaming was legalized by the Oregon Legislative Assembly in 1973. This statute allowed for counties and cities to, by ordinance, authorize social gaming in private business, private clubs, or a place of public accommodation. Social gaming requires there to be no house player, house bank, nor house odds and there is no house income for the operation of the social game – usually poker and blackjack – but not restricted to these games. Social gaming is not regulated by the state and the only regulation requirements are included in the local ordinances that allow social gambling. The number of social gaming locations in the state is difficult to determine as there is not central registration.

In 1976, by Constitutional Amendment, charitable gaming was legalized allowing for charitable, fraternal, and religious organizations to conduct bingo, lotto, and raffle games as a means of raising funds for charitable causes.

² Illegal gambling that is unofficially allowed to continue such as slot machines at private clubs.

In 1984, the Oregon State Lottery was created by a vote of the people through the initiative process and passed by a margin of two to one. The Lottery is governed by a five-member governor-appointed Commission that is approved by the State Senate. The Lottery's statutory mandate is to "produce the maximum amount of net revenues to benefit the public purpose ... commensurate with the public good."³ A minimum of 84% of the Lottery's annual net revenue must be returned to the public in the form of prizes and benefits to the public purpose. The Lottery offers instant tickets (Scratch-Its® were first available in 1985), Megabucks® (1985), Multi-State Lotteries – (Lotto America® from 1989 to 1992 and Powerball® from 1992), Sports Action® (1989) the first and only state lottery game based on the outcome of professional sporting events (discontinued by 2005 legislative action), Keno® (1991), video poker (1992), Pick 4® (2000), and Win for Life® (2001). Video Lottery Terminals (VLT) were converted in 2007 to add line games to the video poker games to be played at all Lottery Retailer locations having the VLTs. With the recent legalization of sports betting there appears to be movement in the state to embrace this as an additional source of income.

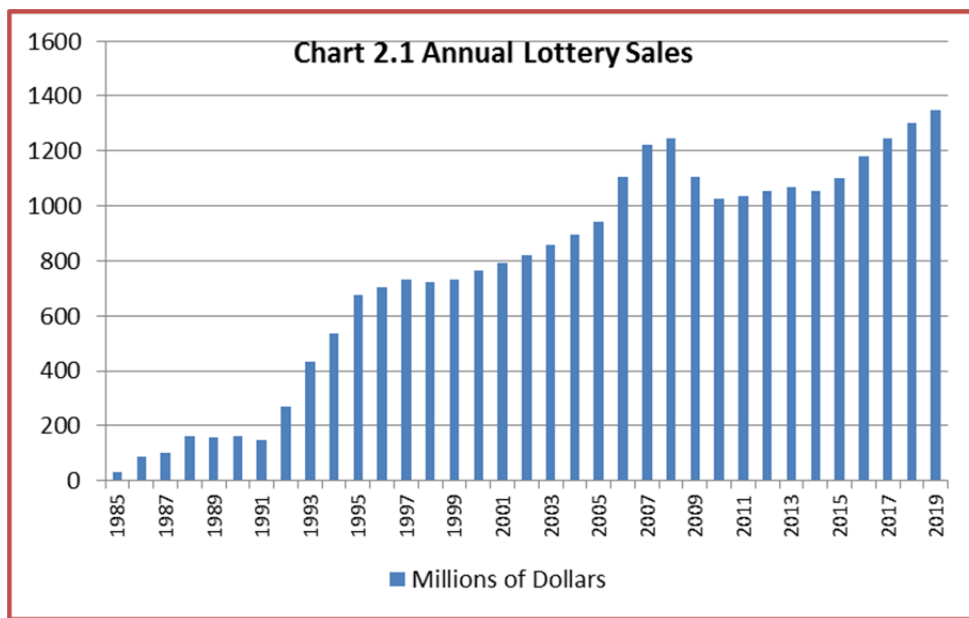
During the 2003 legislative session, the Lottery was authorized to allow retailers to place an additional VLT in their establishments, bringing the total number of machines allowed to six in each establishment.

At the time of this report there were approximately 3,961 Oregon Lottery Retailers. Of these 1,731 sold only traditional lottery products and 2,230 sold video lottery products.

³ Oregon Constitution, Article XV, Section 4. and the Oregon Revised Statutes (ORS) 461.

There were approximately 12,500 video lottery terminals active in the state. Total gross Lottery sales for FY 18-19 were approximately \$1.345 billion.⁴

As can be seen in the following chart, gross Lottery sales increased the first 12 years of operation, then level off in FY 98-99, and followed by a steady increase until 2008 when sales dropped and stayed depressed along with the economy and began to increase again in 2015. (Chart 2.1)



The first Indian Gaming Center (IGC) in the State was established in 1993 under the auspices of the Federal Indian Gaming Regulatory Act of 1988. This act allowed tribes to offer any and all forms of gaming that were otherwise legal in the state. There were nine IGCs in the state, one of which is a Class II casino in Coos Bay. The IGC in Burns has remained closed since 2012. With the combination of charitable, social, and Lottery games regulated in Oregon, these IGCs were able to offer all gaming customarily associated with “Las Vegas” style casinos (except for the Class II facility in Coos Bay).

⁴ M. Ryan, CPA, Senior Budget Analyst, Oregon Lottery®

Portland Meadows, a long standing horse racing venue in the Portland metropolitan area with off-track betting for the past several years, opened a poker room (social gaming); installed 150 video terminals (Class II machines); historical horse racing; and in the fall live horse racing making the facility one of the larger gambling venues in Oregon. The venture was unsuccessful and the facility and race track were sold in 2019. Portland Meadows, in name only, moved to a new location as a poker room and off-track betting establishment.

Program Funding

As noted above, in 1991 the State Legislative Assembly asked the Oregon Lottery to operate VLTs that were then made available in 1992. The statutory changes implemented by the Legislative Assembly included the requirement that three percent of the Video Lottery net proceeds be used to establish and fund treatment programs for disordered gamblers in the State.

In 1994, one of the challenges to the introduction of VLTs, filed by Ecumenical Ministries of Oregon, charged that locating the VLTs in age-restricted establishments made bars, pubs, and restaurants that sold alcohol, into casinos which are illegal in the Oregon Constitution. While the Oregon Supreme Court eventually overturned the challenge, the unintended consequence was to cut off funding for problem gambling treatment programs. This was due to the Oregon Supreme Court ruling that setting aside funds for treatment programs from video poker revenues violated the constitutional amendment that required all lottery revenues to be dedicated to economic development. After several months, during which the problem gambling treatment programs received no funding, except for a few counties that provided continuation funding from their operating budgets, emergency

legislative action was taken to finance these programs from the state general fund rather than using video poker revenues.

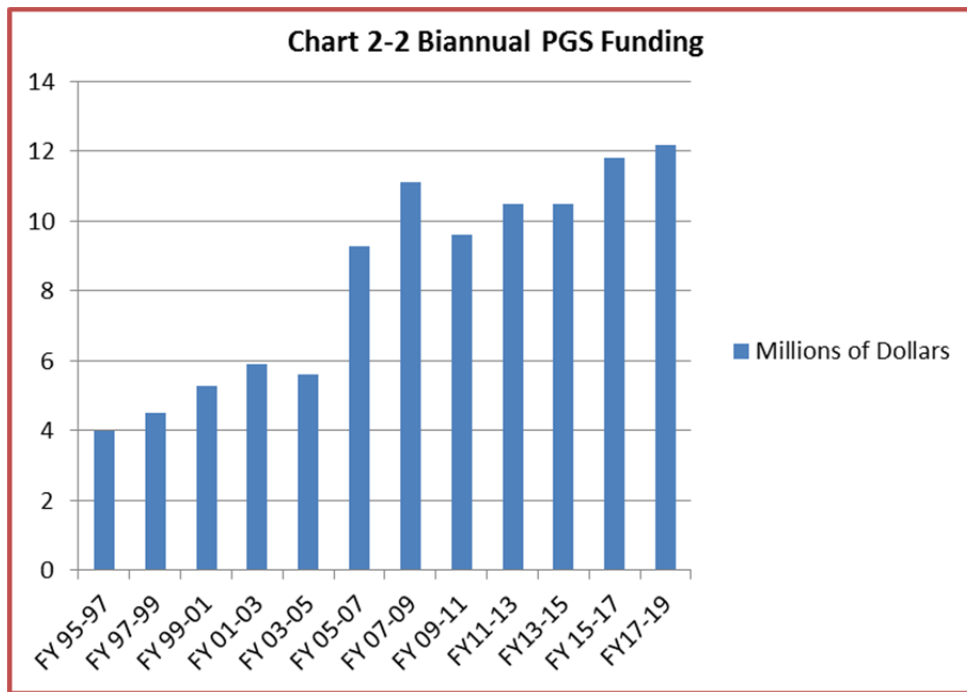
The introduction of Senate Bill (SB) 118, eventually led to the enactment of legislation in 2001 that again tied the funding of problem gambling services to the Lottery proceeds. Oregon Revised Statute (ORS) 409.435 created the Problem Gambling Treatment Fund and ORS 461.549 set aside one percent of the net lottery proceeds annually. These funds were to be transferred from the Administrative Services Economic Development Fund to the problem gambling fund. This transfer was to occur on a quarterly basis and unused funds were to accrue interest. Enactment of this bill also moved administration of the Problem Gambling Services from the Department of Administrative Services to the Department of Human Services (now Oregon Health Authority).

During FY 04-05, the State began to emerge from the worst economic crisis experienced in more than 50 years as discussed in the FY 02-03 report. Unspent monies in the Problem Gambling Treatment Fund during the crisis (approximately 15% of the annual budget for the report period) were swept from the fund and redistributed through the State General Fund. In August 2003, with the passing of the State's FY 03-05 biennium budget, another 20% reduction in funding was incurred. This budget emerged from a record long session that broke impasse only with the passing of an unpopular three-year surtax on the personal income tax. The legislature, knowing the unpopularity of increasing taxes and the potential that this act would be brought to the voters by referendum, enacted additional legislation (House Bill 5077) that would adjust the budget without the legislature having to come back into session. The surtax was voted down and the elimination of problem gambling services was scheduled for May 2004. The Department of Human Services requested to the

Legislative Emergency Board in April of 2004 that their expenditure authority be restored for these funds to preserve problem gambling services. That request was approved and the programs were able to at least continue under a reduced budget through that year.

The FY 09-11 biennium saw an economic recession that made the FY 03-05 downturn look somewhat moderate in comparison while the current biennium has experienced a small, but hopefully, improving economy.

Chart 2-2 is a presentation of the actual program funding levels that do not necessarily reflect the mandated set-aside.



Estimating Treatment Needs

In 1997, the Oregon Gambling Addiction Treatment Foundation (OGATF)⁵ commissioned an adult prevalence study of problem and pathological gambling⁶ in the State.

⁵ The Foundation changed its name to the Oregon Council on Problem Gambling in early calendar 2008.

The study, completed in August 1997, estimated the lifetime problem gambling prevalence at 3.1 percent and the probable pathological lifetime gambling at 1.8 percent. The study estimated the current year problem gambling rate at 1.9% and the current year probable pathological gambling prevalence at 1.4%, for a combined current year disordered gambling prevalence of 3.3%. Based on this study estimates indicated the number of admissions of gamblers to the programs each year should be between 600 and 1,400 individuals. (Volberg, 1997)⁷

Although a study commissioned by Multnomah County, Oregon in 1999, as part of the development of that county's strategic plan for treatment, concluded that the initial estimates for utilization from the 1997 prevalence study were most likely low based on underserved\minority population needs and higher than estimated penetration rates (Moore, T., Jadlos, T., Carlson, M., 2000). A replication prevalence study, commissioned by OGATF conducted in the fall of 2000 (Volberg, 2001; Moore, 2001), found a decreased rate of gambling in general and specifically in the prevalence of both problem and probable pathological gambling (1.4% and 0.9% respectively). Volberg reported similar findings in Louisiana, Montana, North Dakota, and New Zealand, citing a possible combination of a reduced desire among the population to gamble as well as the presence of responsible gambling campaigns and effective treatment. In states where no responsible gambling campaigns were being conducted and no wide-scale gambling specific treatment was available Volberg reported increases in the markers of gambling and disordered gambling.

⁶ Terminology in use at the time of the study.

⁷ Copies of all studies sponsored by OGATF can be downloaded from www.oregoncpg.org

The 2006 adult prevalence study found the combined prevalence had increased insignificantly to 2.7% (1.7% problem gamblers and 1.0% probable pathological gamblers) (Moore, 2006). The most recent study found similar results with an estimated 2.6% of the adult population experience serious problems with gambling (Moore, 2016).

Applying the most recent current year estimates of combined prevalence for problem and probable pathological gambling to the most recent estimate of the adult population in Oregon, the projected enrollments in all programs during the report period was estimated to be approximately 1,600 to 1680⁸ gambler clients.

In 1998 OGATF commissioned a study to estimate the prevalence of disordered gambling among adolescents (13 years to 17 years old). That study estimated 5.0% of adolescents were Level 2 (in-transition) gamblers and 1.4% were problem gamblers (Carlson, M. and Moore, T., 1998).^{9, 10} The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals. Nonetheless, a subsequent anecdotal investigation¹¹ by OGATF found that, in practical terms, the development of adolescent-specific treatment programs would most likely not be cost effective. It continues to be very rare for treatment providers in the state to see adolescents seeking treatment, further confirming the Foundation's recommendation. During 2008, a replication adolescent prevalence study was commissioned by the Problem Gambling Services and found that 1.3%

⁸ In the past, the number of adults seeking treatment was estimated to be 3% of those in potential need. In the spring of 2006 the assumption was increased to 5% (penetration rate) and then subsequently readjusted back to the 3% in 2008. In 2015, due in part to the declining enrollments, the rate was further reduced to 2%.

⁹ Based on the literature for adolescents, the terminology regarding the definition of disordered gambling is slightly different than for adults. "In-transition" is indicative of problems associated with disordered gambling but has not been found predictive of progression to pathological gambling.

¹⁰ Previous reports have cited these as 11.2% and 4.1% which are calculated by the "broad" method. The 5.0% and 1.4% are the prevalence rates as calculated by the narrow method and reported by the authors and are included herein for comparison with the study referenced below.

¹¹ This was evidenced through consultations with Dr. Rina Gupta, McGill University, Canada who was working with the only identified adolescent specific gambling treatment program in North America.

were problem gamblers and another 4.6% were at risk. (Volberg, R., Hedberg, E., Moore, T., 2008)¹² Preliminary findings from a 2016 adolescent study suggest the prevalence rate had continued to decrease to a combined rate of 1.8%.¹³

In 2000, OGATF commissioned a study to estimate the prevalence of disordered gambling among Oregon adults aged 62 years or more and found that 58% of this population reported past year gambling, and an estimated 1.2% were problem gamblers with an additional 0.3% probable pathological gamblers (Moore, T., 2001b).

Gambling Treatment System Design

Background

Formal programs for the treatment of disordered gambling in Oregon were first established with public funding as pilot projects in 1993, although at least one program was operational prior to the availability of those funds.¹⁴ Agencies applying for state funding¹⁵ were required to be a state-recognized substance use disorder (SUD) treatment provider or a community mental health (MH) provider to streamline the approval and implementation process. Nearly all programs were developed within an overarching framework of their sponsoring agency's philosophical approach. Programs that emerged from within an SUD agency tended to adhere to an abstinence-based social treatment model (self-help oriented along the lines of Alcoholics Anonymous {AA} and Gamblers Anonymous {GA}), while

¹² This study used a slightly altered protocol that purposefully omitted charitable gambling (raffles, etc.) from the mix of games. This may have reduced the total number of adolescents reporting any gambling, but most likely had very little effect on the prevalence of problem and at risk gamblers.

¹³ Moore, T. (2016) Unpublished preliminary comparison of rates from the three studies.

¹⁴ Project Stop was one of the earliest "programs" in the state to offer a dedicated treatment track for individuals with gambling problems and their families.

¹⁵ All state funding was directed through the counties. Each agency's contract was with the county in which they operated.

those that were developed by MH agencies tended to be oriented towards harm reduction (controlled gambling) and a psychodynamic approach to therapy.¹⁶ Several agencies developed programs unique to the treatment of disordered gambling, but much had to be quickly learned in the face of little to no available experience in Oregon. Over the past 24 years the programs have evolved and the vast majority continues to rely heavily on a cognitive-behavioral approach.

As education, training, and counselor certification efforts, led and implemented by the informal gambling treatment providers' association,¹⁷ blossomed within the state, most programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.¹⁸

In FY 01-02, a major change in funding occurred when all providers began transitioning from a grant-based payment structure to a fee-for-service basis for payment.¹⁹ Initially, the rate for group counseling sessions was \$27.04 per hour and the rate for individual counseling was \$81.08. On October 1, 2003, these rates were increased to \$27.52 and \$82.52 respectively, raised again to \$29.68 and \$89.00, and finally raised again at the beginning of the new biennium to \$39.60 and \$95.44. Current funding strategies allow for a myriad of treatment and outreach reimbursement categories and, paralleling the efforts of the State's

¹⁶ This is arguably a generalization.

¹⁷ In 1995 when AOCMHP assumed contractual responsibility for oversight and coordination of the gambling treatment, the Executive Director, Michael McCracken, assembled an advisory group, open to all provider agencies. This group had met monthly for several years and has provided a great deal of insight and guidance to the formation of treatment, treatment program standards, and counselor certification. Within the past several years the programs have become stabilized and this group no longer meets regularly.

¹⁸ A few programs have specialized treatment efforts for family members that are not contingent upon the gambler being also enrolled.

¹⁹

compliance with the Affordable Care Act, allow a good deal of flexibility. Substantial funding was also made available for prevention as noted above.

There is no charge to Oregon residents who enroll in the programs and private insurances are not to be billed by providers.

Description of Current Treatment Services

Oregon's Problem Gambling Services are guided by a public health paradigm and approach that take into consideration biological, behavioral, economic, cultural, and policy determinants influencing gambling and health. It incorporates prevention, harm reduction and multiple levels of treatment by placing emphasis on quality of life issues for disordered gamblers, their families, and communities. By appreciating the multiple dimensions of gambling, Oregon's Problem Gambling Services have been developed to incorporate strategies that minimize gambling's negative impacts while recognizing the reality of gambling's availability, cultural acceptance, and economic appeal.

Historically, the most frequent access point to treatment was a call made to the state's Problem Gambling Helpline (877-MY LIMIT) that was established in 1995. The Helpline is staffed 24 hours every day of the year by professional counselors with problem gambling expertise. Callers are informed that problem gambling treatment services in Oregon are at no cost to the gambler, their families or others impacted by the gambling and are confidential. When appropriate, counselors conduct brief assessments and motivational interviews with callers. The counselor then makes referrals based on screening information, clinical judgment, and available resources. To facilitate a successful referral, Helpline counselors can use three-way calling to place the caller in contact with the referral agency and offer follow-

up calls to provide further support. In 2009 a web-based, real-time chat capability was introduced and is maintained by the helpline staff. In 2014, the helpline added a text capability and phone number. In 2016 a new Spanish language phone number of 1-844- TU VALES; and in 2017 Motivational Messaging services.

Philosophically the treatment system design follows a stepped-care approach beginning with a home-based, telephonically supported minimal intervention program that is available for individuals who, for a variety of reasons, prefer not to attend brick and mortar facilities.²⁰ Originally designed as an intervention for those with less severity, the effort has proven to be utilized by many with severity similar to those entering traditional outpatient programs. This program has morphed over the year to become a telehealth model of treatment for those with barriers to attending traditional outpatient services. Traditional outpatient programs comprise the bulk of the treatment effort with non-English services available in some areas. There are two short-stay respite program located in Southern Oregon and Eastern Oregon (started in FY2017) with treatment durations typically five or less days and a social model residential program located in the central part of the state in the city of Salem. Length of stays at this facility typically range from 30 to 40 days. Transportation to and from both the respite and residential programs can be paid by problem gambling funds.

To facilitate timely and convenient care from the traditional outpatient programs, field tests were successfully undertaken to determine the efficacy of technology-based counseling sessions (telephonic and web-based [e.g., Skype]) that have become institutionalized but are currently only rarely utilized. Also, efforts continue to be made to provide culturally specific

²⁰ During the FY 10-11 report period this service was cut due to budget constraints but was re-introduced in FY 11-12.

treatment with Asian, Latino, Native American, and Black/African American programs or program components.

Mirroring efforts in the addictions and mental health systems, the use of peer recovery support personnel (mentors) with the ability for qualified individuals' efforts to be encountered. These services were first reported in late 2014. Most of this effort was focused in the Portland metropolitan area due primarily to availability of training and access to a larger pool of recovering persons.

Early Prevention Efforts

Prior to the summer of 2001, the Oregon Lottery and two local programs were the primary efforts in the state for prevention and outreach, although earlier agreements from the state with the counties called for the treatment programs to also conduct outreach, early intervention, and prevention.

With the incorporation of the fee-for-service reimbursement for treatment, the Problem Gambling Services also identified the necessity to move prevention activities away from generalized requirements of the treatment programs and move towards performance based contracts with the counties. Nonetheless, in some situations, the treatment provider remained involved in prevention and outreach activities.

Problem Gambling Services Strategic System Improvement Initiatives

Starting in October of 2014, the state office embarked on the endeavor to create a strategic plan to guide improvements within the problem gambling service system. Through the help of a consultant, over the year, in-person and telephone semi-structured interviews were

conducted, and reports and program documents were reviewed in order to identify program strengths and challenges. This information was then taken to community forums of problem gambling providers and partners to assist with the prioritization of critical issues and development of possible solutions.

In December 2015 the Problem Gambling in Oregon 2016-2020 System Improvement Plan was published. The 5 year system improvement plan outlines goals, current activities and initiatives for the advancement of an effective problem gambling prevention, treatment, and recovery system. Oregon state PGS staff have developed work plans designed to implement the System Improvement Plan. The System Improvement Plan and associated updated work plans are located at: <http://www.oregonpgs.org/about/2016-2020-oregon-pgs-system-improvement-plan/>.

3. PROBLEM GAMBLING PREVENTION SYSTEM

Overview

Problem gambling prevention and outreach programs are directed at avoiding or reducing the emotional, physical, social, legal, and financial consequences of gambling for the individual experiencing gambling related problems, family members impacted, and the community at-large.

Oregon Health Authority (OHA) Problem Gambling Services leads efforts to prevent gambling-related problems, promote informed and balanced attitudes, and protect vulnerable groups. These goals are accomplished by promoting healthy public policy, developing collaborative relationships between various stakeholder groups, and providing local governments with funds to develop a public health model, employing strategies similar to those used in evidence-based alcohol, tobacco, drug, and other prevention efforts. Oregon's problem gambling prevention efforts are guided by the Center for Substance Abuse Prevention's (CSAP) six core prevention strategies. The design of these efforts utilizes community-based strategies intended to provide activities and messaging across the Social Ecological Model (Appendix A).

Funding

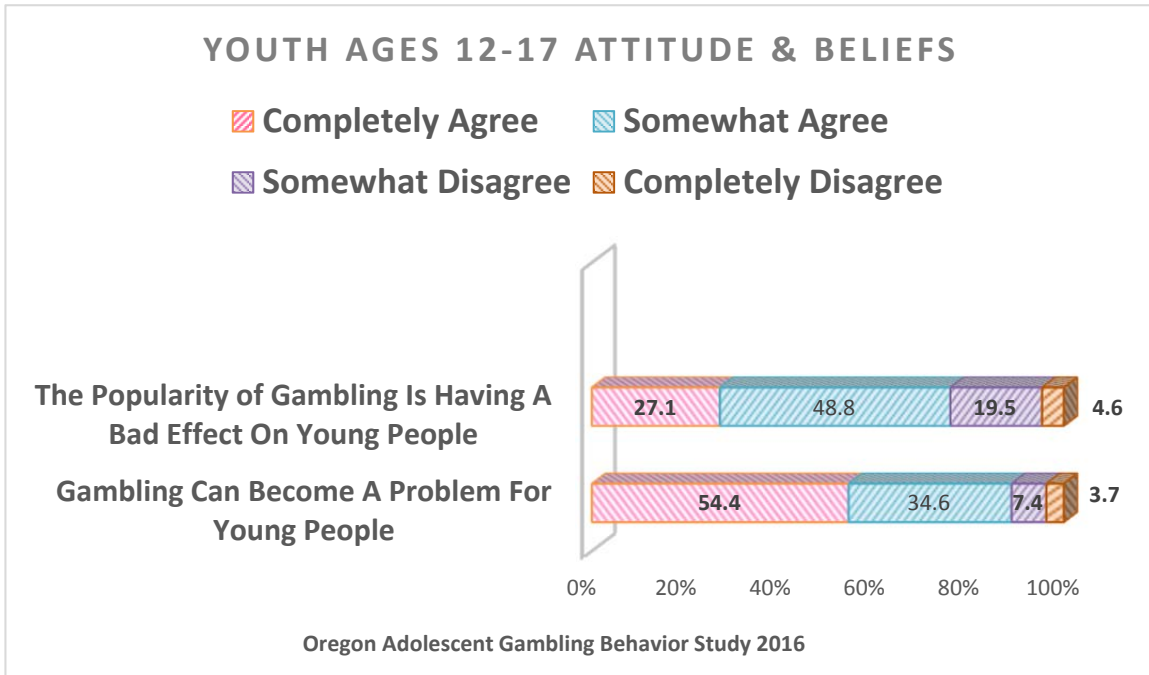
The State of Oregon Problem Gambling Services invested over 1.1 million dollars for problem gambling prevention and outreach services at the community level during this reporting period. In addition, The Oregon Lottery devoted over 3 million dollars statewide during this reporting period to responsible gaming and problem gambling awareness campaigns.

Outcomes

Data available from the 2016 Adolescent Prevalence Study reflects a decrease in the estimated Problem/Disordered Gambling Rates reflecting that adolescents at-risk of developing a problem with gambling decreasing from 5.2% in 2008 to 2% in 2016. While adolescents who meet the criteria for a problem with gambling in 2008 was 1.5%, this rate decreased to 0.2% in 2016.

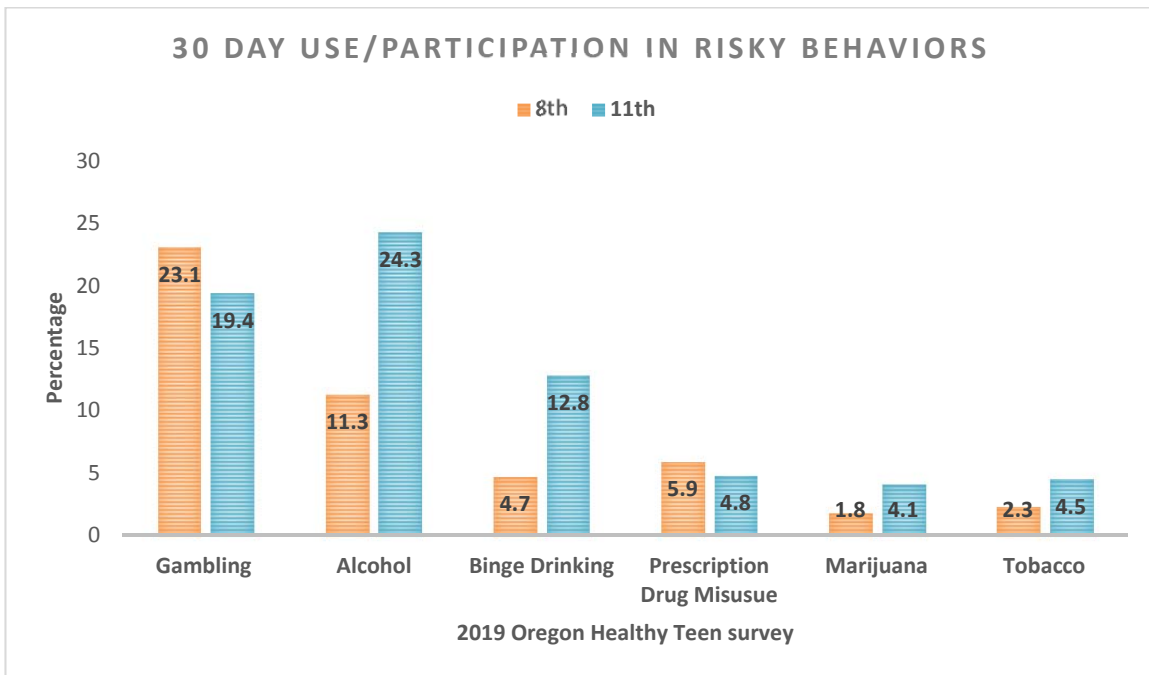
Level	SOGS-RA					
	2016		2008		1998	
	Narrow %	Broad %	Narrow %	Broad %	Narrow %	Broad %
Non-Gambler	93.8	66.0	38.6	38.6	34.0	34.0
Non-Problem Gambler	4.4	31.8	55.5	54.7	50.7	50.7
At Risk	1.7	2.0	4.6	5.2	5.0	11.2
Problem	0.1	0.2	1.3	1.5	1.4	4.1

The 2016 Adolescent Prevalence Study provided information regarding Oregon youth ages 12-17 attitudes and beliefs regarding gambling behaviors. Over half of the youth surveyed (54.4%) completely agreed with the statement, “gambling can become a problem for young people,” and 76.9% either completely or somewhat agree with the statement that “the popularity of gambling is having a bad effect on young people.”



Problem gambling was included in OHA’s Student Wellness Survey. Available data reflects:

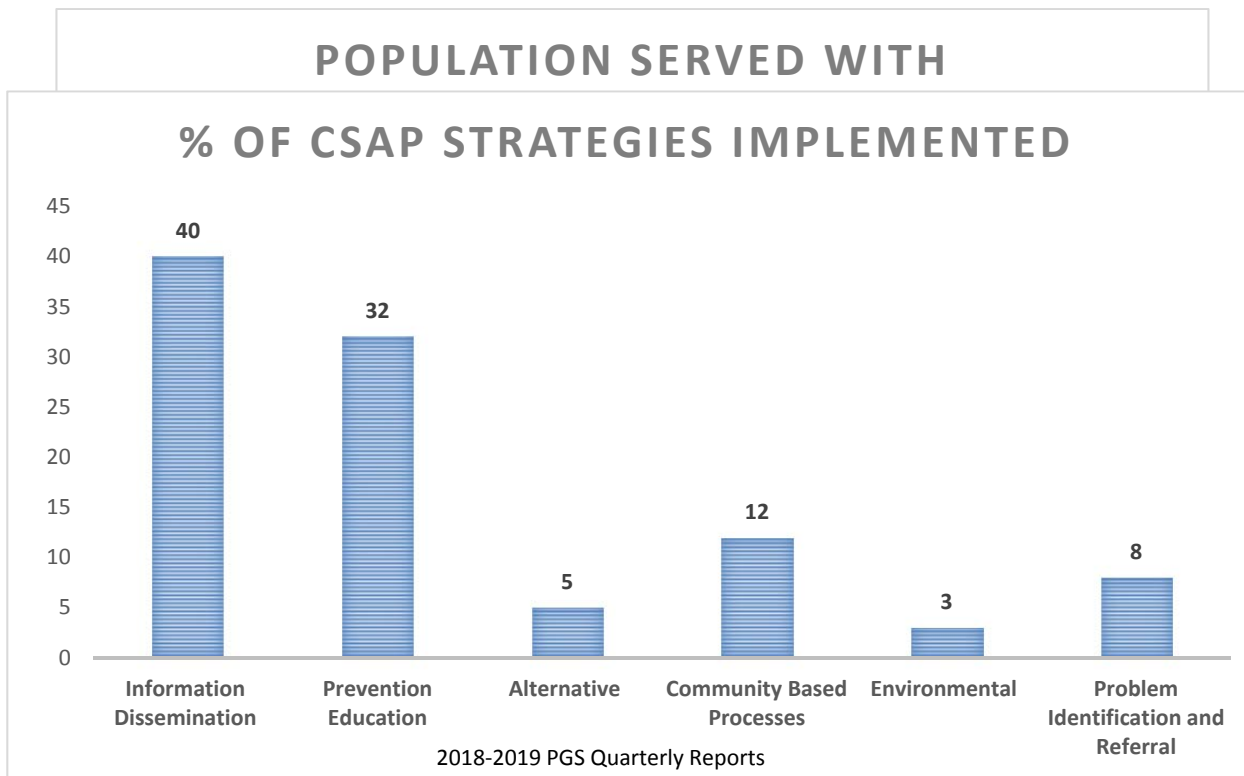
- Oregon 8th youth reported gambling more in the past 30 days than other risky behaviors such as alcohol, prescription drug misuse, and tobacco. With the exception of alcohol use, Oregon 11th graders reported gambling more in the past 30 days than had engaged in other risky behaviors (OHT 2019), as shown below:



Local Regions' Accomplishments

Oregon Problem Gambling Services has directed its regional prevention/outreach providers to utilize the Center for Substance Abuse Prevention (CSAP) strategies as a research-based framework for implementing regional gambling prevention efforts. Because “best practices” in gambling prevention are still being developed, Oregon relies on principles of alcohol and drug abuse prevention programs, whose efficacy is well documented, on the belief that many of the same risk and protective factors are at play. A vast majority of the problem gambling prevention efforts across the state are targeted at the youth population, nonetheless a concerted effort has been made in this past two reporting period to include the adult population as a focus area.²¹

²¹ 2018-2019 PGS Quarterly Reports



Of the CSAP strategies (see Appendix C) employed by Oregon providers the following were the most successful:

Community partnerships and integration of problem gambling prevention is fundamental to the success of raising awareness of problem gambling and tackling the issue of gambling disorder and related problems. Developing a broad range of partnerships among organizations working at various socio-ecological levels has been identified as a key element in achieving change. Regional programs reported developing partnerships with a variety of organizations at the community level. The graphic below captures those most frequently reported partnerships:



Community Readiness Assessment

PGS rolled out the Community Readiness Assessment Model as a tool to measure the local community’s “readiness” level to address problem gambling. Community readiness is the degree to which the community is prepared to take action to address an issue.

Determining the community readiness level will allow for outcome driven planning and matching the appropriate interventions to the community’s level of readiness to address problem gambling. Twenty-one regional providers completed the Community Readiness Assessment within their counties, and the remainder of the regional programs are completing the assessment in FY2019-2020. Providers receive an individual score in each of the dimensions that indicate what stage of the nine stages of community readiness the region is in each dimension (Appendix E).

The combined results of assessment completed by the regional providers reflect a low level of readiness/awareness across all dimensions of readiness that gambling is an activity

that carries risk, on-going efforts to prevent problem gambling, attitudes about problem gambling, leadership and the resources available.

Regional Providers Community Readiness Assessment Scores by Dimension						
Region	Dimension A	Dimension B	Dimension C	Dimension D	Dimension E	Dimension F
Baker	Currently Being Assessed					
Benton	Currently Being Assessed					
Clackamas	Currently Being Assessed					
Coos	2	1	1	1	1	1
Clatsop	2	1	1	1	2	1
Crook	2	2	1	2	2	1
Columbia	1	2	1	1	2	1
Curry	Currently Being Assessed					
Deschutes	5	2	1	1	1	2
Douglas	2	2	1	1	2	1
Gilliam	Currently Being Assessed					
Grant	Currently Being Assessed					
Harney	Currently Being Assessed					
Hood River, Sherman, Wasco	Currently Being Assessed					
Jackson	2	2	2	1	2	1
Jefferson	5	2	1	1	2	1
Josephine	2	2	2	2	3	2
Klamath	Currently Being Assessed					
Lake	2	1	1	1	2	1
Lane	3	2	2	1	2	1
Lincoln	2	2	1	2	2	1
Linn	5	3	1	1	3	2
Marion	3	2	1	1	2	1
Malheur	2	2	1	2	1	3
Morrow	Currently Being Assessed					
Multnomah	4	2	2	1	2	2
NARA	Currently Being Assessed					
Polk	Currently Being Assessed					
Tillamook	4	4	2	2	4	4
Union	3	2	1	1	2	2
Umatilla	3	2	1	2	2	2
Wallowa	3	2	2	1	2	1
Washington	4	3	1	2	3	2
Wheeler	Currently Being Assessed					

All three of the administrative bodies addressing problem gambling (OHA, Lottery, and county governments) will maintain efforts to address problem gambling through a comprehensive approach. Oregon intends to maintain its reputation as a nationwide leader in promoting healthy communities through programs aimed at reducing the harm caused by problem gambling.

4. TREATMENT PROGRAM UTILIZATION

Once the treatment programs became established statewide in FY 95-96, the average annual increase in enrollments was approximately 18.4% until FY 99-00. From FY 99-00 to FY 00-01 the rate of increase was less than 1% then dropped 6.9% the following year.

The plateau in the number of gamblers enrolling in treatment in FY 00-01 was hypothesized to have been influenced by two primary factors. In the spring of 1999, a successful legislative effort²² was launched to increase treatment program funding and attach the level of funding to a minimum percent of the lottery proceeds in the state. That effort included actions intended to stabilize the programs by moving the management and coordination function from the temporary contractual situation, established in July of 1995 with the AOCMHP,²³ to a state agency. The unintended consequences of the passage of legislative action was an 18-month period of contractual uncertainty including short term funding cycles, continual discussions of varying funding levels, and general loss of statewide coordination of outreach and treatment efforts. Effects of this uncertainty permeated throughout most provider agencies²⁴ until the state placed the services under the AMH and created/filled a Problem Gambling Services Manager position.

The second intervening variable that contributed to a flat enrollment rate in FY 00-01 was the fact that the Oregon Lottery, tasked by the legislature to conduct the “Play Responsibly” campaign that included effective paid advertising (print, radio, and television) promoting free treatment, was in the process of a major research and design effort for a new

²² Senate Bill 118

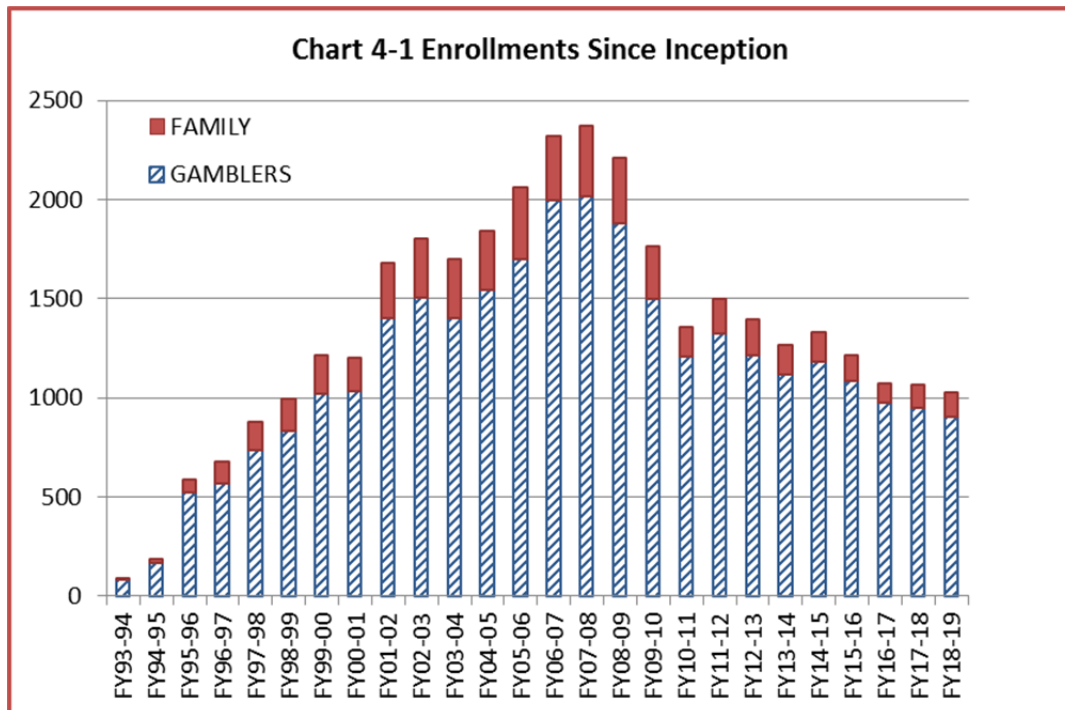
²³ AOCMHP is a membership organization, comprised mainly of county mental health directors within the state with focus on activist and lobbying activities to support the advancement of mental health care in the state.

²⁴ This conclusion is based on extensive, informal contact by the evaluator with program managers and counselors throughout the state.

media campaign and consequently, the purchase of media appeared to decrease during the year. A new campaign was aggressively deployed in the fall of 2001 and subsequently enrollment began to increase again with a 36.2% increase over FY 00-01.

This phenomenal growth in FY 01-02 was speculated to have been influenced by five factors. The first two factors were the reversals of the two that contributed to the flat growth rate in FY 00-01 discussed in the preceding paragraph (set budgets and clear leadership). The third factor was the implementation of several innovative contracts by the PGS with counties for localized outreach and prevention efforts, and the fourth is most likely an artifact of better record keeping by the providers. The fifth and most likely primary factor, noted above, was the effectiveness of the Lottery advertising campaign.

Enrollments grew by only 7.2% in FY 02-03 and then decreased by 6.9% in FY 03-04. That year was the first major recent drop in the economy since the programs were initiated. The decrease was hypothesized as being a direct result of the devastating effects of the worst economy the State had experienced in several decades. The ensuing massive budget cuts to the state-funded mental health and addictions programs, in which the gambling treatment programs are housed, experienced a significant loss in infrastructure and subsequently fewer clients were enrolled. It was further hypothesized that the budget cuts already experienced by the gambling programs during that period, compounded by the concern of potential decimating cuts to the gambling treatment services, with the pending ballot measure to rescind the income surtax, had caused programs to simply lose momentum from the loss and pending loss of infrastructure.



Over the next three years, enrollments increased by an average of 12.6% each year. In FY 07-08 the economy began another rapid descent and enrollments dropped nearly 42% from FY 07-08 through FY 10-11. The following year enrollments came back 9.3% (essentially back to FY 01-02 levels) and then dropped 8.1% in FY 12-13 and another 7.8% in FY 13-14. Total enrollments then rose 5.6% in FY 14-15 and subsequently descended 8.5% for FY 15-16 and another 10.0% for FY 16-17. This reporting year gambler enrollments in all programs decreased approximately 4.6% from the previous year. (Chart 4-1)

Prior to July 1, 2001, as discussed above, providers were funded on a grant basis and there was little incentive for them to complete the paperwork necessary to report contacts for individuals that may have only shown up for an evaluation or attended, for example, two or possibly three sessions. A very rudimentary analysis comparing the ratio of individuals that were reported in FY 00-01 with three or fewer sessions and those reported in FY 01-02

revealed a statistically significant²⁵ difference. The artifact of a change in the funding source that required a client be “enrolled” before the provider was able to receive fee-for-service credit may have accounted for an increase in 100 to 150 enrollments. Another potential artifact of the more precise reporting²⁶ was the finding that the annual recidivism rate of gambler for FY 01-02 was 6.1%, up from 2.4% reported during the previous fiscal year.

Approximately 27.2% of the outpatient gamblers enrolling this year had at least one prior enrollment at the same outpatient program. This rate has been fairly consistent over the past few years. For those with more than one enrollment, the average number of enrollments was 2.9. Approximately 11.3% (n = 22) of those with multiple enrollments had five or more enrollments in the same agency. This data excludes enrollments in the specialty respite, residential, minimal intervention, and prisons programs that would be duplicative for re-enrollments.

As noted above, during the current year there were 37 agencies funded with 50 treatment programs funded (not all reported admissions) including the statewide residential program in Marion County; short-term respite programs in Josephine County and Baker County; the home-based minimal intervention programs (GEAR) based in Lane County; and, three prison programs based in Clackamas, Multnomah, and Marion Counties. Seven of the programs were funded but did not report enrollments. This was due to efforts in the more rural counties to provide minimal funding since approximately 2009 in an effort to provide outreach and a minimal services base while maintaining critical system infrastructure. (Table 4-1)

²⁵ Chi square $P < .01$. Statistical significance is only reported in this document where $p < .05$.

²⁶ Providers are required to close cases if the client has been inactive for a period greater than 30 days.

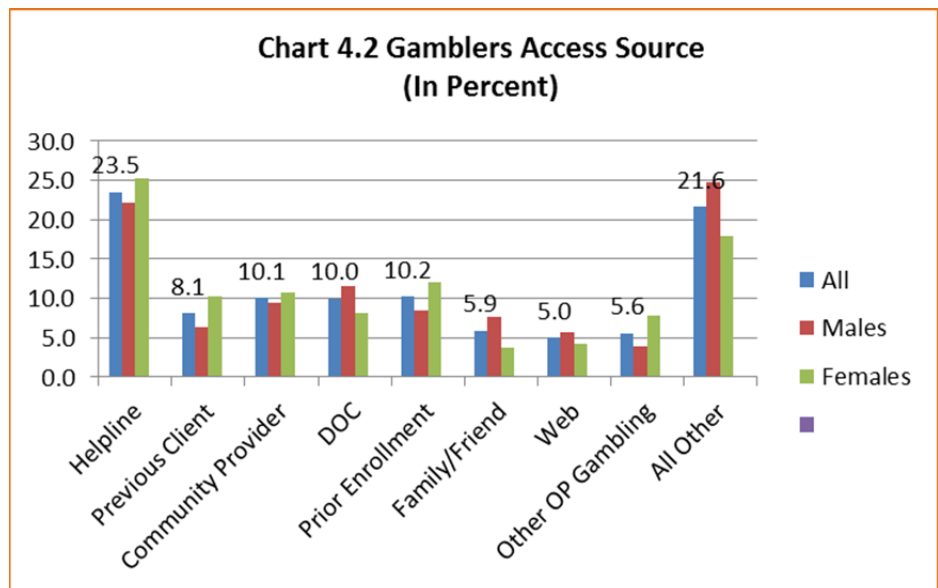
Table 4-1 Treatment Enrollments FY 18-19**Funded Programs**

County- Agency/Program	Gamblers	Family	Total
BAKER-NEW DIRECTIONS NORTHWEST	2	0	2
CLACKAMAS-CASCADIA CLACKAMAS	55	5	60
CLACKAMAS-CASCADIA DOC OUTPATIENT	33	0	33
CLATSOP-CLATSOP BEHAVIORAL HEALTH	5	0	5
COLUMBIA-COLUMBIA COMMUNITY MENTAL HEALTH	10	0	10
COOS-ADAPT	20	0	20
CROOK-LUTHERAN COMMUNITY SERVICES	9	1	10
CURRY-CURRY COUNTY	2	0	2
DESCHUTES-DESCHUTES BESTCARE	18	4	22
DOUGLAS-ADAPT DOUGLAS COUNTY	11	0	11
GILLIAM-COMMUNITY COUNSELING SOLUTIONS	0	0	0
GRANT-COMMUNITY COUNSELING SOLUTIONS	2	0	2
HARNEY-SYMMETRY CARE	0	0	0
HOOD RIVER-MID COLUMBIA/HOOD RIVER	6	0	6
JACKSON-ADDICTIONS RECOVERY CENTER	24	5	29
JOSEPHINE-OPTIONS FOR SOUTHERN OREGON	21	0	21
JEFFERSON-BESTCARE RESIDENTIAL	0	0	0
JEFFERSON-BESTCARE	0	0	0
KLAMATH-BESTCARE	10	0	10
LAKE-LAKE HEALTH DISTRICT	1	0	1
LANE-CENTRO LATINO AMERICANO	2	0	2
LANE-EMERGENCE	77	7	84
LEWIS & CLARK COLLEGE-LEWIS & CLARK CLACKAMAS	4	4	8
LEWIS & CLARK COLLEGE-LEWIS & CLARK MULTNOMAH	24	9	33
LEWIS & CLARK COLLEGE-LEWIS & CLARK WASHINGTON	8	3	11
LINCOLN-LINCOLN COUNTY	14	1	15
LINN/BENTON-LINN COUNTY	30	3	33
MALHEUR-LIFEWAYS MALHEUR	1	0	1
MARION-BRIDGEWAY	70	11	81
MORROW-COMMUNITY COUNSELING SOLUTIONS	1	0	1
MARION-MULTI-CULTURAL CONSULTANTS	35	0	35
MULTNOMAH-ASIAN HEALTH SERVICES CENTER	0	0	0
MULTNOMAH-CASCADIA	74	9	83
MULTNOMAH-CASCADIA DOC	23	0	23
MULTNOMAH-VOLUNTEERS OF AMERICA	31	2	33
MULTNOMAH-LEWIS AND CLARK COLLEGE	47	28	75
POLK-POLK COUNTY	13	1	14

TILLAMOOK-TILLAMOOK FAMILY COUNSELING	3	0	3
UMATILLA-NEW HORIZONS	3	0	3
UMATILLA-UMATILLA COUNTY	4	0	4
UNION-CENTER FOR HUMAN DEVELOPMENT	1	0	1
WALLOWA-WALLOWA VALLEY CENTER FOR WELLNESS	0	0	0
WASCO-MID COLUMBIA/WASCO CO	8	1	9
WASHINGTON-LIFEWORCS NW	72	9	81
WHEELER-COMMUNITY COUNSELING SOLUTIONS	0	0	0
YAMHILL-YAMHILL COUNTY	26	4	30
STATEWIDE-BRIDGEGWAY RESIDENTIAL	47	0	47
STATEWIDE-EMERGENCE MINIMAL INTERVENTION	49	16	65
STATEWIDE-NATIVE AMERICAN REHABILITATION ASSOCIATION	7	0	7
STATEWIDE-JOSEPHINE RESPITE	0	0	0
STATEWIDE-BAKER RESPITE	0	0	0
	903	123	1026

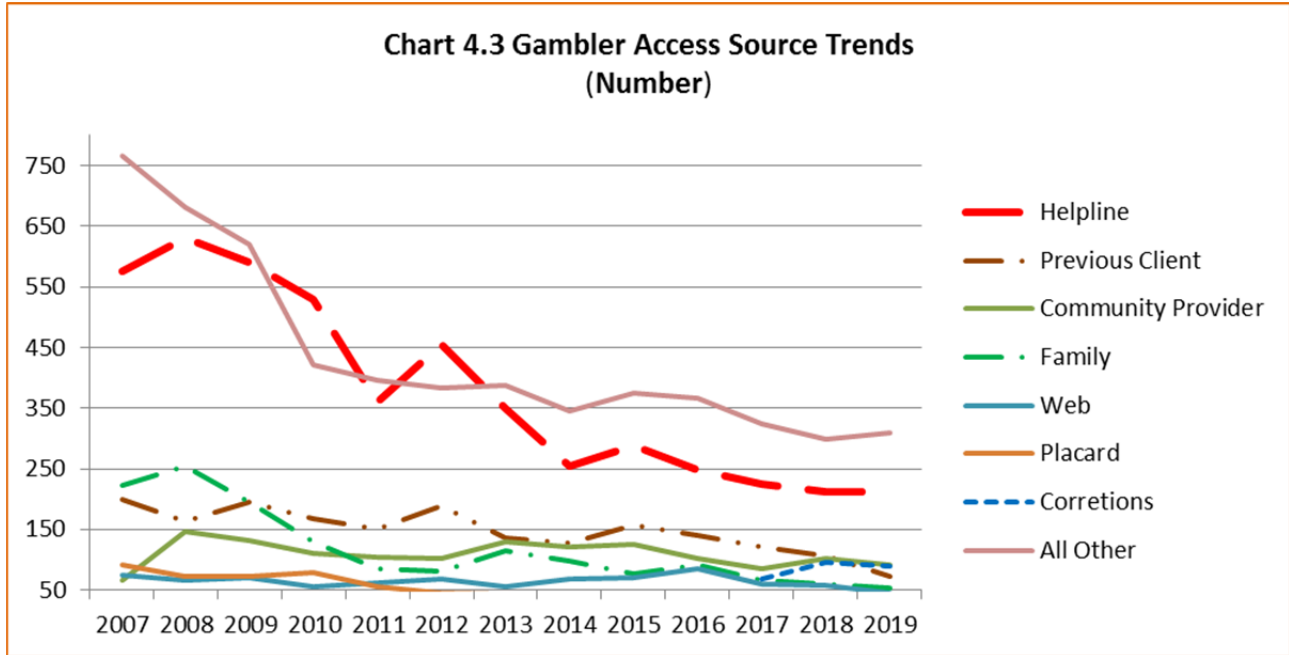
Of the 903 gambler enrollments system wide, 81.8% were in traditional outpatient programs, 10.1% were corrections programs, 5.4% in minimal intervention, and 5.2% in residential.

System wide (all programs), and consistent with

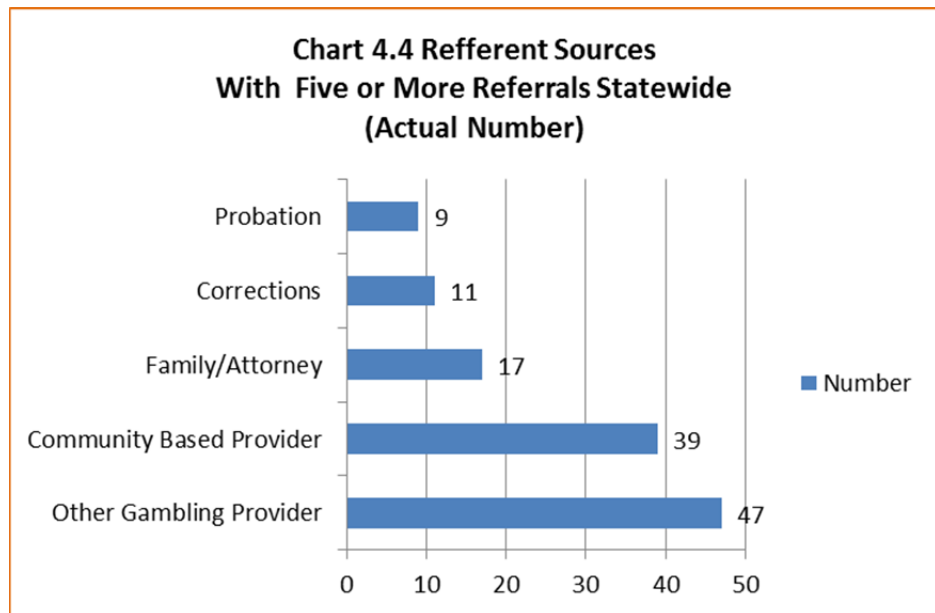


previous reports, approximately 23.5% reported accessing the treating agency contact information from the Helpline; 8.1% reported receiving the contact information from a current or previous client; 10.1% community provider; 10.2% previous client; 5.9% family member; 5.0% web/internet; and, 5.6% from another OP gambling treatment program. (Chart 4.2)

The actual number of clients reporting the source for the treating agency contact information is provided in the accompanying chart. (Chart 4.3)



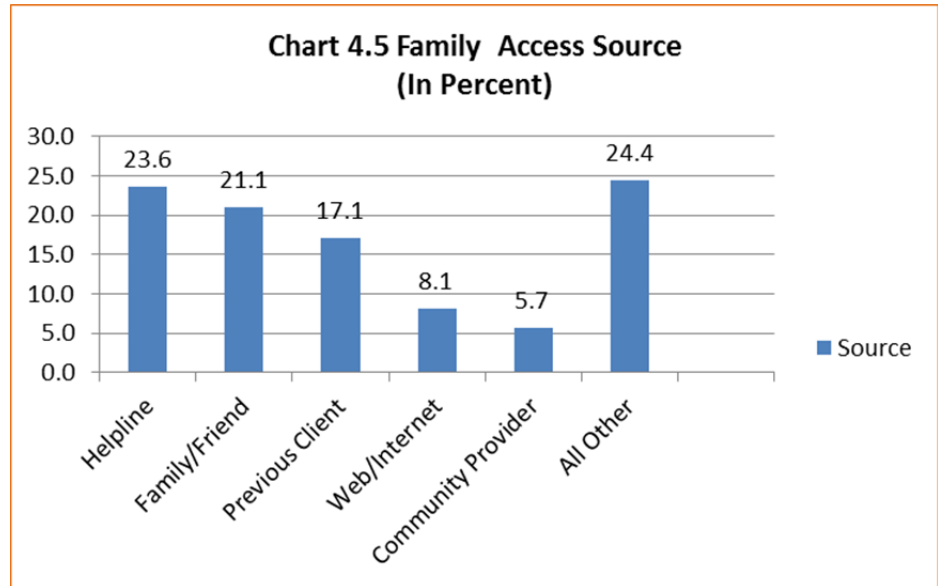
As with previous years, this year experienced a slight shifting in the distribution of gambling clients that received “deliberate” referrals to gambling treatment programs.



Forty-seven were reported as receiving a referral from another program providing treatment for gambling and 39 from community based substance use disorder or mental health treatment

provider; 17 from a family, friend, or attorney and 20 from either probation a state department of corrections facility. (Chart 4.4)

The largest referral sources for family member access was reported as the helpline (23.6%) followed by a family, friend or attorney (21.1%), or



previous, or current, client of the program (17.1%) which would be expected as some agencies send out invitations to family members with the consent of the gambler client. (Chart 4.5)

Approximately 10.3% of those enrolling in any program were reported as having some veteran status. For males, it was 15.0% and for

Status	All	Males	Females
Active Duty Never Deployed to Combat	1.0	1.6	0.2
Active Duty Previously Deployed to Combat	1.2	1.2	1.2
Veteran Never Deployed to Combat	3.5	5.3	1.5
Veteran Deployed to Combat	2.4	3.9	0.7
Disable Veteran Never Deployed to Combat	0.6	0.6	0.5
Disabled Veteran Deployed to Combat	1.6	2.4	0.5
Total	10.3	15.0	4.6

females 4.6%. Approximately 5.2% overall were reported as having combat experience.

Some estimates suggest that seven to eight percent of Americans have served, or are serving in the US military. (Table 4.2)

5. GENERAL GAMBLING ACTIVITIES & CONSEQUENCES

This section addresses general gambling activities and consequence across all programs.

As has been consistently reported over the past two decades, machine games, including video poker, video line games, and traditional slots, as a group, have been overwhelmingly reported as the

primary game of choice. Females continue to report choosing machine games as their primary activity (93.8%) significantly²⁷ more often the males (88.0%). They were also more likely to report video line games (45.2%) more frequently than video poker (35.2%).²⁸ Males continued to be significantly²⁹ more likely to report card games (6.9%) as their primary gambling activity more than females (2.4%). The distributions of the other available games were too small to statistically test. (Table 5.1)

There was no statistically significant difference between males and females in the distribution of those reporting video poker or mechanical reel slot machines as their primary game of choice. Nonetheless,

females were significantly more likely to report video line games than males.³⁰ (Table 5.2)

**Table 5.1 Primary Gambling Activity
(In Percent)**

Game	All	Males	Females
Machines	88.0	83.0	93.8
Cards	4.9	6.9	2.4
Traditional	1.6	1.6	1.5
Sports	1.7	3.0	0.0
Keno	1.1	1.4	0.7
All Other	2.7	4.1	1.6

**Table 5.2 Machine Games by Gender
(In Percent)**

Game	All	Males	Females
Video Poker	38.2	40.8	35.2
Video Line Games	37.8	31.4	45.2
Slot/Mechanical Reel	12.0	10.8	13.4

²⁷ p < .01

²⁸ p < .02

²⁹ p < .01

³⁰ p < .01

Approximately 96.9% of the clients reported their primary gambling location was in Oregon while 1.1% reported Washington, 0.6% California, and 0.4% Nevada.

As consistently reported over the years, the primary gambling location was at video lottery retailers (71.0%), followed by casino/IGC (16.3%), and restaurant/bar with no video lottery sales (4.3%). Females were

significantly³¹ more likely this year to report gambling at a video lottery retailer than males. Approximately half of those reporting other primary gambling locations were participants enrolled in the prison-based programs.

(Table 5.3)

Location	All	Males	Females
Video Lottery Retailer	71.0	68.2	74.3
Casino/IGC	16.3	16.2	16.4
Restaurant/Bar Non-Video	4.3	4.3	4.4
Food/Convenience Store	1.8	1.4	2.2
Internet	1.7	2.4	0.7
Card Room	1.0	1.4	0.2
All Other	3.9	6.1	1.8

The primary protocol for diagnosing pathological gambling since 1994 had been the clinical criteria found in the Diagnostic and Statistical Manual IV - TR (DSM) published by the American Psychiatric Association (APA). Problem gamblers were those with endorsement of three or four of the ten criteria (see sidebar) and those individuals endorsing five or more are considered pathological gamblers.

However, in 2013 APA published a revision of the Manual (DSM 5) that moved gambling from the category of impulse control disorders, not elsewhere classified, to the category of substance-related and addictive disorders. Subsequently such terms as pathological and problem gambling were replaced with “gambling disorder.” Additionally, other terminology adjustments included changing “is preoccupied with gambling” to “is often

³¹ p < .05

preoccupied...;” “gambles as a way to escape from problems” to “gambles when feeling distressed;” and clarifies, “chasing one’s losses” as the “frequent, not short-term, chase of losses.” Finally, “committing illegal acts” was omitted and included in the clarification for “lying.” The DSM 5 also specifies that the criteria must be met in the past 12 months, not included in the DSM IV, but included in the state’s PGS protocol since its inception. Using the DSM IV criteria, problem gamblers are those with endorsement of three or four of the ten criteria (see sidebar) and those individuals endorsing five or more are considered pathological gamblers.

**DSM-IV TR Diagnostic Criteria
for Pathological Gambling**

1. Preoccupation with gambling.
2. Need to gamble with increasing amounts of money to achieve the desired level of excitement.
3. Repeated unsuccessful efforts to control, cut back, or stop.
4. Restless or irritable when attempting to cut down or stop.
5. Gambles as a way of escaping from problems or of relieving a dysphoric mood.
6. Returns after losing money to get even.
7. Lies to others to conceal gambling.
8. Committed illegal acts to finance gambling.
9. Jeopardized or lost significant relationship, job, or opportunity because of gambling.
10. Relies on others to provide money to relieve a desperate financial situation caused by gambling.

The new classification categories include mild disorder (4 to 5 criteria met); moderate disorder (6 to 7 criteria met); and, severe disorder (8 to 9 criteria met).

For evaluation purposes the determination was made to continue to utilize the DSM-IV ten-item criteria for consistency with over two decades’ of data. Importantly, eligibility for state provided gambling treatment services is not restricted to a preset criteria and treatment providers are able to accept gamblers and their families into the programs as long as there is an assessment made that tailored treatment is appropriate.

The average score of those coming into the system was 7.8 of 10 criteria with males averaging 7.6 items and females 8.0 items³² - essentially unchanged from the previous report. The relative severity of gambling related problems is more thoroughly discussed in each of the following section so the reader will have the opportunity to see the difference between outpatient, residential, and minimal intervention programs.

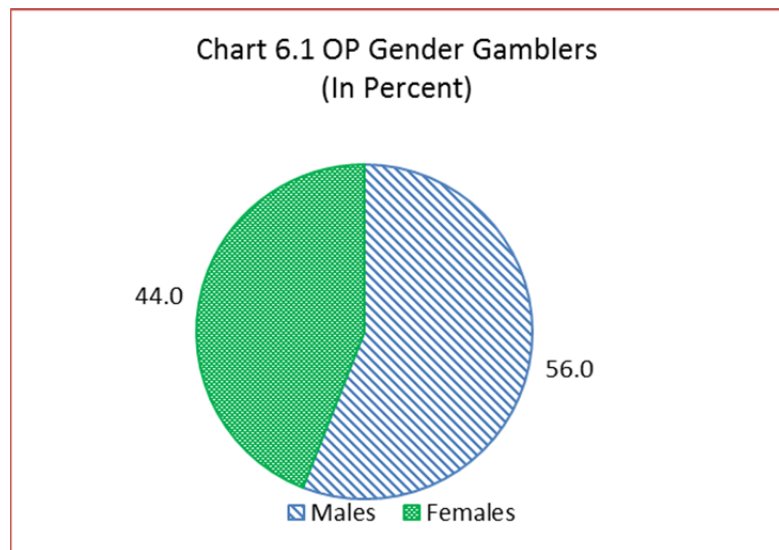
³² Females were significantly ($p < .05$) more likely to endorse a greater number of items than males system wide.

6. TRADITIONAL OUTPATIENT PROGRAMS

Outpatient Demographics

There were 37 programs that reported enrollments in their traditional outpatient (OP) treatment services. One county had three programs and some agencies provided services for multiple counties. During the report period 716 gambler and 107 family member clients were reported as enrolling in the traditional OP services. This was approximately 4.4% below the number of outpatient gambler enrollments reported last year.

As previously reported, males (56.0%) were significantly³³ more likely to enroll in OP programs than females when compared with the general adult population of the state. This difference increased by 4% for the current year. (Chart 6.1)



The average age for OP gamblers was 48.4 years, essentially the same as last year. Females were again significantly more likely³⁴ to be older (51.5 years) than males. (Table 6.1)

	n	mean	sd
All	713	48.4	13.3
Males	399	45.9	13.4
Females	313	51.5	12.5

This year, 77 OP gambler clients (down from 94) were reported as being 65 years old or older. The youngest was 20.4 years and the oldest

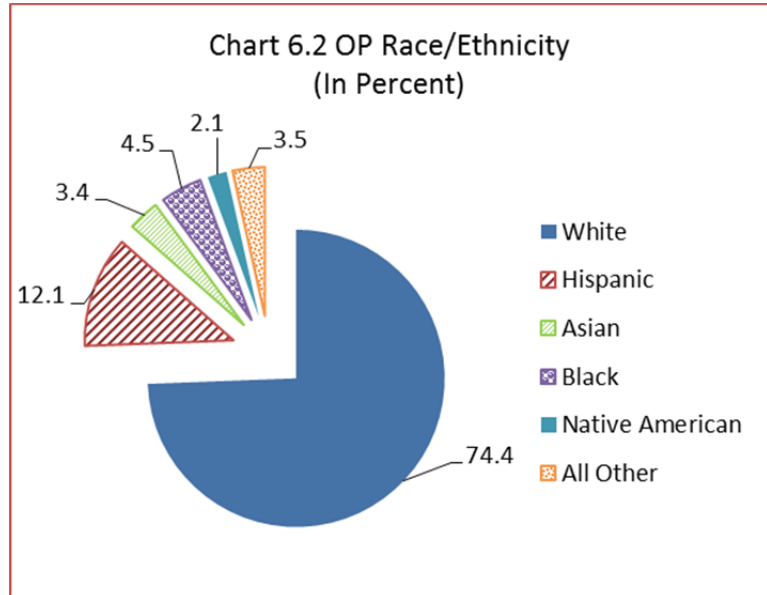
³³ p < .05

³⁴ p < .01

83.4 years with the median age of 48.1 years.

The distribution of Whites enrolling in the OP programs decreased again this year to 74.4% from 77.6%.

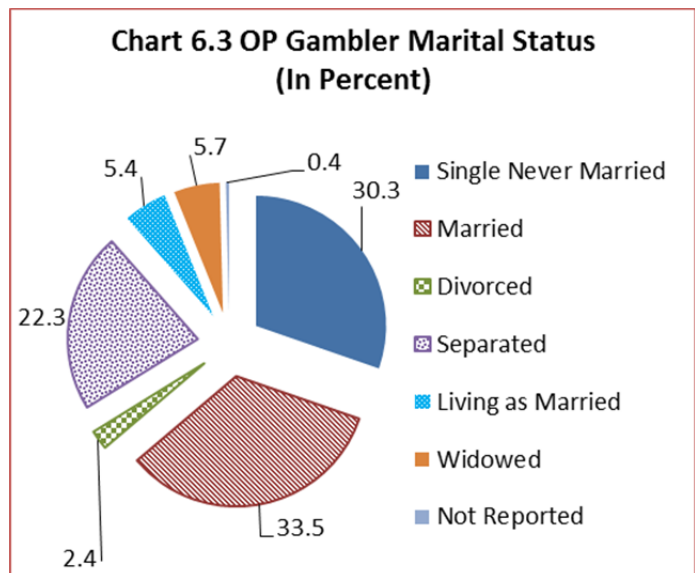
Hispanic/Latino increased again this year from 9.1% to 12.1%, while Asians decreased from 4.1% from 3.4%. The distribution of Black/African American increased 3.9% to 4.5%, and Native Americans decreased from 2.8%



to 2.1%. This shifting is primarily due to Hispanic/Latino specific programs becoming more efficient in case finding. (Chart 6.2)

	n	mean	sd
All	713	13.0	2.5
Males	398	12.7	2.7
Females	314	13.4	2.1

The average number of years of formal education was 13.0 overall, essentially unchanged from the last year. (GED included as 12 years). Females were significantly³⁵ likely to report a higher level of education than males this year. (Table 6.2)



The distribution of married

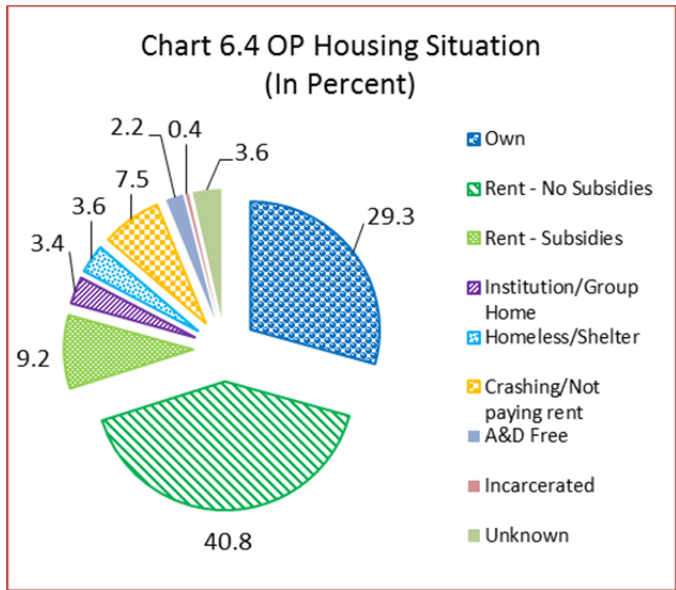
³⁵ p < .01

individuals enrolling in OP treatment continues to fluctuate slightly from 29.8% to 33.5% this year. There were shifts in the other marital categories with the distribution of married females increasing from 29.2% to 34.1% for example. Females were more likely to be separated or divorced than males and less likely to be single/never married. (Chart 6.3)

Males were significantly³⁶ more likely to be single (never married) and less likely to be separated than females as previously reported.³⁷ (Table 6.3)

Approximately 29.3% of the OP clients reported living in a residence owned by them or their family. 40% reported living in a market rental with no rental subsidies and 9.2% reported living in subsidized housing. (Chart 6.4)

	All	Males	Females
Single Never Married	30.3	35.4	23.9
Married	33.5	33.2	34.1
Divorced	2.4	1.5	3.2
Separated	22.3	17.5	28.7
Living as Married	5.4	5.0	6.1
Widowed	5.7	7.2	3.8
Not Reported	0.4	0.2	0.2



³⁶ p < .05

³⁷ p < .01

Females were significantly³⁸ more likely to report living in a home owned (32.2%) than males (27.2%) and subsequently males were significantly more likely to be living a non-subsidized rental (42.9%). (Table 6.4)

	All	Males	Females
Own	29.3	27.2	32.2
Rent - No Subsidies	40.8	42.9	38.2
Rent - Subsidies	9.2	8.2	10.2
Institution/Group Home	3.4	4.2	2.2
Homeless/Shelter	3.6	3.7	3.5
Crashing/Not paying rent	7.5	9.0	5.7
SUD Free	2.2	1.5	3.2
Incarcerated	0.4	0.2	0.6

As previously reported, males continued to be significantly³⁹ more likely to be working full-time (52.6%) than females (34.7%) while females were significantly⁴⁰ more likely to be unemployed part-time. There were only minor fluctuations in the employment categories when compared with

Status	All	Males	Females
Full-Time	44.7	52.6	34.7
Part-Time	10.9	8.5	14.0
Irregular	6.0	4.7	7.6
Unemployed Looking	9.1	9.7	8.3
Unemployed - Not Looking	6.6	5.5	8.0
Retired	9.9	9.2	10.5
Disabled	10.9	9.0	13.4
Other/Not Reported	1.9	1.7	3.5

previous years. (Table 6.5)

The average household income for OP clients who reported an income was \$42,486 up significantly⁴¹ from \$37,960. Females again reported an average income below that of males and the difference was statistically significant

	n	mean	sd
All	664	42,486	41,646
Males	371	47,097	46,695
Females	292	36,677	33,348

³⁸ p < .05

³⁹ p < .01

⁴⁰ p < .05

⁴¹ p < .05

⁴² this year. Overall, the median income was \$36,000. For males it was \$39,000 and \$30,000 for females – all higher than last year. (Table 6.6)

Wages were most frequently (56.3%) cited as the source of the household income followed by retirement/pension

(12.2%), disability (9.5%), public assistance (4.6%), and other sources (8.9%).

Approximately 8.5% were reported as having no income. Males were significantly more likely⁴³ to report wages while females were significantly more likely to report disability⁴⁴ and public assistance⁴⁵ as their source of income than males. (Table 6.7)

	All	Males	Females
Wages	56.3	62.6	48.4
Public Assistance	4.6	3.2	6.4
Dividends/Interest	0.0	0.0	0.0
Retirement/Pension	12.2	10.5	14.0
Disability	9.5	8.7	10.5
Other	8.9	6.3	12.4
None	8.5	8.7	8.3

Approximately 85.7% of clients entering OP were reported as being covered by some form of private or public insurance and approximately 46.1% being covered by some form of public coverage. Females were significantly more like to be covered by MEDICAID,⁴⁶ and MEDICARE,⁴⁷ while males were significantly more likely to have

	All	Males	Females
Private	35.9	34.2	38.2
MEDICAID/OHP	30.6	28.7	33.1
MEDICARE	10.8	7.2	15.0
VA	4.7	7.2	1.6
Other Insurance	3.1	4.0	1.9
Unknown	1.3	2.0	0.6
Other Public	0.6	0.2	1.0
None	13.0	16.5	8.6

⁴² p < .01

⁴³ p < .001

⁴⁴ p < .05

⁴⁵ p < .001

⁴⁶ p < .05

⁴⁷ P < .001

VA insurance,⁴⁸ or no insurance at all.⁴⁹ It must be noted that all treatment is paid for by the state regardless of insurance coverage. (Table 6.8)

Outpatient System Performance

Treatment providers are contractually required to have appointment availability in the outpatient programs within five work days. The

	n	mean	sd
Calendar Days	716	4.0	4.4
Work Days	716	3.6	3.2

average number of work days to the first available appointment was 3.6 work days, essentially the same as previously reported. The average number of calendar days from the prospective client’s first call to the program and the first available appointment was 4.0 days, up slightly from 3.6 days previously reported. The average lag from first call to admission in the outpatient programs was 6.6 calendar days accounting for client delays and essentially the same as last year. There were no significant gender differences in the lag time to first available appointment or to first seen again this year. (Table 6.9)

The average length of stay (LOS) in the OP programs was 176.9 days, essentially unchanged from last year. Females were significantly⁵⁰ more likely to remain in treatment than males – a trend that has been relatively stable over the years. (Table 6.10a)

	n	mean	sd
All	691	176.9	224.2
Males	378	159.8	205.7
Females	312	198.0	243.4

⁴⁸ p < .01

⁴⁹ p < .05

⁵⁰ p < .05

Individuals who were reported as successfully completing treatment remained, as expected, significantly⁵¹ longer (333.5 days) than the overall length of care (176.9 days) and was essentially the same as

	n	mean	sd
All	195	333.5	245.1
Males	102	278.6	216.0
Females	93	393.7	260.4

previously reported for treatment completers previously. (Table 6.10b)

The unadjusted⁵² program completion rate for the OP programs was 28.2%, essentially

Status	All	Males	Females
Stopped Attending ASA	49.8	51.9	47.1
Successful Completion	28.2	27.0	29.8
Evaluation Only	4.9	5.0	4.8
Refused Service	4.8	2.9	7.1
Further Treatment Not Appropriate	2.3	2.6	1.9
Moved from Catchment Area	2.3	2.9	1.6
Physical/Mental Illness	2.2	2.6	1.6
Conflicting Hours	1.7	1.6	1.9
Incarcerated	1.4	2.1	0.6
Program Closure - Non Cap	0.6	0.3	1.0
Non-Compliance With Rules	0.3	0.0	0.6
Deceased	0.1	0.3	0.0
No Transportation	0.0	0.0	0.0
Other	1.3	0.8	2.0

unchanged from the previous report. Females were only slightly more likely to report a higher

successful completion rate (29.8%) than males (27.0) (Table 6.11)

The average number of OP treatment encounters for those discharged during the report period was 20.0, essentially unchanged and the average number of treatment encounters for those successfully completing treatment was 38.4, also essentially unchanged.

⁵¹ p < .01

⁵² Prior reports included as “adjusted successful program completion” that was originally used to compare gambling programs with other state addictions treatment outcomes. That marker is no longer use by the state and has been omitted from this and future reports.

The average case cost for all gamblers was \$1,743.00, up somewhat from \$1,706.30 and the average case cost for successful completers was \$3,239.60, up somewhat from \$3,138.70 previously reported. These figures exclude services that were reported as outreach and/or

	n	mean	sd
Encounters			
All Gamblers	663	20.0	30.5
Successful Completers	195	38.4	40.2
Dollars			
All Gamblers	663	1,743.0	2,422.2
Successful Completers	195	3,239.6	3,065.8

flexible spending that historically have not been associated with individual cases. (Table 6.12)

Outpatient Gambler Activities and Consequences

The average age of the first gambling experience for the outpatient clients was 24.0 years, essentially the same as previously reported. Males continued to report their first gambling experience at a significantly⁵³ younger age (22.1 years) than females (26.3 years). (Table 6.13)

	n	mean	sd
All	704	24.0	12.2
Males	396	22.1	11.4
Females	307	26.3	12.6

Similarly, males reported a significantly⁵⁴ earlier age (34.1 years) of the onset of problems with gambling than females (40.2 years) and the overall average age was 36.8 years, essentially the same as previously reported. (Table 6.14)

	n	mean	sd
All	696	36.8	13.8
Males	391	34.1	13.4
Females	305	40.2	13.4

The average number of years between age first gambled and the onset of problems with

⁵³ p < .05

⁵⁴ p < .01

gambling was approximately 15.2 years overall. Males were significantly⁵⁵ more likely to report a shorter number of years between first gambled and problem onset (14.0 years) than females (16.7 years).

As noted above, even though there has been a change in scoring of the DSM criteria, a decision was made to continue using the 10-item criteria for consistency across two decades of data. The average number of items endorsed by those enrolling in the outpatient programs was 7.8 items, essentially unchanged from that previously reported with no significant difference between genders. (Table 6.15)

	n	mean	sd
All	711	7.8	2.0
Males	397	7.7	2.0
Females	313	7.9	2.0

	All	Males	Females
Unsuccessful attempts to stop	91.7	90.7	93.0
Preoccupation	91.4	89.9	93.3
Escaping	89.6	87.7	92.0
Returning to get even	88.0	88.2	87.9
Increasing size of bets	87.5	86.6	88.5
Lying	85.8	85.1	86.6
Restlessness	79.5	77.1	82.4
Jeopardized relationship/job	67.7	71.3	62.9
Relies on others for money	63.4	62.7	64.2
Committed illegal acts	33.2	28.5	39.0

An item analysis revealed females were again significantly more likely to endorse restlessness⁵⁶ and escaping.⁵⁷ Interesting, males were less likely to report doing things not necessarily legal⁵⁸ than females (flipped from previous reports), and continued to be significantly⁵⁹ more likely to have jeopardized a significant relationship or job. (Table 6.16)

⁵⁵ p < .01

⁵⁶ p < .05

⁵⁷ p < .001

⁵⁸ p < .01

⁵⁹ p < .01

Approximately 29.1% of those enrolling in the outpatient programs reported to their counselors having thoughts of suicide in the past six months. About 1.1% reported making suicidal threats, 2.5% reported having a plan, and 2.4% indicated they had attempted to commit suicide. Although there were differences in the distributions between males and females the differences were not statistically significant. Interestingly, from the written confidential enrollment survey, approximately 43.6% endorsed having thoughts of suicide (always 2.4%, often 5.0%, 15.9% sometimes, and 20.3% rarely) while 3.3% reported attempting suicide (always, often, or sometimes).⁶⁰ (Table 6.17)

	All	Males	Females
Thoughts	29.1	28.4	29.6
Threat	1.1	0.8	1.6
Plan	2.5	2.7	2.2
Action	2.4	1.5	3.5

Approximately 51.9% reported experiencing significant relationship problems, 15.4% reported problems at work, 8.3% legal problems, and 7.9% reported having filed, or planned to file, for bankruptcy in the past six months. Females were significantly⁶¹ more likely to report bankruptcy problems than males. (Table 6.18)

	All	Males	Females
Relationships	51.9	53.7	49.8
Job	15.4	14.4	16.7
Legal	8.3	7.7	8.8
Bankruptcy	7.9	5.4	11.0

Approximately 5.7% reported on their survey experiencing physical violence in the six months prior to enrollment; 24.6% reported verbal, emotional, or psychological abuse; and, 21.7% reported feeling controlled or trapped in

	All	Males	Females
Physical	5.7	4.0	7.9
Non-Physical	24.6	21.4	27.7
Controlled/Trapped	21.7	19.7	23.1

⁶⁰ The enrollment survey structure is discussed below.

⁶¹ p < .01

a relationship. These distributions were similar to previous years with females being more likely to report these types of violence. (Table 6.19)

Approximately 69.3% of the clients reported having a gambling related debt at enrollment. The average amount owed was \$25,609.30, up slightly from last year. Males were somewhat more likely to report a larger debt than females. The average debt to income ratio remained similar to that previously reported a 1:0.86. (Table 6.20)

	All	mean	sd
All	494	25,609.3	51,425.8
Males	269	27,338.8	54,216.1
Females	224	23,557.4	47,900.8

Approximately 33.3% reported having any prior SUD treatment episodes of care. The average number of prior SUD treatments was 2.5. For the data point, episodes of care include both residential/inpatient and outpatient but excluded self-help activities. These were very similar to those previously reported. (Table 6.21)

	n	mean	sd
All	238	2.5	2.6
Males	148	2.2	2.0
Females	89	3.1	3.3

Approximately 43.1%, up from 35.9% of the clients were reported as having prior mental health (MH) episodes of care. For these individuals, the average number of MH episodes was 3.1. As with

	n	mean	sd
All	308	3.1	3.7
Males	139	2.4	2.7
Females	169	3.6	4.2

the SUD, MH episodes of care included both inpatient and outpatient and excluded self-help. Females were significantly⁶² more likely to report prior MH treatment than males as were also more likely to report more episodes of care on average. (Table 6.22)

⁶² p < .05

Approximately 14.7% of the outpatient clients were reported as being concurrently enrolled in SUD treatment. Of these, 9.4% were in the same agency, 4.5% were enrolled in another publicly funded agency, and 0.8% were receiving services at a private agency. Concurrent enrollment in a mental health program was reported for 23.6% (up from 17.4% reported prior) of the gamblers. For this care, 10.1% were enrolled in the same agency, 7.0% in another publically funded agency, and 6.5% in a private agency. Overall, 7.0% (up from 5.2%) were reported as being concurrently enrolled in MH and SUD treatment. This was comprised of 5.6% of the males and 8.9% of the females. (Table 6.23)

<i>Location</i>	<i>All</i>	<i>Males</i>	<i>Females</i>
SUD Treatment			
Same Agency	9.4	9.8	8.9
Other Public Agency	4.5	4.5	4.5
Other Private Agency	0.8	0.8	1.0
<i>Total</i>	14.7	15.0	14.4
MH Treatment			
Same Agency	10.1	7.8	13.1
Other Public Agency	7.0	7.5	8.6
Other Private Agency	6.5	11.5	6.4
<i>Total</i>	23.6	26.8	28.1

Of those enrolling in the outpatient programs, 44.0% were reported as having prior gambling treatment enrollments. The average number of prior enrollments was reported as 2.2. (Table 6.24)

	n	mean	sd
All	315	2.2	1.8
Males	157	2.0	1.8
Females	157	2.3	1.7

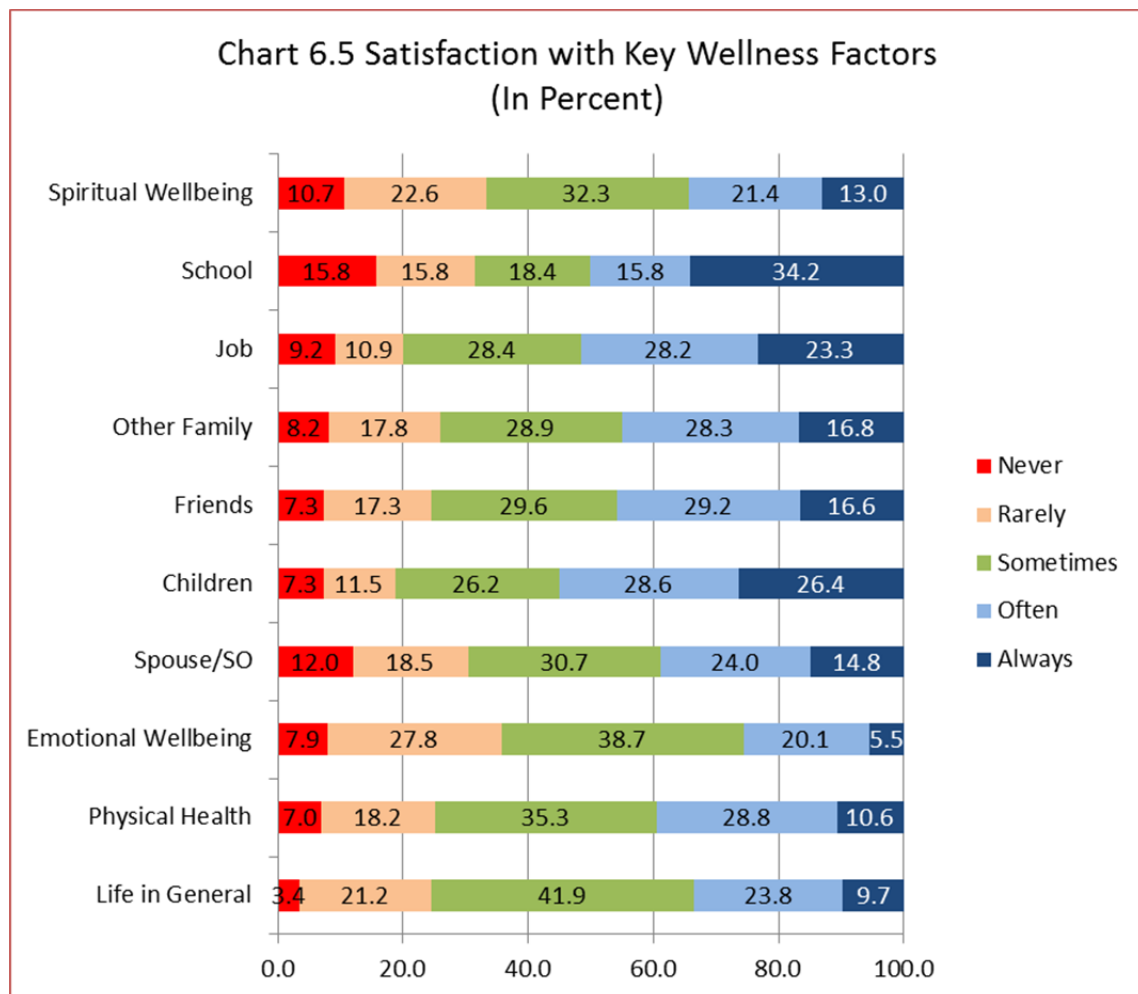
At the time of enrollment, approximately 10.3%, up from 6.8%, reported they were currently active in self-help, while 16.9% reported they had previously been involved with self-help. (Table 6.25)

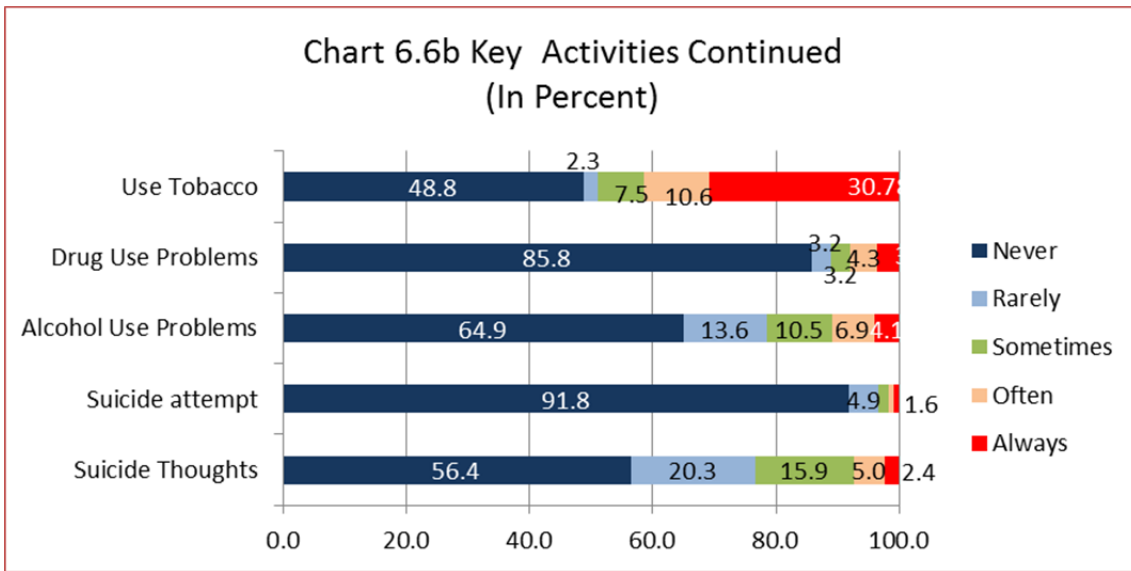
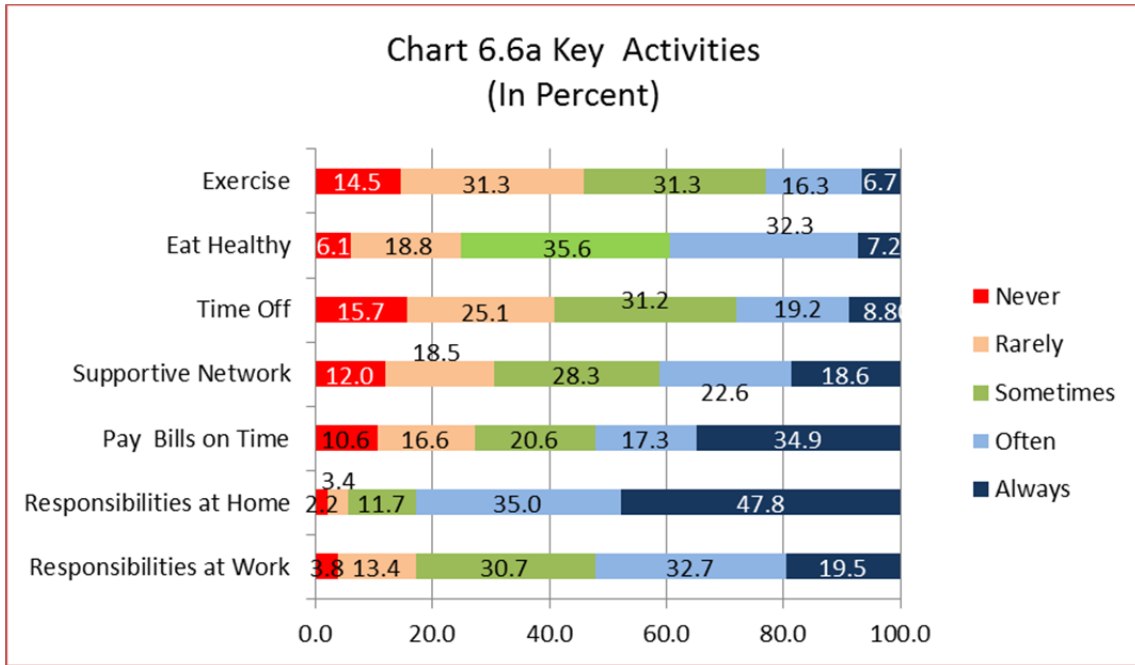
	Previous	Current
All	16.9	10.3
Males	15.0	9.2
Females	19.4	11.5

At enrollment, clients are requested to rate their level of satisfaction on a survey based

on a five-point Likert-type scale ranging from never to always. This data is then compared with their responses at follow-up to determine, statistically, the direction and strength of any improvements in several key recovery domains.

As can be seen in the accompanying charts, clients generally tend to not report exceedingly strong dissatisfaction with any of the key recovery markers as has been consistently reported. (Charts 6.5, 6.6a, and 6.6b)





Outpatient Gambler Outcomes

Self-reported abstinence has remained relatively stable across past years with some minor shifts. This year, at 12-month follow-up, 33.3%, down from 39.7%, of the participants reported abstinence since enrolling in the program while 50.9%, up from 38.1%, gambling

much less than before enrollment. Only 1.8% reported gambling more gambling and none reported much more gambling than before treatment. Again, only program completers are tracked at 12 months post discharge.

At six months the abstinence rate for program completers was 33.8%, down from 51.1%, with 44.6%, up from 37.8%, reported gambling much less. For those who did not successfully complete treatment their reported abstinence was 14.0%, down from 21.0%, with 29.8%, up from 25.8%, reporting much less gambling. These rates vary from year to year and do not appear to be trending up or down. (Table 6.26)

	None	Much Less	Less	Same	More	Much More
12-Month Completers	33.3	50.9	8.8	5.3	1.8	0.0
6-Month Completer	33.8	44.6	16.9	1.5	1.5	1.5
6-Month Non-Completers	14.0	29.8	24.6	14.0	15.8	1.8

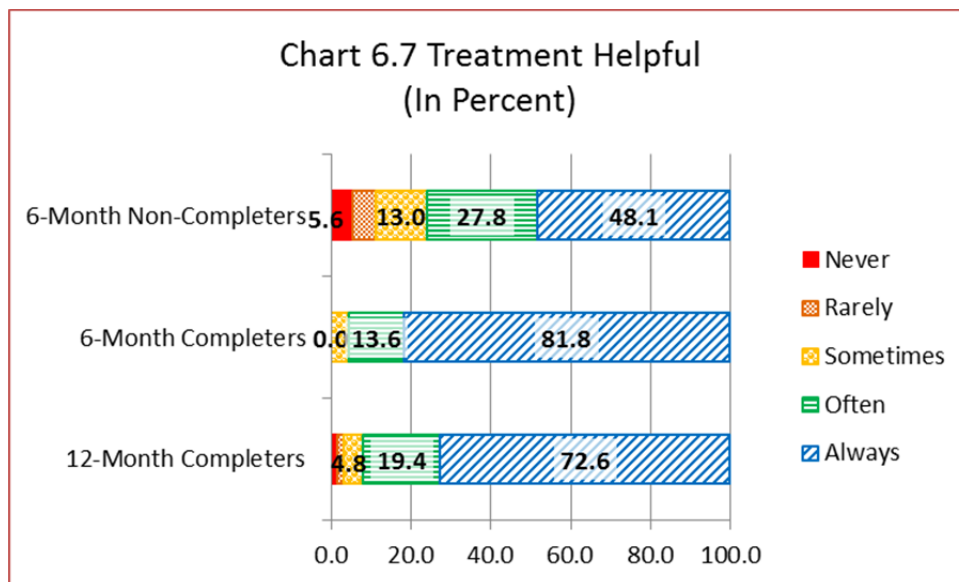
A statistical analysis of variance (ANOVA) between individually matched scores on the baseline survey administered at admission with scores reported on the follow-up surveys demonstrated significant improvement in nearly all of the ten DSM criteria. The only criteria not to see significant improvement across all three groups was doing illegal activities to get money to gamble with. Since this was one of the lowest endorsed criteria the lack of change is due to the low number of initial endorsements. Only the completers demonstrated significant improvement in their level of satisfaction with life in general, emotional wellbeing, and spiritual wellbeing. (Table 6.27)

Table 6.27 OP ANOVA Pre/Post Survey

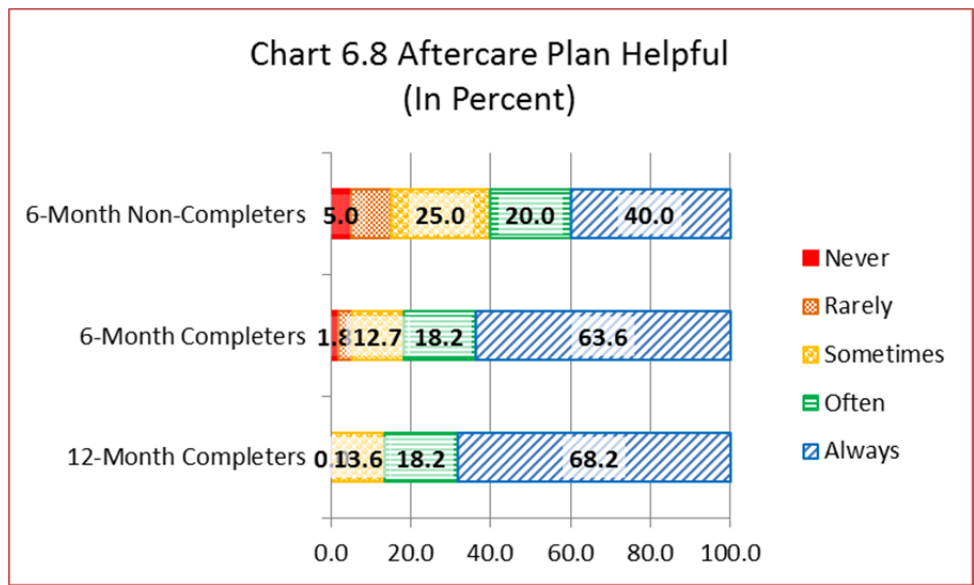
	Six-Month Completers	Six-Month Non- Completers	Twelve Month Completers
Satisfaction With			
Life in General	↑ p < .01	↔ ns	↑ p < .01
Physical Health	↔ ns	↔ ns	↔ ns
Emotional Wellbeing	↑ p < .01	↔ ns	↑ p < .01
Relationship with Spouse/SO	↑ p < .01	↔ ns	↔ ns
Relationship with Children	↔ ns	↔ ns	↔ ns
Relationship with Friends	↔ ns	↔ ns	↑ p < .05
Relationship with other Family	↔ ns	↔ ns	↔ ns
Job	↔ ns	↔ ns	↔ ns
School	↔ ns	↔ ns	↔ ns
Spiritual Wellbeing	↑ p < .05	↔ ns	↑ p < .05
Activities			
Accomplish Responsibility at Home	↔ ns	↔ ns	↔ ns
Accomplish Responsibility at Work	↔ ns	↔ ns	↔ ns
Pay Bills	↔ ns	↔ ns	↔ ns
Thoughts of Suicide	↑ p < .05	↔ ns	↔ ns
Attempt to Commit Suicide	↔ ns	↔ ns	↔ ns
Drink Alcohol	↔ ns	↔ ns	↔ ns
Problems with Alcohol	↔ ns	↔ ns	↔ ns
Use Illegal Drugs	↔ ns	↔ ns	↔ ns
Problems with Illegal Drugs	↔ ns	↔ ns	↔ ns
Use Tobacco	↔ ns	↔ ns	↔ ns
Commit Illegal acts to get Money	↔ ns	↔ ns	↔ ns
Maintain Supportive Friend/Family	↔ ns	↔ ns	↑ p < .01
Take off Time to Rest/Relax	↔ ns	↔ ns	↔ ns
Eat Health Foods	↔ ns	↔ ns	↔ ns
Exercise	↔ ns	↔ ns	↔ ns
Attend GA/Community Support	↑ p < .05	↔ ns	↔ ns
DSM Criteria			
Thinking about gambling	↑ p < .01	↔ ns	↑ p < .01
Gambling with more money	↑ p < .01	↑ p < .01	↑ p < .01
Unsuccessful attempts to stop	↑ p < .01	↑ p < .01	↑ p < .01
Restless when attempting to control	↑ p < .01	↑ p < .01	↑ p < .01
Gambled to escape	↑ p < .01	↑ p < .01	↑ p < .01
Chasing	↑ p < .01	↑ p < .01	↑ p < .01
Lying to hide gambling	↑ p < .01	↑ p < .01	↑ p < .01
Illegal ways to get money	↔ ns	↔ ns	↔ ns
Risk/lost significant relationship/opportunities	↑ p < .01	↑ p < .01	↑ p < .01
Borrowed from others	↑ p < .01	↑ p < .01	↑ p < .01
Key: ↑ Improvement; ↓ Regression; ↔ No Change			

Care should also be taken in interpreting the ANOVA findings as the findings are not from a controlled study and intervening variables, such as higher levels of satisfaction in the key wellness and recovery domains at enrollment for example preclude the opportunity to numerically demonstrate improvement for some participants. Second, the six and twelve-month samples are not comprised of the same participants; therefore, no inferences are possible from the reported date regarding changes from six to twelve months.

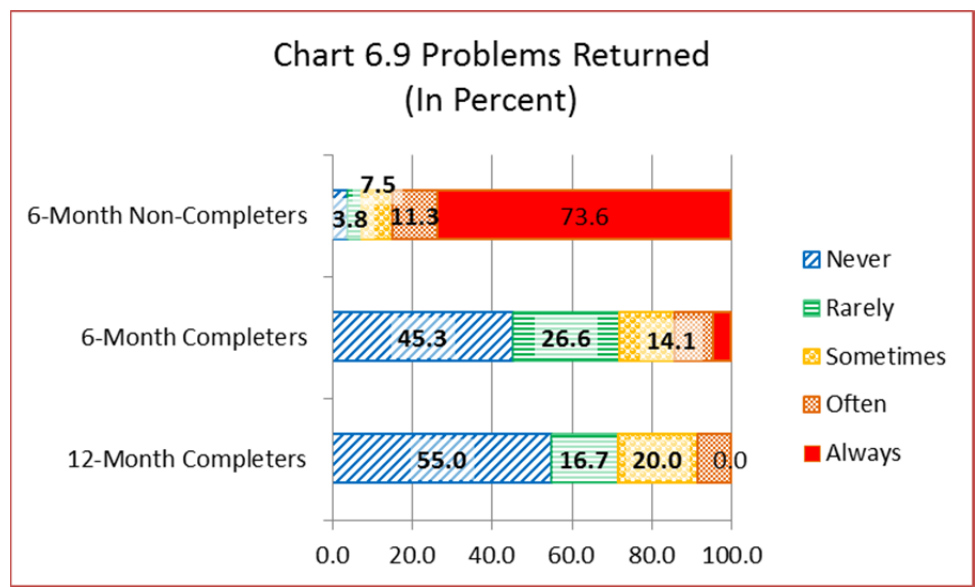
Individuals who completed treatment were again this year very positive regarding the helpfulness of their treatment experience. Approximately 92% of those in the 12-month sample were positive (72.6% always; 19.4% often) with a shift towards always. Approximately 95.4%, up from 88.9%, of the six month successful completer sample reported positive satisfaction. Approximately 75.9%, down slightly from 78.2%, of the non-completers endorsed this item as often or always. (Chart 6.7)



Approximately 86.4%, up somewhat from 84.7%, of the twelve-month sample and 81.8% , essentially the same as previously reported, of the six-month reported positive satisfaction with the helpfulness of their aftercare/continuing care plan compared with 60.0%, down from 78.2%, of the non-completers . (Chart 6.8)

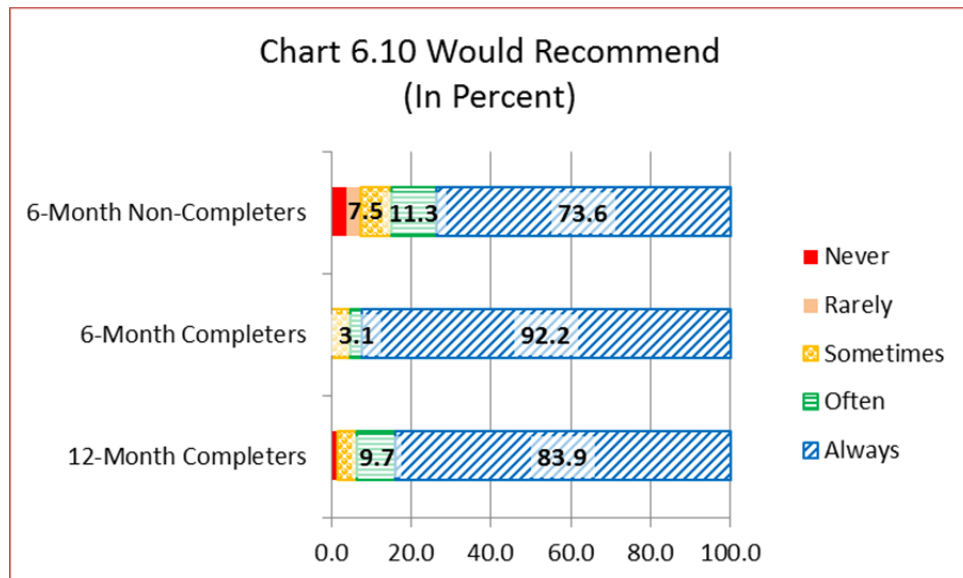


As previously reported, one of the more telling charts of this section is the high return rate of the problems that brought them to treatment for the non-completers with 84.9%, down from 87.7%, reporting always or often. The six month completers' sample endorsed not having the problems return with 45.3%, down from 60.0%, indicating never and 26.6%, up



from 22.2%, rarely. Those in the 12-month sample were more positive with 55.0% reporting always, up from 37.9%, reporting never and 16.7%, down from 27.3%, rarely. (Chart 6.9)

As has been consistently reported in previous reports, after several decades consulting with a large number of behavioral health service providers, the evaluation team has established a rule of thumb regarding clients' willingness to recommend the program to others. Those agencies with a combined score below 85% (always and often) have been found to have ample opportunity for quality improvement and have tended to document poorer long term success with their clients. The willingness to endorse the program to others by the 12-month sample was quite strong at 93.6%, down slightly from 95.4%. Similarly, the six-month sample demonstrated a 95.3% positive endorsement, essentially unchanged from last year. As expected, those who did not successfully complete the programs reported a lower endorsement rate of 84.9%, down somewhat from 87.7%, which is still considered good for those who left the program prior to completion. (Chart 6.10)



7. RESIDENTIAL CARE

The only active residential program, located in Marion County (Salem), is operated by Bridgeway Recovery Services and has a varied-length treatment program for male and female adults. Traditionally, the residential program is available to accept referrals from any of the state-funded outpatient programs and other approved sources on an emergent basis.

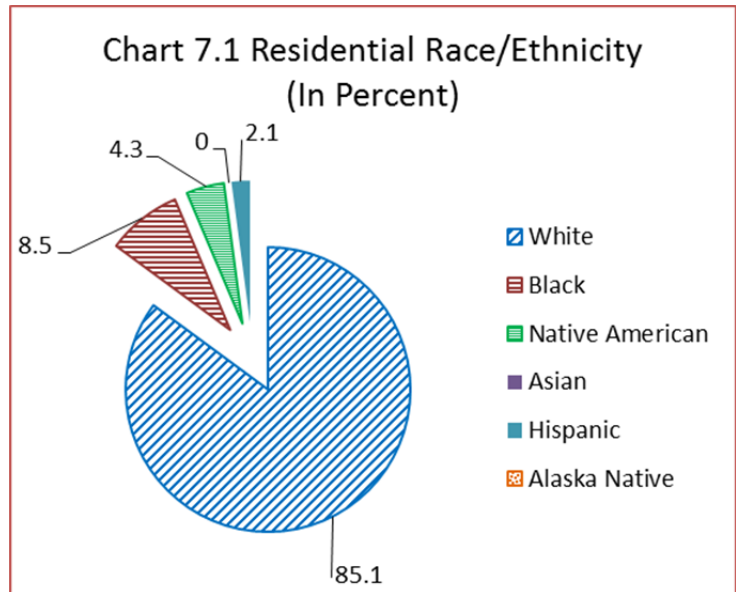
In order for individuals to be eligible for residential or respite care they normally need to have a referral from a state-approved gambling treatment program and are expected to be referred back to that outpatient program following treatment. During the period, 47, down from 55, individuals were enrolled. This was the third consecutive year of declining enrollment numbers. The decline was most noticeable in males for which 18 were reported this year, down from 27 last year. Approximately 19.2%, up from 13.1%, of the clients had received prior treatment at the program since 2009. There is a trend of seeing increasing numbers of prior clients returning that can be expected as the number of years increase. For those returning, the average number of treatments was 2.6.

The average age of clients in the residential program was 47.2, up slightly from 46.8 years. This was statistically similar to the age of those enrolling in the outpatient programs. There was also no significant

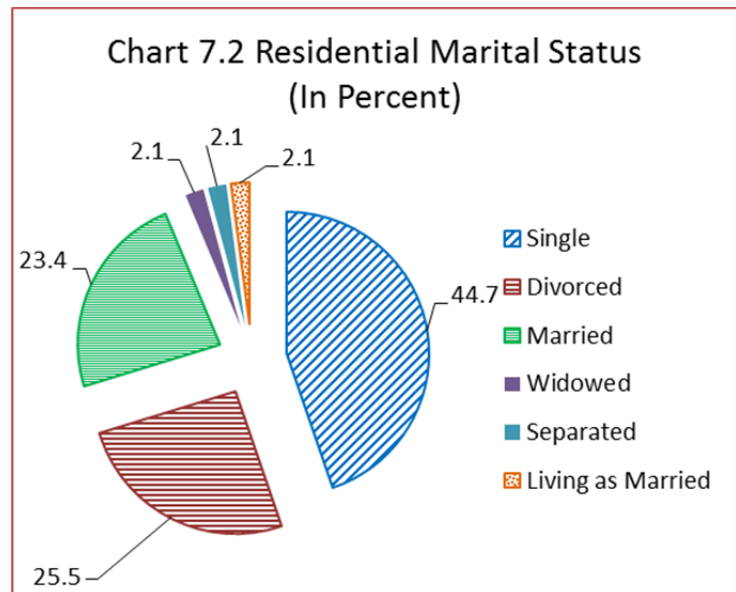
difference between males and females in regards to age. This year, approximately 61.7% were female, down from 50.9% previously reported. (Table 7.1)

	n	mean	sd
All	47	47.2	10.0
Males	18	45.0	9.6
Females	29	48.6	10.0

Approximately 85.1% of the clients were reported as White, 8.5% Black/African American, 4.3% Native American and 2.1% Hispanic/Latino. Differences in distribution across years and gender were not significant. (Chart 7.1)



This year the distribution of single clients increased to 44.7% from 32.7% and married also increased to 23.4% from 16.4%. The distribution of divorced clients decreased this year to 25.5% from 36.4%. Again this year, there was shifting of the distributions of marital status from last year but, due to the small sample size, none were statistically significant. (Chart 7.2)



The average annual household income was reported as \$24,984.50, up from \$17,392 previously reported. Although appearing to be a large difference it was not statistically significant. This

	n	mean	sd
All	46	24,984.5	30,687.3
Males	17	31,612.9	35,774.5
Females	29	21,098.9	26,507.6

year, females were somewhat more likely to report a lower average income at \$21,098 than males at \$31,612.90. The median income was \$24,000, up from \$21,600. The males' median income was reported as \$28,800 and females' was \$18,000. (Table 7.2)

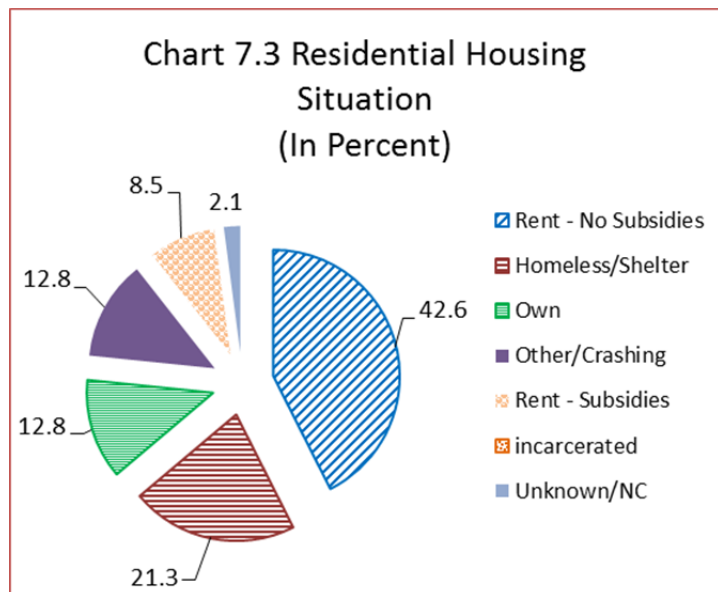
Approximately 85.1% of the residential clients were reported as having a debt related to gambling. The average gambling related debt was approximately \$46,416, up strongly, but not significantly from \$31,647 previously reported.

	n	mean	sd
All	40	46,416.0	70,479.1
Males	13	46,350.0	64,630.4
Females	27	46,447.8	73,128.5

Males' average debt of \$46,350 was essentially the same as females. (Table 7.3)

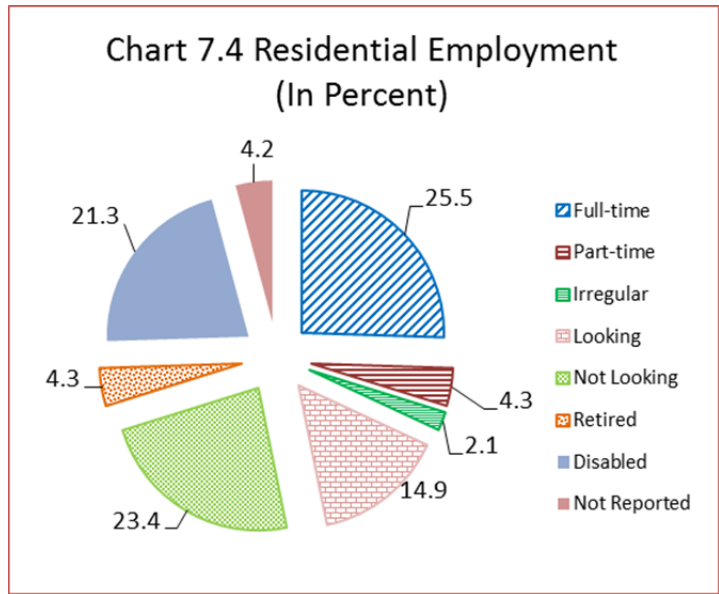
The average number of years of education was 13.0, down slightly from 13.4 reported last year. Females again were reported as having more years' education than males with 13.4 compared with 12.4 years for males.

This year, clients were significantly⁶³ less likely to report being homeless (21.3%) than previously reported (41.8%). This difference was also seen in the rent with no subsidies that rose to 42.6% from 21.8%. (Chart 7.3)



⁶³ P < .05

Again this year there was shifting in the distribution of employment categories. This year, 25.5% were reported as having full-time employment compared with only 10.9% last year. Part-time employment was reported for 4.3% this year down from 10.9%. The only two categories that remained



relatively constant were those working irregular hours and those reported as disabled. Due to the small sample sizes it was not possible to calculate statistically significant difference between females and males. (Chart 7.4)

The primary gambling activity of residential clients was again video line games, 70.2% compared with 69.1% previously reported. Video poker saw 21.3% compared with 16.4%. This year none of the clients reported slot machines and the distribution of cards

	All	Males	Females
Video Line Games	70.2	61.1	75.9
Video Poker	21.3	22.2	20.7
Cards	6.4	11.1	3.4
Animals	2.1	5.6	0.0

remained very similar to last year. Females tended to report video line games (75.9%) more than males (61.1%) while males reported cards (11.1%) more frequently than females (3.4%). Only males reported their primary gambling activity as animals. Due to the small sample sizes statistical analysis was not possible. Approximately 78.7% reported primarily gambling

at a lottery retailer (bar/pub) and 14.9% at a casino/IGC – essentially unchanged from the previous report. (Table 7.4)

The average age of first gambling experience was 19.5 year, down from 22.2 years. Males reported averaging 14.9 years old and females 22.3 years, down from 28.6 years. The average age of onset of problem gambling was reported as 35.4 years, up slightly from 34.7 years with males somewhat younger (33.1 years) than females (36.9 years).

The average number of DSM IV (10 items) criteria endorsed by the residential clients was 8.9 that was significantly⁶⁴ higher than the average 7.7 items endorsed by the outpatient clients. There

	All	Males	Females
Preoccupation	97.9	94.4	100.0
Increasing size of bets	97.9	100.0	96.6
Escaping	97.9	94.4	100.0
Unsuccessful attempts to stop	95.7	88.9	100.0
Returning to get even	95.7	94.4	96.6
Lying	95.7	94.4	96.6
Restlessness	93.6	88.9	96.6
Jeopardized relationship/job	91.5	100.0	86.2
Relies on others for money	74.5	66.7	79.3
Committed illegal acts	46.8	38.9	51.7

was no statistical difference between the males and females, and the only criterion that was less likely to be endorsed was that of committing acts that were not strictly legal. (Table 7.5)

Approximately 36.2%, down from 40.0%, of the residential clients reported having thoughts of suicide. One reported threatening suicide; 4.3%, up from 3.6%, reported having a plan; and, 2.1%, down from 7.3%, reported making an attempt at suicide in the past six months.

	All	Males	Females
Thoughts	36.2	33.3	37.9
Threat	2.1	0.0	3.5
Plan	4.3	11.1	0.0
Action	2.1	0.0	3.5

Females were more likely to report making an attempt but the difference was not statistically

⁶⁴ p < .01

significant due to the small sample size. (Table 7.6)

Approximately 51.1%, up from 41.8%, reported having employment problems; 12.8%, down from 16.4%, reported filing for, or planning to file, bankruptcy; 85.1%, up from 69.1%, reported relationship problems related to their gambling; and, 21.3%, down from 23.6% reported legal problems. The differences between years are reflective of the changing demographics of clients this year. (Table 7.7)

	All	Males	Females
Job	51.1	61.1	44.8
Bankruptcy	12.8	11.1	13.8
Relationship	85.1	94.4	79.3
Legal	21.3	33.3	13.8

Lag time from initial call to first availability of a bed was 5.8 calendar days, down significantly⁶⁵ from 13.2 days previously reported. The average number of work days to first available was 5.0 days

	n	mean	sd
All	47	5.8	9.0
Males	18	4.9	4.1
Females	29	6.3	11.0

down from 11.7 work days. The average lag time from first call to first seen was 10.7 calendar days, down from 14.5 days. There was no statistically significant difference between males and females. (Table 7.8)

Based on enrollment data, the average length of stay (LOS) at residential treatment was 46.7 days, up slightly from 44.7 days previously reported. For those successfully completing treatment, the average number of days enrolled was 64.4, up from 59.2 days. There was essentially no difference between males and females length of stay. (Table 7.9)

	n	mean	sd
All	46	46.7	29.6
Males	20	43.6	29.8
Females	26	49.2	29.2

⁶⁵ p < .01

The unadjusted successful completion rate was 60.9%, up from 51.8% previously reported. Approximately 20% were reported as refusing treatment, 8.7% leaving against staff advice (ASA), and 4.3% for non-compliance with rules. (Table 7.10)⁶⁶

	All	Males	Females
Successful	60.9	50.0	69.2
Client Refused	19.6	30.0	11.5
Against Staff Advice	8.7	5.0	11.5
Non-Compliance Rules	4.3	5.0	3.8
Physical/Mental Illness	4.3	5.0	3.8
Further Tx Not Appropriate	2.2	5.0	0.0

Based on encounter data, the average number of service days billed for all clients who were discharged during the year was 47.8 compared with 45.0 previously reported. For clients who successfully completed treatment the average number of

	n	mean	sd
Days			
All Gamblers	45	47.8	29.1
Successful Completers	28	64.3	18.7
Dollars			
All Gamblers	45	11,457.9	6,989.6
Successful Completers	28	15,410.4	4,566.6

billable days was 64.3 days compared with 59 service days previously reported. The average case cost for all clients was \$11,457.9 compared with \$9,888.0 last year. For those who successfully completed the program the case cost was \$15,410.4 compared with \$12,870.6 last year. (Table 7.11)

It should be noted for informational purposes that the residential facility was allowed to be credited with beds for up to seven days that were being held for clients whether they enrolled or not. During the report year this was done for 42 individuals for a total of 192 service days.

⁶⁶ In the past an adjusted successful completion was reported that was considered to be somewhat misleading.

8. MINIMAL INTERVENTION PROGRAM (GEAR)

The demonstration minimal intervention treatment program was initially fielded in July, 2001. The effort was conceived as filling the gap in available treatment for individuals who were experiencing problems associated with gambling, but would not meet the full diagnostic criteria as disordered gamblers. A secondary purpose of the demonstration was to serve disordered gamblers who could not access traditional brick and mortar outpatient programs due to disabilities or very distant proximity to the programs. The program was originally named SAFE (Statewide Assistance for Excessive Gambling) and the name was later changed to Gambling Evaluation and Reduction (GEAR).

Initially, GEAR was designed to utilize limited telephone counseling and a pragmatic, consciousness raising workbook, in a brief format, to provide a home based therapeutic intervention to prescribed callers/clients wishing to modify self-identified, negative gambling patterns. The philosophy of the model was strongly aligned with that of Motivational Interviewing, and was derived from the research of Dr. David Hodgins of Calgary, Canada.

After becoming operational, the intervention strategy lost fidelity with the model and changed significantly to only offering the participants the opportunity to call and speak with a counselor if they wanted to, instead of attempting to schedule the three to four counseling sessions in accordance with the evidenced based practice. With the introduction of a new contractor in 2007, the program appeared to have moved back towards a more proactive relationship with the clients and began accepting a few family clients.

The program is operated under a separate contract with the State by Emergence located in Springfield, Oregon. Historically, the program had not received as many referrals as expected and those who had been referred to the program, by-and-large, had serious

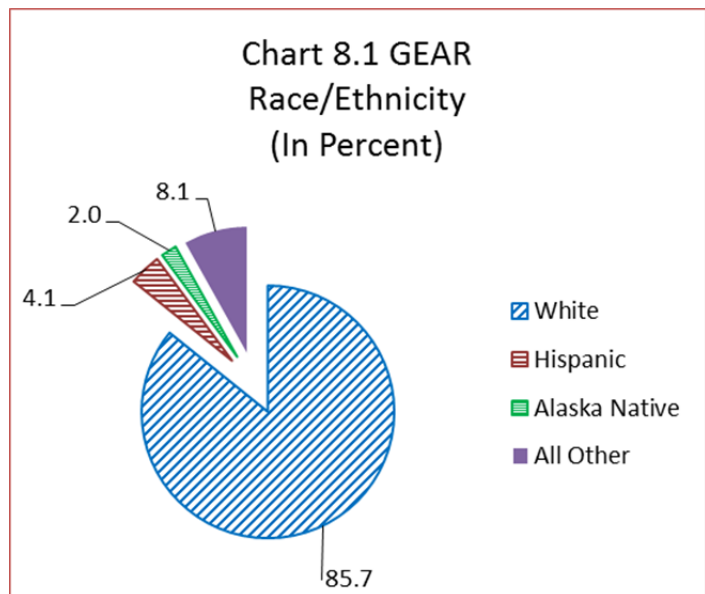
problems with gambling, and had been diagnosed as disordered gamblers. Due to funding shortages and lack of extensive utilization, the program was temporarily closed in FY 10-11 and refunded for a partial period of FY 11-12.

The total number of gamblers reported this year was 49 compared with 48 reported last year. This year 16 family clients were enrolled, up from five last year. Due to the very small number of family member clients, their data is excluded from this report.

The average age of clients was 57.8 years, significantly⁶⁷ older than the 51.3 years previously reported and significantly⁶⁸ more likely to be older than those in the outpatient programs. Females were somewhat younger than males this year were significantly⁶⁹ more likely than males to enroll in the GEAR program than as in the outpatient programs. (Table 8.1)

	n	mean	sd
All	49	57.8	13.4
Males	16	61.1	13.0
Females	33	56.2	13.3

Approximately 85.7%, down from 87.5%, were reported as White, while approximately 4.1%, down from 6.3%, were reported as Hispanic and 2.0% Alaska Native. (Chart 8.1)

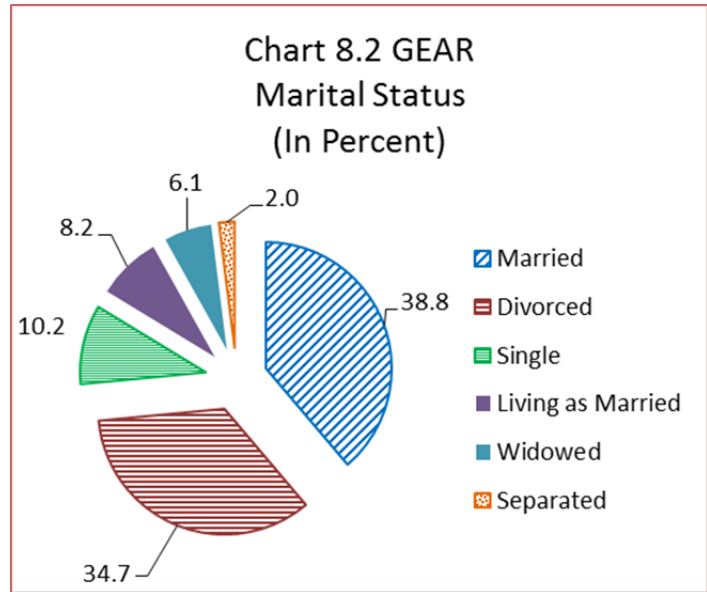


⁶⁷ p < .01

⁶⁸ p < .01

⁶⁹ p < .01

Approximately 38.8%, down from 35.4%, of those enrolling in GEAR were reported as being married; 34.7%, up from 31%, were reported as divorced; 10.2%, down from 22.9%, were reported as single never married; 8.2%, up from 2.1% were reported as living as married; and, 6.1% were



reported as widowed. These were not significant due to the small sample size and normal fluctuations due also to small sample size. (Chart 8.2)

The average annual household income for the GEAR clients was \$44,576.0, down from \$47,670.5. The median income was \$42,000, up from \$36,000 previously reported. The average income was somewhat higher than the outpatient

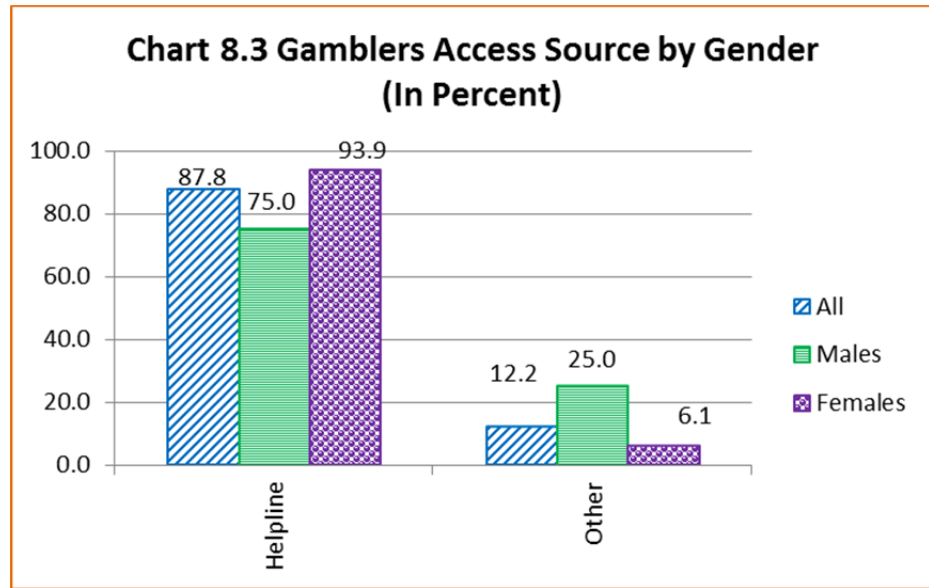
	n	mean	sd
All	48	44,576.0	30,518.6
Males	16	47,592.0	36,665.6
Females	32	43,068.0	26,796.8

clients' and there was no statistically significant difference between the genders. (Table 8.2)

The average numbers of years of education completed was 13.9, slightly more than 13.5 years previously reported with no difference significant between males and females. (Table 8.3)

	n	mean	sd
All	49.0	13.9	2.6
Males	16.0	14.9	2.0
Females	33.0	13.4	2.7

A majority of the clients (87.8%) reported accessing the GEAR program through the Helpline⁷⁰ and 12.5% reported



learning of the program from other sources such as previous clients (4.1%) and TV ads.

(Chart 8.3)

As previously reported, the primary gambling activity for both males and females were machines, 87.7% up from 85.4%, with some expected differences between the genders. Again the subsamples were too small to test for statistical significance. (Table 8.4)

	All	Males	Females
Video Poker	40.8	37.5	42.4
Slot Machines	26.5	12.5	33.3
Video Line Games	20.4	25.0	18.2
Cards	10.2	18.8	6.1
Scratch/Pull Tabs	2.0	6.3	0.0

Approximately 69.4% reported video lottery retailers as the primary location followed by casino/IGC 22.4%, essentially unchanged from the previous report. All other venues were only endorsed by one individual. Females were somewhat less likely to report casino/IGC (18.2%) than males (31.3%).

The reported lag time from initial call to first available was reported as 14.0 days, up from 12.5 days. There was essentially no statistical difference between males and females.

⁷⁰ It should be noted that the same agency operates the Helpline and GEAR.

The lag from initial call to first clinical contact was reported as 16.7 days, up from 15.6 days previously reported. (These longer lag times are an anomaly in that staff mail out the packet at the same time of the initial call, but have to wait until the prospective participant mails back the release and consent forms.)

Those enrolling in the GEAR program reported the age of their first gambling experience as 32.1 years, up from 27.1 years. Females were more likely⁷¹ reported an older age (35.6 years) than males (24.5 years). (Table 8.5)

	n	mean	sd
All	48	32.1	16.6
Males	15	24.5	14.9
Females	33	35.6	16.2

The average age of onset of gambling problems was 42.7 years, up from 37.4 years previously reported. Females were somewhat more likely to report older age (45.0 years) than males (38.1 years). (Tables 8.6)

	n	mean	sd
All	48	42.7	14.3
Males	16	38.1	14.8
Females	32	45.0	13.5

The average number of DSM IV criteria endorsed was 8.4, same as reported last year. This average was significantly⁷² greater than the average for the outpatient population which was 7.8.

Two males and one female were reported as having had thoughts of suicide in the past six months prior to enrollment while two females reported making suicidal threats. (Table 8.7)

	(%)
Thoughts	6.1
Threat	4.1
Plan	0.0
Action	0.0

One female was reported as having job problems and one

⁷¹ p <.05

⁷² p < .05

male reported having issues related to bankruptcy due to gambling.

The average length of time reported being enrolled in GEAR was 256.7 days, up from 249.1 days previously reported with no significant differences in length of stay for males and females. (Table 8.8)

	n	mean	sd
All	47	256.7	214.1
Males	14	228.9	173.7
Females	33	268.4	228.1

The average length of enrollment for those who were reported as successfully completing the program was 316.8 days, down significantly⁷³ from 405.8 days previously reported. Females who were reported as successfully completing the program remained longer than males but the difference was not significantly so due to the small sample size. (Table 8.9)

	n	mean	sd
All	22	316.8	151.8
Males	8	356.6	113.2
Females	14	294.1	165.7

The unadjusted successful completion rate was 46.8%, up from 37.5% previously reported. Although males were more likely to be reported as successful completers (57.1%) than females (42.4%) the difference was not significant.

⁷³ p < .01

9. CORRECTIONAL INSTITUTION PROGRAMS

For the regular reader of this report, the Coffee Creek Correctional Facility (CCCF) and the Columbia River Correctional Institution (CRCI) educational programs were discontinued in FY 15-16. In their place Cascadia Behavioral Health Care, in coordination with PGS and the Department of Corrections (DOC) implemented an “out-patient” based treatment service for those identified with gambling problems that was briefly discussed in earlier reports. This year a spin-off of the Cascadia model was implemented in the Oregon State Correctional Institution (OSCI) by a new contractor to PGS - Multicultural Consultants.

The Gambling Reduction & Recovery for Incarcerated Populations (GRIP) program’s purpose is to provide incarcerated individuals experiencing gambling problems with an opportunity to learn recovery skills. GRIP is offered only within existing DOC SUD treatment communities including Turning Point, LIFT, and Westcare.

GRIP is a one session per week for 12 weeks closed group-based psycho-educational treatment model focusing on increasing motivation for change; skill building and relapse prevention; identifying connections between substance, criminality and gambling; and, developing a wellness plan and connecting participants with recovery resources in the community before release. Efforts are made to maintain the group size at 12 individuals. This program is loosely based on the same curriculum as that used for the original minimal intervention program (GEAR) discussed above.

During the report period 91, down from 95 previously reported, incarcerated individuals were enrolled in the three programs with 23 at CRCI, 33 at CCCF, and 35 at

OSCI. Those enrolled at CCCF are all females. Due to the nature of these programs a much abbreviated dataset was utilized for the documentation and evaluation.⁷⁴

The average age of the CRCI participants was 38.1 years, down slightly from 38.7 years; for the CCCF participants the average age was 33.2 years, down from 39.7 years; for OSCI participants the average age was 34.7 years, up slightly from 33.1 years. Over the years the averages ages have fluctuated but with no trends developing. As expected, all three groups were significantly⁷⁵ younger than those in the

	n	mean	sd
CRCI Males	23	38.1	9.7
CCCF Females	33	33.2	8.0
OSCI Males	35	34.7	8.6

traditional outpatient programs. (Table 9.1)

As with the traditional programs, White/Caucasian was the largest racial/ethnic group in the corrections programs. Nonetheless, minorities were more likely to be present in the corrections programs than in the

	CRCI	CCCF	OSCI
White	56.5	84.8	65.7
Hispanic	30.4	6.1	22.9
Black	4.3	0.0	2.9
Native American	4.3	9.1	5.7
All Other	4.5	0.0	0.0

traditional outpatient programs, as would be expected, as they are more likely to be represented in the incarcerated population. (Table 9.2)

The average number of years of education for all programs was 11.7 years, significantly⁷⁶ less than that of those in the traditional outpatient programs and essentially unchanged from the

	n	mean	sd
CRCI Males	22	11.5	1.2
CCCF Females	33	12.1	1.0
OSCI Males	35	11.4	1.2

⁷⁴ Due to special request for corrections personnel some questions were not asked of these individuals during the intake process.

⁷⁵ p < .01

⁷⁶ p < .01

previous report. Average educational years were essentially the same as those previously reported. (Table 9.3)

As can be seen in the accompanying table, there are differences in the distributions among the programs, but due to small sub-sample sizes determination of statistical significance was not possible. (Table 9.4)

	CRCI	CCCF	OSCI
Single Never Married	39.1	51.5	62.9
Married	13.0	9.1	8.6
Widowed	0.0	0.0	0.0
Divorced	30.4	36.4	22.9
Separated	8.7	3.0	0.0
Living as Married	4.4	0.0	2.9
Not Reported	4.4	0.0	2.9

Overall, the average age of first gambling was 18.2 years, essentially unchanged from the previous report and significantly⁷⁷ younger than the outpatient population. Males were reported with an average age of 17.5 years and females 19.5 years. The difference was not statistically significant. (Table 9.5)

	n	mean	sd
CRCI	22	17.6	6.6
CCCF	33	19.5	7.7
OSCI	34	17.4	4.2

The average age of onset of problems related to gambling was 23.5 years, down from 25.8 years previously reported and significantly⁷⁸ earlier than that reported by the outpatient participants (keeping

	n	mean	sd
CRCI	22	24.5	6.6
CCCF	33	24.3	7.2
OSCI	34	22.1	6.3

in mind that this is a younger population and subsequently would expect lower ages of onset). Males were somewhat more likely to report a younger age (23.1 years) than females (24.3 years) and again mostly likely an artifact of the younger age range of the sample. (Table 9.6)

⁷⁷ p < .01

⁷⁸ p < .01

The average number of DSM criteria endorsed by this group was 7.1, up from 6.5 previously reported but still significantly⁷⁹ less than the average reported by those in the traditional outpatient programs. Males were significantly⁸⁰ more likely to report a smaller average number of endorsed criteria than females in the corrections programs. (Table 9.7)

	n	mean	sd
CRCI	23	7.5	1.9
CCCF	33	8.0	2.5
OSCI	35	5.9	2.7

Only 23.1% corrections participants were reported as having a debt related to gambling. The overall average debt was \$11,310.3 up from \$7,140.0 and no significantly different from the outpatient population. Males we reported as having an average debt of \$10,801.4 and females with an average debt of \$11,772.7. The difference was not statistically significant. (Table 9.8)

	n	mean	sd
CRCI	5	9,200.0	6,368.7
CCCF	11	11,772.7	28,001.1
OSCI	5	12,402.8	9,309.9

During the report period 84 cases were closed with 68 (81.0%) reported as successful completions. The average number of encounters overall was 10.6 with an average of 12.1 encounters for those reported as successfully completing their course of treatment. The average case cost overall was \$561.50 and for the successful completers it was \$634.00. (Table 9.9)

	n	mean	sd
Encounters			
All Gamblers	84	10.6	5.5
Successful Completers	68	12.1	4.8
Dollars			
All Gamblers	84	561.5	400.5
Successful Completers	68	634.0	400.3

⁷⁹ p < .01

⁸⁰ p < .01

10. PEER SUPPORT SERVICES

Peer Delivered Service is defined as any service in an array of agency or community-based services and support that is provided by peers, and peer support specialists, to individuals or family members with similar lived experience. These services are designed to support the needs of individuals and families as applicable by current policy.

A peer support specialist is defined by the state as a person providing peer delivered services to an individual or family member with similar life experiences, under the supervision of a qualified clinical supervisor. These individuals must complete a training program that is approved by OHA. They are individuals who have self-identified as a person in recovery from a gambling disorder, who meets the abstinence requirements for recovering staff in gambling addiction treatment programs; or a family member of an individual who is a current or former recipient of gambling addictions services. There are additional requirements regarding length of abstinence required as specified by the state.⁸¹

Prior to the issuance of the billing codes for peer services, Voices of Problem Gambling Recovery (VPGR)⁸² working closely with the Mental Health and Addiction Certification Board of Oregon (MHACBO) took the initiative to develop and implement a training curricula that would meet the certification standards of MHACBO and be consistent with standards associated with peer support in mental health and other addictions.⁸³ The terminology utilized by MHACBO is Certified Gambling Recovery Mentor (CGRM).⁸⁴

⁸¹ Extracted from Oregon PGS Procedure Codes and Rates 2015-16

⁸² A consumer-based 501 (c) 3 funded by PGS and based in Portland, Oregon

⁸³ Previously known as ACCBO, MHACBO is affiliated with the International Certification & Reciprocity Consortium

⁸⁴ The rehttp://accbo.com/general_images/pdf_files/PRCCertification.pdf

The first cadre of individuals was trained by VPGR in 2012 and the first formal MHACBO certifications were issued on June 1, 2012.

It was envisioned that peer support specialists would work with existing state-funded gambling treatment programs to increase engagement as well as successful program completion. Billing for peer support services of mentors working for traditional programs (not working for VPGR) was first used in October 2014; and, since initiation, only ten agencies reported any peer mentor encounters and only seven reported any encounters for the current report period. Several other agencies have accessed these services from VPGR and that activity is reported below.

The seven traditional agencies reported providing individual mentor services to a total of 22 clients, up from only seven previously reported.

Total Clients Served	22
Total Encounters Reported	61
Total Cost of Services	\$3,113.3

A total of 61 encounters were reported, up from only 17. The total cost of these agency-based services was \$3,113.30, up from \$761.40. (Table 10.1)

The average age of clients served by mentors was 44.3 years, down from 57.4 years previously reported. Approximately two-thirds were reported as successfully completing their outpatient course of treatment. (Table 10.2)

	n	mean	sd
All	22	44.3	13.3
Males	8	62.3	8.9
Females	14	50.4	12.3

In addition to the traditional treatment program-based peer services, VPGR continued to provide mentoring services with funding from Multnomah County for the opportunity to pilot a mentoring project that was community based (not run by a PGS funded treatment

program), but coordinated with local state-funded treatment programs,⁸⁵ and able to provide support services to individuals enrolled and not enrolled in state-funded treatment.

The first clients in the VPGR community mentoring project were enrolled in February, 2015. Since that startup, a total of 153 individuals have been reported as enrolled. During the report period a total of 41 clients were enrolled with 51.2% reported

	n	mean	sd
All	41	50.2	12.1
Males	21	47.5	14.1
Females	20	52.9	8.8

as female. The average age was reported as 50.2 years with females being somewhat older than males. (Table 10.3)

During the report period, clients were reported as coming from four state-funded agencies and the community. Approximately 85.5%, down from 91.5% previously reported, were from the state-funded agencies and 14.5% were from the

Volunteers of America	41.5
Lewis & Clark	22.0
Cascadia Multnomah	17.1
Bridgeway Residential	4.9

community including Gamblers' Anonymous (GA) 4.9% (not associated with any state-funded program). (Table 10.4)

During the report period, 23 cases were reported as closed with an 8.7% as successfully completing mentor services. Over the life of the project the evaluation team was able to match 85 mentor clients with their outpatient treatment program data. Of these, 79 had been discharged from the outpatient program with an unadjusted successful completion rate of 45.6%.

⁸⁵ This was state PGS funding that was not used for the established treatment programs in the County.

Encounter data was submitted for 63 active VPGR clients with approximately 2,726.8 direct service hours. The program is grant funded (not a fee for service model) so it is difficult to determine actual case costs. (Table 10.5)

Total Clients Served	63
Total Direct Service Hours	2,726.8

Overall the average number of contact hours was 0.8 hours per week per client. (These figures were not adjusted for length of enrollment.) During the year one participant averaged 5.7 services hours per week, three between two and four hours per week, and 16 with between one and two hours per week.

There were three mentors actively providing services during the year. Their level of effort averaged approximately 0.4 FTE each. Of the total hours reported, 2,331.75 were one-on-one activities with individual participants, 6 hours were services

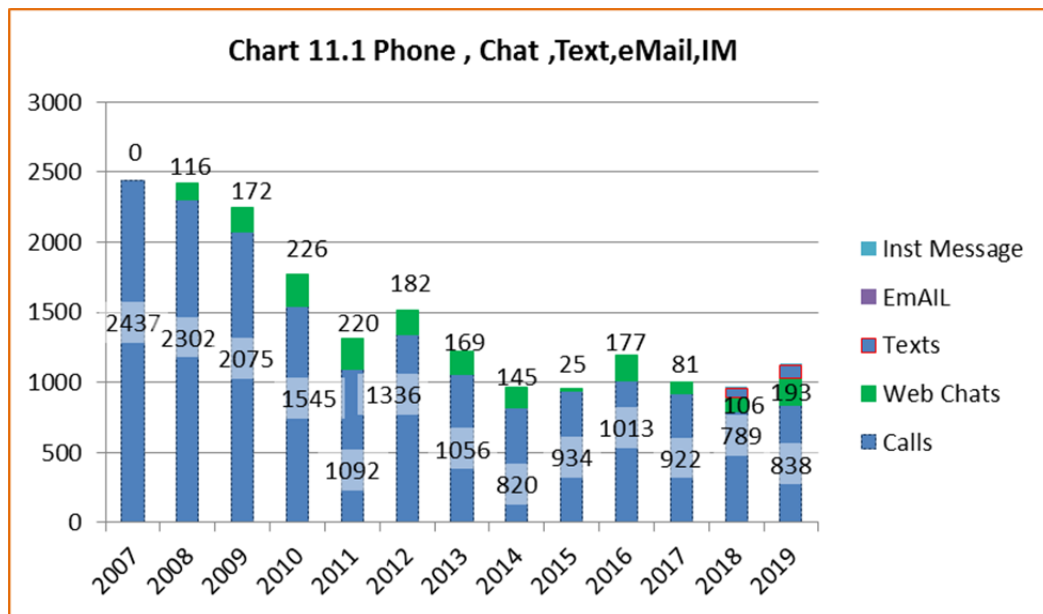
Individual Counseling	2,331.75
Group Counseling	6.00
Case Management	21.50
Supervision	78.00
Outreach	289.50
Total	2,726.75

provided with groups of participants, and 21.5 hours were reported as administrative, or case management, activities. Supervision hours were the time spent with their supervisor and outreach was primarily devoted to case finding and public informational sessions. (Table 10.6)

11. HELPLINE

The Helpline was originally established in 1995 under contract with a private national crisis call center and subsequently moved to a more specifically qualified agency that was also providing state funded treatment for gamblers and family. Since that time the Helpline has been staffed 24-7 by qualified gambling counselors who have hands-on experience within the problem gambling treatment setting. In 2009 (FY 08-09) the Helpline undertook the operation of a live chat web site that has been operational since and most recently added telephone texting capabilities.

Over the last ten years contact with the Helpline has remain depressed with some fluctuations compared to earlier years. This year 838 phone calls for assistance were reported to the evaluation team. The total number of chat sessions was reported as 193 and the number of text messages was 91. Two instant messaging contacts were also reported. Again there appears to be some potential issues with missing data. This is the second year the number of text messages has been reported. (Chart 11.1)



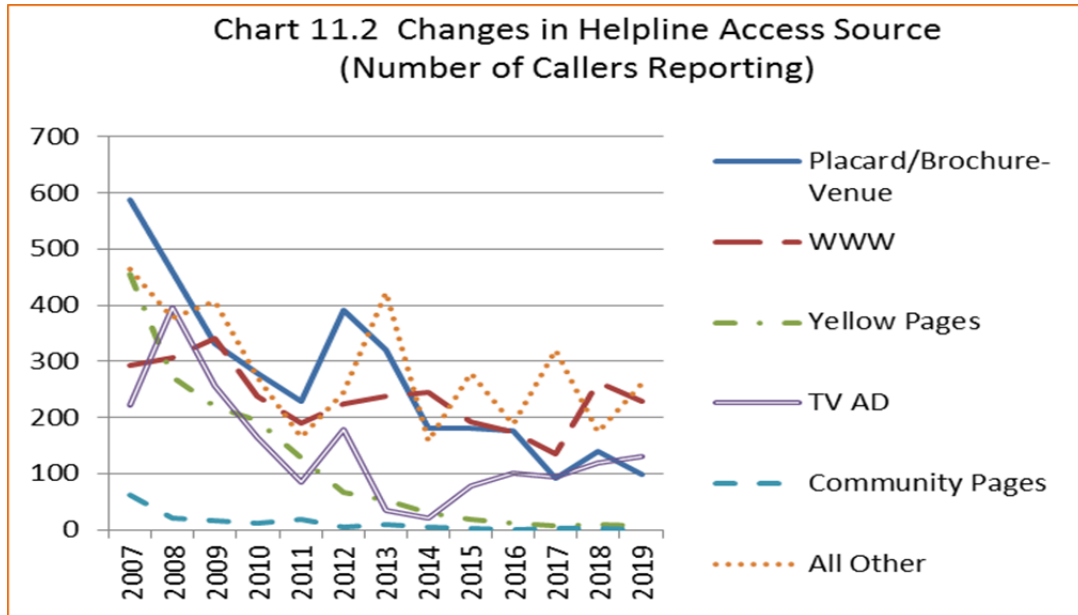
Tracking Spanish language calls was initiated for the FY 15-16 report period where 100 (9.6%) of all the calls for assistance were reported as Spanish speaking callers that year. The number of Spanish speaking callers has remained relatively stable since inception.

After individuals have engaged with the helpline staff and any impending crisis has been sufficiently resolved, the callers are asked a short series of questions to track both the nature of the call and how the caller acquired the Helpline phone number.

During the current reporting period, and as previously reported, the most frequently cited access source for the contact information was the phone number was the internet (31.4%), followed by TV advertisements (17.9%), VLT placard (13.5%) and print advertisement (11.3.%) which increased from 0.3% previously reported. The somewhat large distribution in the other field was comprised of approximately 20% family or friends plus a large amount of missing data. (Table 11.1)

11.1 Access Source for Contact Info (In Percent)	
WWW/Internet	31.4
TV Ad	17.9
VLT Placard	13.5
Print Ad	11.3
Brochure/Poster Local	5.0
Radio	1.8
Brochure/Poster Community	1.0
Yellow Pages	1.0
Billboard	0.7
Print Story	0.1
White Pages	0.1
Community Pages	0.1
Presentation	0.0
TV Program	0.0
Other	16.1

As can be seen in the accompanying table, sources for the phone number have fluctuated extensively due to a plethora of intervening variables over the years such as the movement towards technology and use of the internet. (Chart 11.2)⁸⁶



Approximately 57.0%, up somewhat from 52.8% of the calls reported were made during normal work hours. After-hours calls (weekdays) remained relatively stable at 16.3% and weekend calls dropped a bit to 26.7% from 29.7%. (Table 11.2)

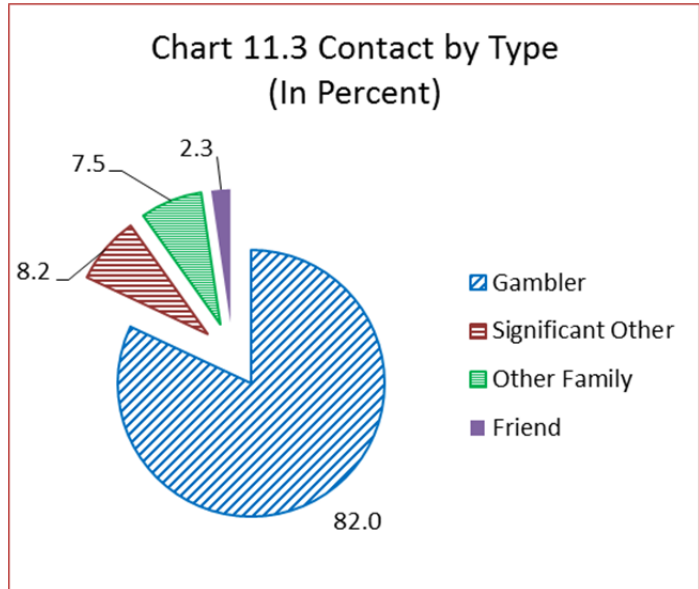
Normal Work Hours	57.0
After Hours	16.3
Weekend	26.7

Approximately 82.0%, down from 83.3%, of the contacts for assistance, or information, were reported as coming from the individual who was experiencing the gambling problem. Approximately 8.2%, down slightly from 8.8%, came from a spouse or significant other and another 7.5%, up from 5.9%, from other family members. Approximately 2.3%, essentially the same as previously reported, of the contacts were reported as coming from a

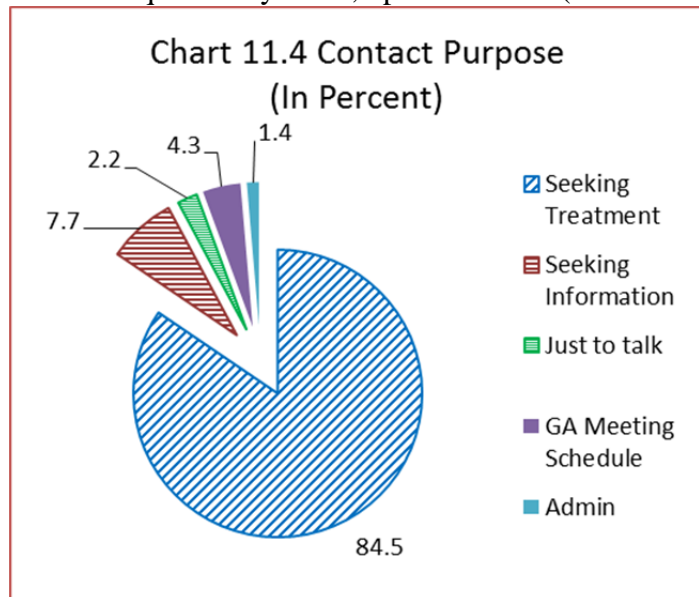
⁸⁶ There was extensive missing data for FY 16-17 therefore that time period should be viewed with caution.

concerned friend or co-worker. This distribution of the type of individuals contacting the helpline services has remained fairly constant over the years. (Chart 11.3)

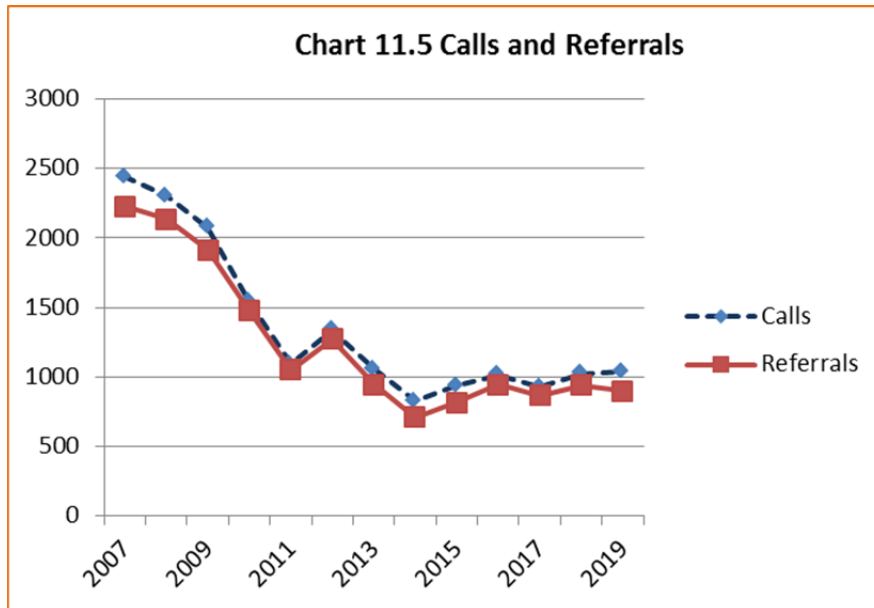
The majority of contacts were from those seeking treatment with a distribution of 84.5%, down from 89.7% previously expected. Approximately 7.7%, up from 2.5%, contacted helpline services seeking information about treatment of problem gambling and 2.2% just to talk for support. Information regarding GA was requested by 4.3%, up from 3.2%. (Chart 11.4)



The Helpline staff is equipped to make “hands on” (direct connect) referrals to treatment agencies throughout the state. These types of referrals are usually restricted to normal working hours when treating agency personnel are available.



During the report period 181, down from 221, direct referrals were reported. Overall, 86.5% of all calls resulted in a referral to a local treating agency. (Chart 11.5)



Sixteen individuals, up from twelve previously noted, were reported as experiencing suicidal ideation, three were reported with having recent attempts, two with a plan but not considered to have a means of carrying out the plan, and one with both a plan and the means to carry out the suicidal plan. (Table 11.3)

Ideation	16
Plan/Means	1
Plan/No Means	2
Recent Attempts	3

There was an extremely large amount of missing data submitted to the evaluation team regarding demographic information. The rationale for the missing data has been attributed to the nature of many crisis calls where the collection of demographic information is secondary to dealing with the emergent crisis. Nonetheless, with approximately 20% missing data in the gender field, approximately 51.8% of those reported were males.

The race/ethnicity field experienced 40% missing data. Based on the data reported, 70.7% were White, 17.3% Hispanic/Latino, 4.0% Black/African American, and 2.3% Asian.

Finally, the birthdate field experienced 36% missing data and the resulting average age was 41.3 years old. Again this data should be viewed with a good deal of caution.

12. Family Client Demographics

In 1995, when the pilot programs were consolidated statewide, a well-supported decision was made to incorporate funding for family treatment. From the start, this treatment was envisioned to be capable of stand-alone effectiveness (i.e., to provide value to the family member by increasing personal well-being), as well as developed strategies to effectively break unhealthy family interactions, even if the gambler was not concurrently enrolled in treatment.

The operational definition of family members included immediate family, extended family (e.g., parents of adult children who are problem gamblers, but not living at home), and other individuals who were key social supports for the problem gambler (e.g., occasionally a best friend or key co-worker/employer).

This year, the number of family clients enrolled in the traditional outpatient programs was 104, down from 112. Females were much more likely⁸⁷ to be enrolled, 75.0%, up from 73.0%, than males. This year females were somewhat more likely to be older than males (46.2 years compared with 45.7 years). There were seven individuals enrolled in family treatment who were younger than 18 years old. Six were

Table 12.1 Family Average Age (In Years)

	n	mean	sd
All	104	46.1	17.4
Males	26	45.7	21.3
Females	78	46.2	15.9

Table 12.2 Family Relationship to Gambler (In Percent)

	All	Males	Females
Spouse/SO	63.7	43.5	70.6
Parent	14.3	17.4	13.2
Child	16.5	30.4	11.8
Sibling	2.2	4.4	1.5
Other Family	2.2	4.4	1.5
Co-Worker/Friend	1.1	0.0	1.5
Employee/Employer	0.0	0.0	0.0
Other	0.0	0.0	0.0

⁸⁷ p < .05

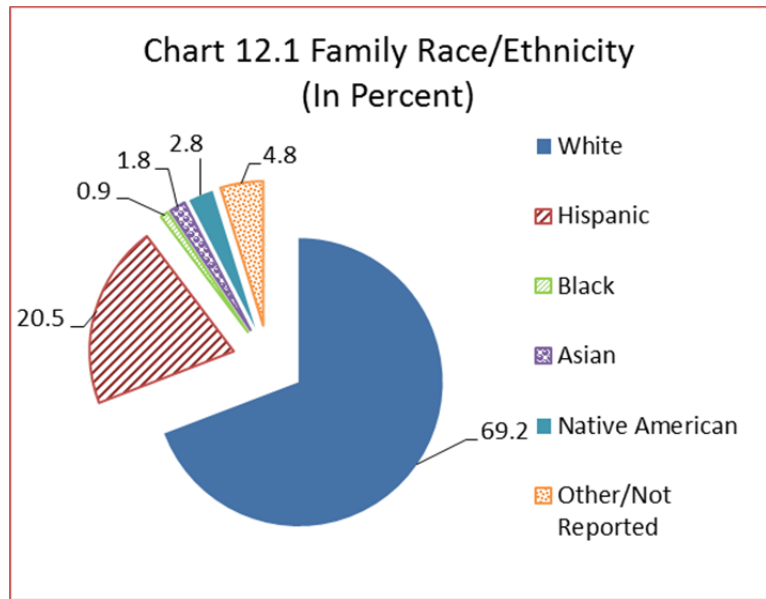
from Lewis & Clark and one from Deschutes (Table 12.1)

The majority, 63.7%, down slightly from 65.3%, of family clients were the spouse or significant other (SO) of a gambler with the SO significantly⁸⁸ more likely to be female as consistently reported in previous reports. Parents represented 14.3% of the participants and children 16.5%. (Table 12.2)

Approximately 52.0% of the family members were reported as having a family member identified as enrolled in gambler treatment. As consistently reported previously, male gamblers were significantly⁸⁹ more likely to have a female family member attending treatment than females. This year, gamblers successfully completing treatment during the year were not significantly more likely to have a family member enrolled in treatment. (Table 12.3)

Gambler Male - Family Male	9.4
Gambler Male - Family Female	65.6
Gambler Female - Family Male	12.5
Gambler Female - Family Female	12.5

Family client race/ethnicity somewhat mirrored that of the overall gambler population as would be expected. The majority were



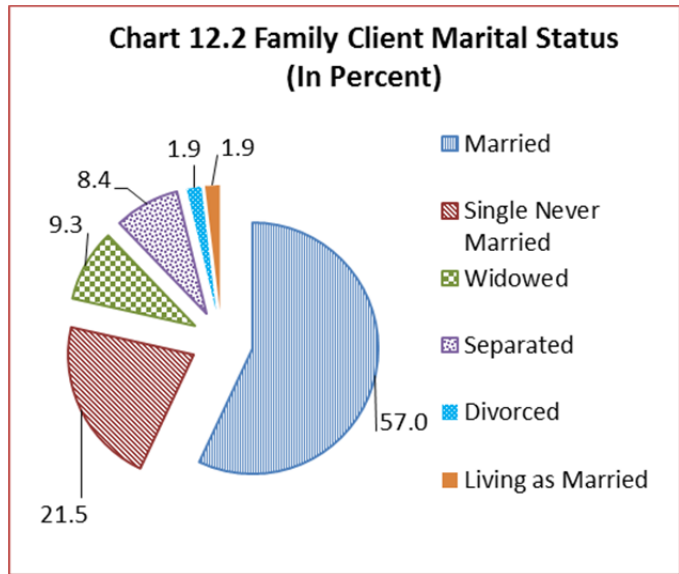
reported as White, 69.2%, down from 73.2%, followed by Hispanic, 20.5%, up from 16.1%, Native American 2.8%, Asian 1.8% and Black/African American 0.9%. The increase in

⁸⁸ p < .05

⁸⁹ p < .01

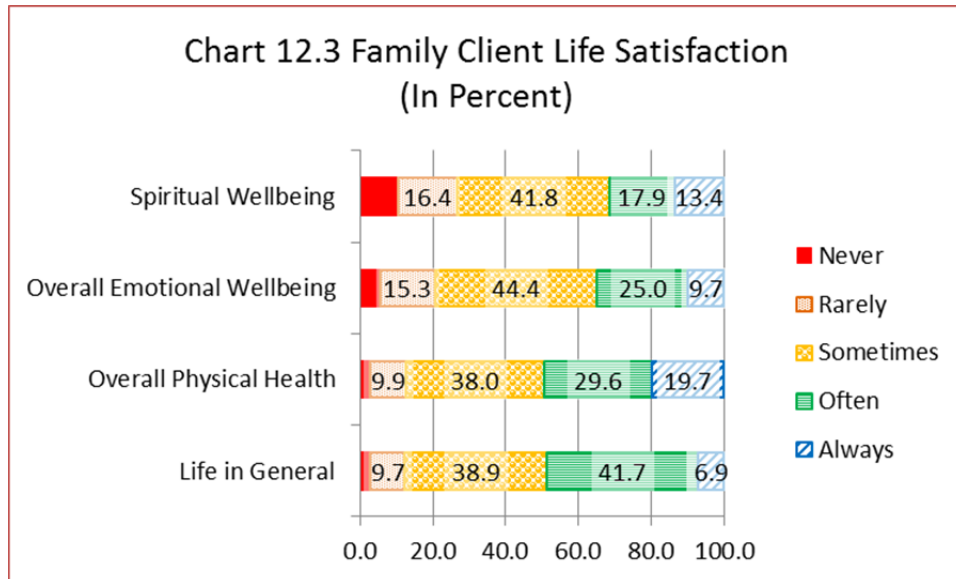
Hispanic family clients was attributed to the increased emphasis on Spanish speaking programs implemented in Multnomah, Clackamas, and Washington counties by Lewis & Clark College as well as the implementation of a special contract with the College to strengthen family care statewide. (Chart 12.1)

Approximately 57.0%, down from 67.0%, of the family clients were married, 21.5%, up from 12.5% ,were reported as single - never married, 9.3% widowed, 8.4% separated, and 1.9% divorced. (Chart 12.2)



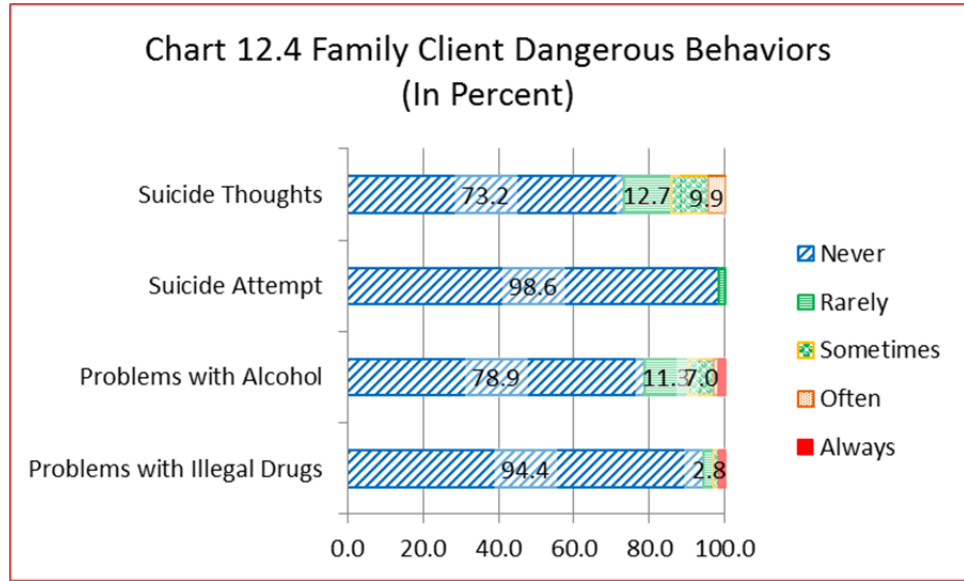
At enrollment, family clients were only moderately satisfied with

their life in general and overall physical health. Satisfaction with spiritual and emotional wellbeing was low similar to last year. (Chart 12.3)



Approximately 26.8%, up from 15.9%, of the family members reported having any thought of suicide in the past six months, with 4.2% reporting often. Approximately 1.4% reported

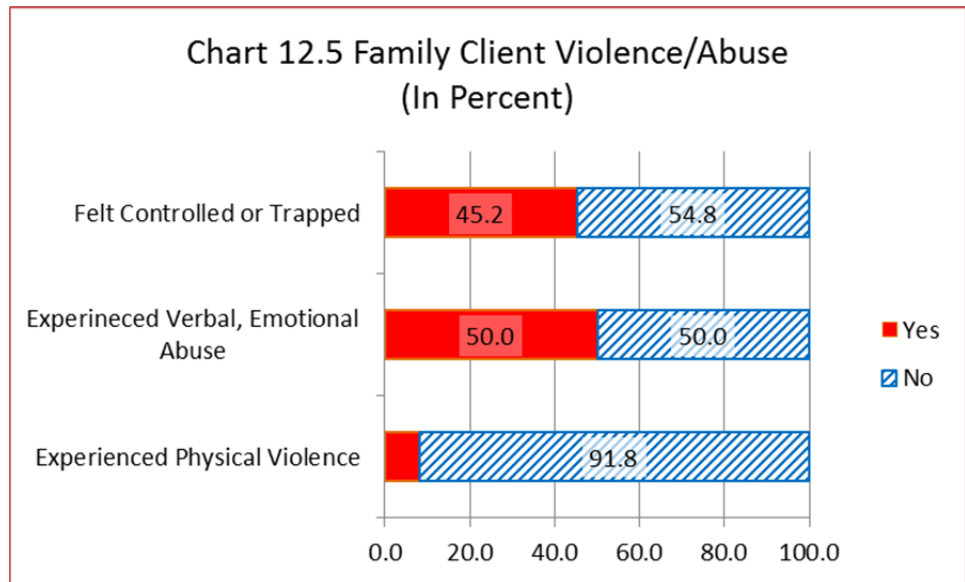
attempting suicide rarely. Having any problems with alcohol were endorsed by 21.1% of the family clients and



5.6% reported having any problems with drugs. These markers can vary significantly from year to year but do not demonstrate any trends. (Chart 12.4)

Approximately 8.2% of the family clients reported experiencing any physical violence

in the previous six months, while 50% reported experiencing verbal or emotional abuse and 45.2%



reported feeling controlled or trapped in their relationship. These findings are similar to those previously reported. (Chart 12.5)

Family clients reported moderate helpfulness of their aftercare plans at six month follow-up and all

of those

contacted at

twelve months

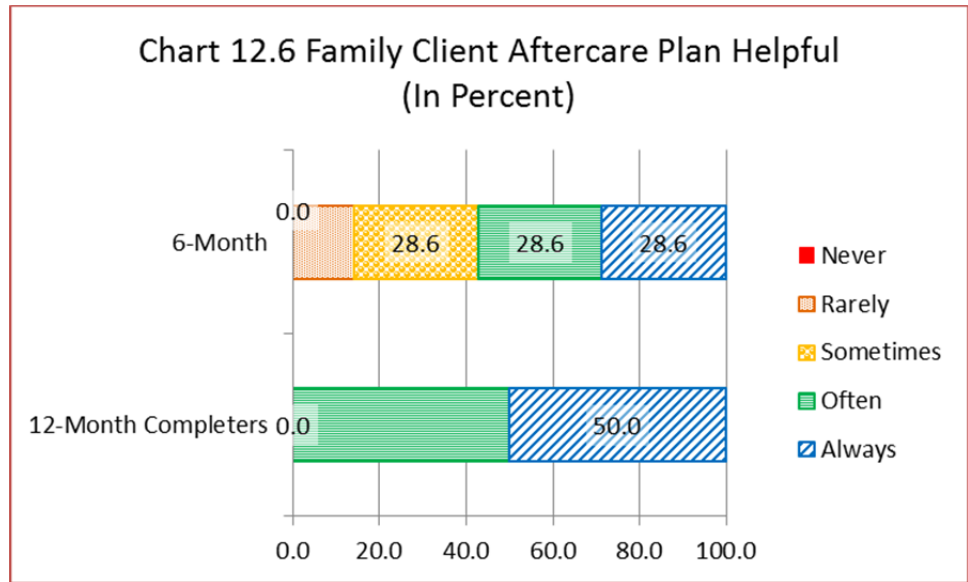
reported their

aftercare plan

helpful always or

often. It should

be noted that

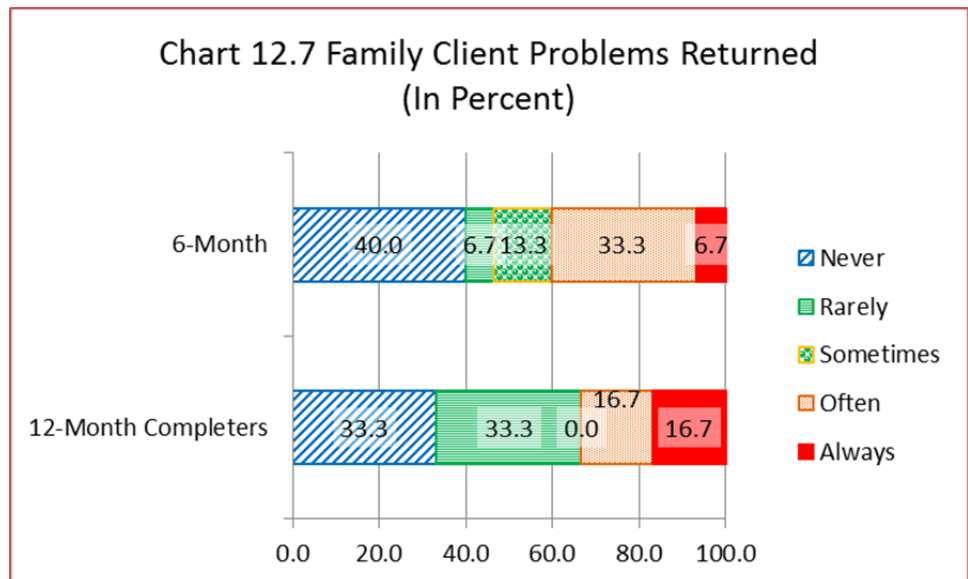


family treatment encompasses an extremely broad range of care – from simple short-duration education to in depth, long term therapy – based on the needs of the individual. With this in mind, satisfaction with continuing care, or aftercare plans, also has a broad range of meaning

for the family clients. (Chart

12.6)

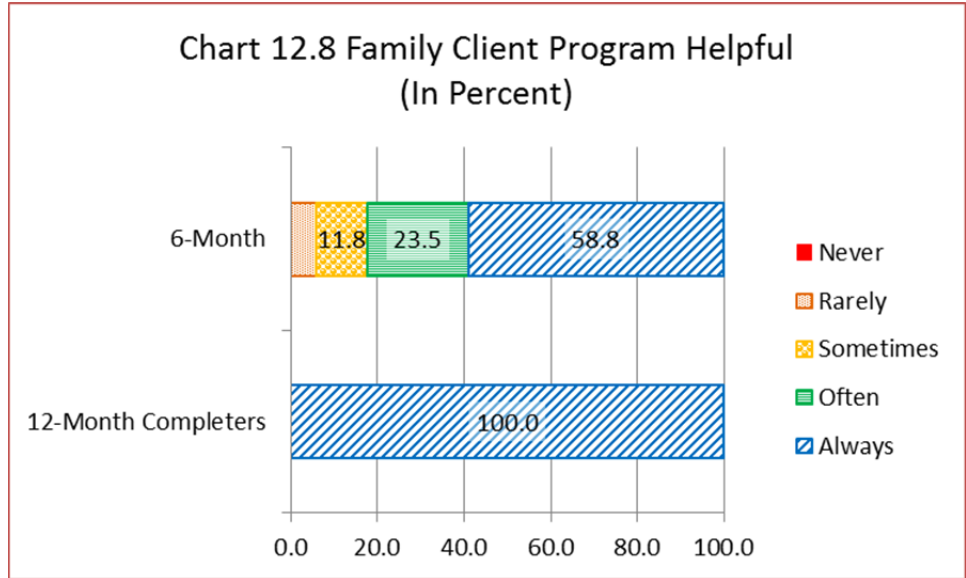
About 46.7% of the family at six-month follow-up



reported that the problems that brought them to treatment had returned never or rarely. For the participants in the twelve-month follow-up that distribution was approximately 66.6%.

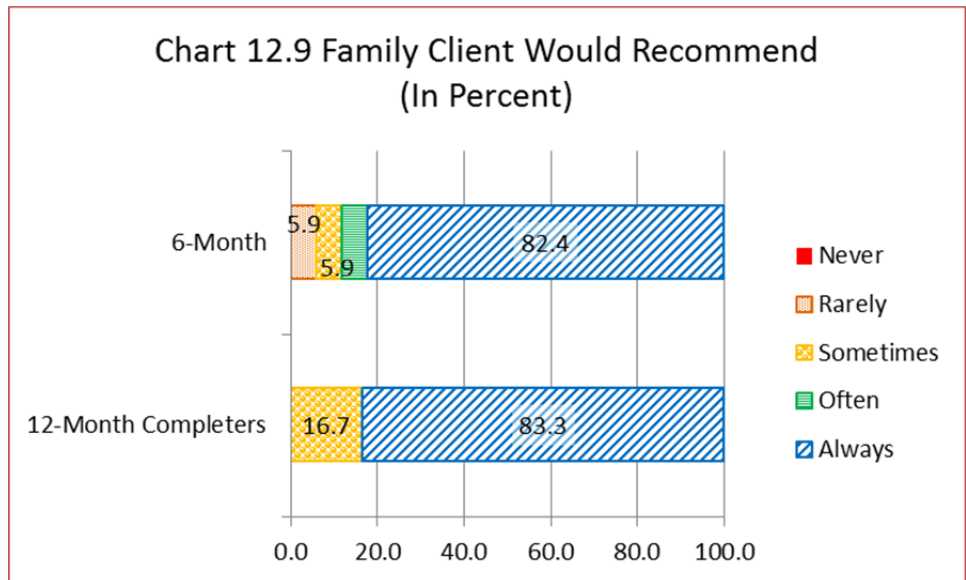
(Chart 12.7)

About 82.3% of the six-month sample reported the family program helpful always or often and 100% of the



twelve-month follow-up reported the program was helpful always helpful. (Chart 12.8)

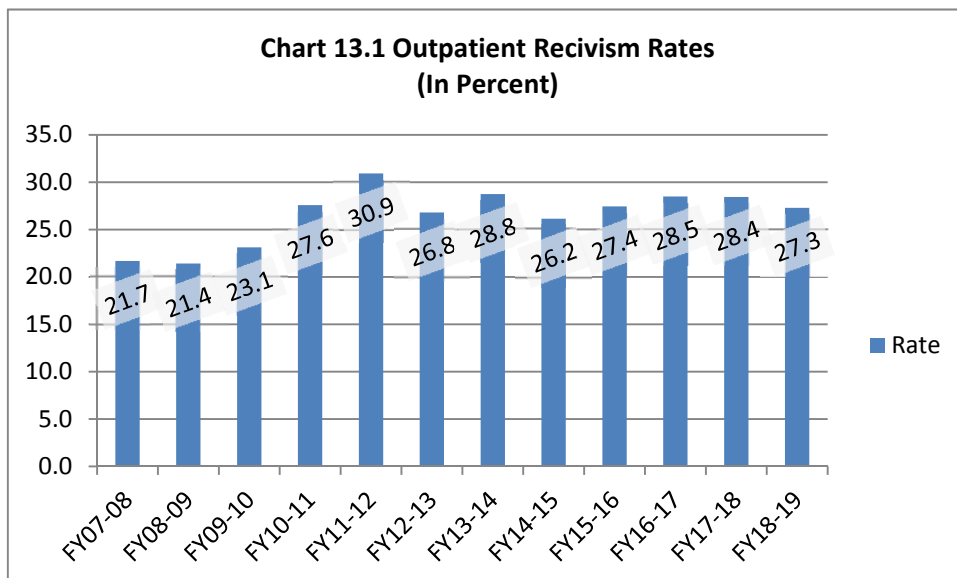
A moderate willingness to recommend the family program to others was reported by participants in



both the six and twelve-month follow-up groups. (Chart 12.9)

13. COMMENTS AND SUMMARY

Returning enrollment rates have remained somewhat stable over the past ten years averaging 28.0% of the outpatient



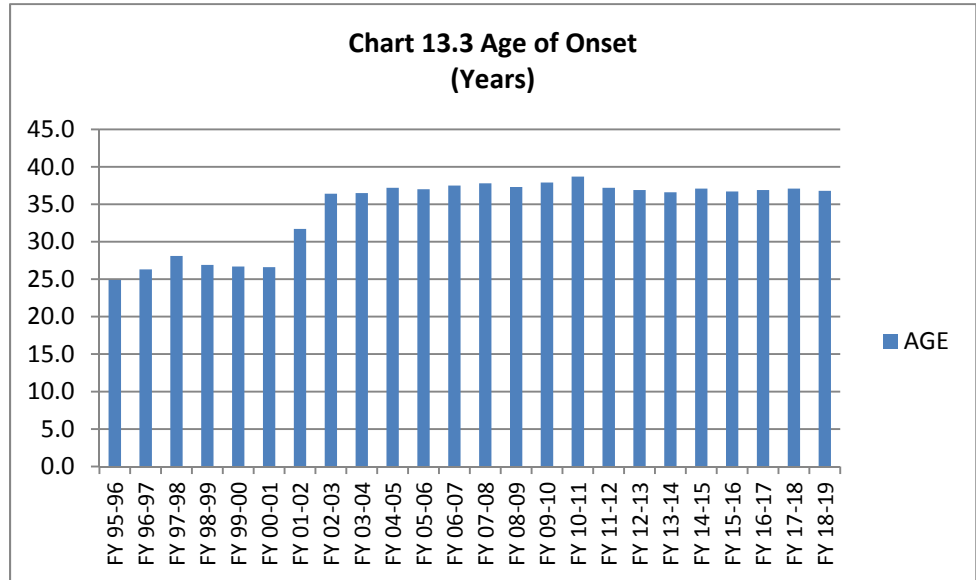
enrollments with a range from 26.2% to 30.9%. This year the recidivism rate was 27.3%. As noted the past few years in the annual reports, adult prevalence studies conducted in Oregon since the late 1990's have generally seen a fairly stable rate of problem gambling in the adult population. These studies have also suggested a decline in the rate of gambling by adults in Oregon. The National Council on Problem Gambling also reports that this decline in enrollments is being seen on a national basis. (Chart 13.1)

As noted above, the Oregon Lottery has an extensive history of promoting responsible gambling as well as access to treatment. Over the last five fiscal years the amount of that investment has risen from approximately \$0.7 million to approximately \$2.8 million last

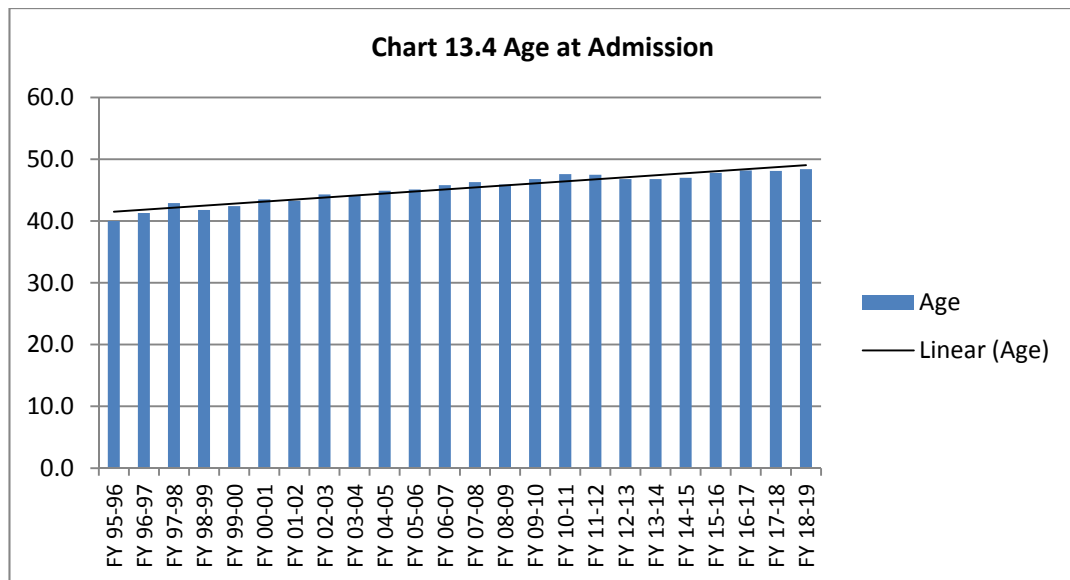


year. It is seemingly apparent that this investment did not increase enrollments in treatment, but the argument could be made that it had a continuing preventative impact. (Chart 13.2)

In the first decade of treatment availability, the age of onset of problem gambling rose significantly⁹⁰ from an average of



24.9 years to 37.2 years with the first the major jump in years coming for FY 00-01 to FY 02-03. However, that trend has not continued since with a current age of 36.8 years and an average over the past 10 years of 37.2 years of age. (Chart 13.3)



⁹⁰ p < .01

Further analysis of the available historic data continued to demonstrate, that since inception of the outpatient treatment programs, the average age at the time of enrollment has continued to increase. In fact, the difference in the current age at enrollment of 48.4 years compared to 46.8 years in FY 09-10 was statistically⁹¹ significant. Just in the past five years the increase has been statistically⁹² significant. (Chart 13.4)

As expected, the average age of individuals reenrolling in the same agency was 52.4 years, significantly⁹³ older than the 46.9 years of those enrolling for the first time (in the same agency). Looking at the average age of those enrolling for the first time over the past 10 years found no significant change that ranged approximately from 45.6 years to 46.9 years.

It is apparent that the demand for treatment has diminished in the general population, but the one remaining question would be what would have potentially happened to enrollments if these outreach, responsible gambling, and treatment promotion efforts had not been in place. Also in play are the prevention efforts discussed in Section 3 of this report as those efforts in the schools and community have been in place long enough that many younger adults in Oregon have been exposed to preventative measures for problem gambling.

Although beyond the scope of this report, there are potentially untapped populations that could benefit from disordered gambling specific treatment. As discussed in Chapter 9, therapeutic treatment interventions were continued in the three prisons. A recent study in Oregon⁹⁴ strongly supported the potential need for additional intervention into disordered gambling within the corrections system.

⁹¹ p < .01

⁹² p < .01

⁹³ p < .001

⁹⁴ Not released for publication at the time of this report.

As discussed in Section 6, over one-third of the outpatient gamblers were reported as having prior mental health treatment or SUD treatment (with an average of about three prior episodes). The co-occurrence and/or co-morbidity of disordered gambling with other mental health and substance use issues are well documented and it is estimated that a relatively large portion of the mental health and addictions patients could benefit from problem gambling specific treatment.

APPENDIX A: SOCIAL ECOLOGICAL MODEL

Applying a Socio-Ecological Model to Prevention

Health disparities are created and can be averted by considering multi-layered determinants of health behaviors. We are influenced not only by traits specific to us or what we think and believe, but by our relationships with others, by the institutions and communities to which we belong, and by broader society in which those institutions and communities are embedded. The socio-ecological model allows us to consider the different contexts in which risk and protective factors exist and to intervene using evidence-based programs, practices, policies

and strategies that influence those factors at the various levels.

Individual Level:

Includes strategies that focus on the individual.

Relationship Level:

Includes strategies that involve the individual's social circle, such as family and peers.

Community Level:

Includes strategies that focus on the settings where social relationships occur such as schools, workplaces, and neighborhoods.

Societal Level:

Includes strategies that focus on changing social and



cultural norms such as broad-based policy changes.

Reference: SAMHSA – Using Prevention Research to Guide Prevention Practice
SAMHSA's Center for Application of Prevention Technologies (January 2016)

APPENDIX B: STRATEGIC PREVENTION FRAMEWORK

The US Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) is a planning process for preventing substance use and misuse.

The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and involves community members in all stages of the planning process.

Diagram showing the five steps of the Strategic Prevention Framework centered around the guiding principles of sustainability and cultural competence:

The steps of the SPF include:

- Step 1: Assess Needs: What is the problem, and how can I learn more?
- Step 2: Build Capacity: What do I have to work with?
- Step 3: Plan: What should I do and how should I do it?
- Step 4: Implement: How can I put my plan into action?
- Step 5: Evaluate: Is my plan succeeding?

The SPF also includes two guiding principles:

- Cultural competence: The ability to interact effectively with members of diverse population
- Sustainability: The process of achieving and maintaining long-term results



Reference: SAMHSA – Using Prevention Research to Guide Prevention Practice
SAMHSA's Center for Application of Prevention Technologies (January 2016)

APPENDIX C: CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) STRATEGIES

Information Dissemination

This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services.

Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. [Note: Information dissemination alone has not been shown to be effective at preventing substance abuse.]

Community-Based Process

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Education

This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Alternatives

This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to--or otherwise meet the needs usually filled by--alcohol and drugs and would, therefore, minimize or obviate resort to the latter. [Note: Alternative activities alone have not been shown to be effective at preventing substance abuse.]

Problem Identification and Referral

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Environmental

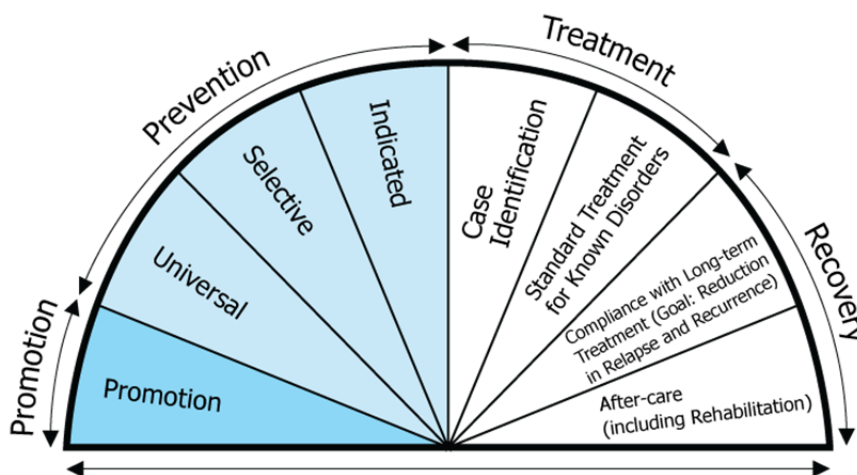
This strategy establishes changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Reference: Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies. (2002). Best and Promising Practices for Substance Abuse Prevention (3rd ed.). Also available online: <http://www.unr.edu/westcapt/bestpractices/bpcsap.htm>

APPENDIX D: THE BEHAVIORAL HEALTH CONTINUUM OF CARE MODEL

The Behavioral Health Continuum of Care Model helps us recognize that there are multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes the following components:

Behavioral Health Continuum of Care



- Promotion—These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- Prevention—Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- Treatment—These services are for people diagnosed with a substance use or other behavioral health disorder.
- Recovery—These services support individuals’ abilities to live productive lives in the community and can often help with abstinence.

Reference: SAMHSA – Prevention of Substance Abuse and Mental Illness (<http://www.samhsa.gov/prevention>).

APPENDIX E: OREGON PREVALENCE CITATIONS

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- Volberg, R.A., Hedberg, E.C. & Moore, T.L. (2008). Oregon Youth and Their Parents: Gambling and Problem Gambling Prevalence and Attitudes. Salem, OR: Oregon Department of Human Services.

APPENDIX F: BRIEF HISTORY OF LEGAL GAMBLING AND PROGRAM DEVELOPMENT

- 1933 Legislature legalizes pari-mutuel wagering on horses and dogs (same year repeals prohibition)
- 1973 Social gambling legalized in counties and cities
- 1976 Constitutional amendment legalizes charitable gambling (bingo, raffles)
- 1984 Constitutional amendment creates The Oregon Lottery (Scratch-its™ Megabucks™)
- 1987 Legislature legalizes off-track pari-mutuel wagering
- 1989 Multi-state lotteries incorporated into Lottery
- 1989 Lottery introduces Sports Action™ (Stopped in: NFL 1990; NBA 2007)
- 1991 Lottery introduces Keno™
- 1991 Contentious legislative session approves video poker but only with 3% of net to treatment (ORS 461.549 1992 – amount to 1%)
- 1992 Video Poker machines introduced
- 1992 Treatment programs established (ORS 409-435); Problem Gambling Treatment Fund created (ORS 409.430); Funding DAS to Counties (no apparent restrictions)
- 1993 First of nine IGCs established (Federal Indian Gaming Regulatory Act 1988)
- 1994 State Supreme Court rules PG treatment funding illegal under constitution. Legislature takes action and funded at 1%
- 1995 PG Treatment consolidated statewide Association of Community Mental Health Providers (AOCMHP)
- 1995 Helpline established
- 1996 Governor's Taskforce (Executive Order 96-03)
- 1996 2nd Iteration of the Oregon Council established as Oregon Gambling Addiction Treatment Foundation
- 1997 Adult Gambling & Prevalence Study (Volberg)
- 1997 Adolescent Gambling Study (Moore & Carlson)
- 1998 Oregon Council received permanent IRS non-profit status finding
- 1999 Administration of Problem Gambling Services moved to AMH and at least 1% of lottery proceeds to services (SB 118) (ORS 409.435 and ORS 461.549).
- 2001 PG treatment & prevention services commences with state employees
- 2001 First of two respite treatment programs opened
- 2001 Win for Life introduced
- 2001 Adult Gambling Replication Study (Volberg)
- 2001 Older Adult Gambling Prevalence Study (Moore)
- 2001 PGS expands for two to fifteen 15 regional prevention programs
- 2002 Etiology of Pathological Study (Moore)
- 2003 PGS prevention activities moved away from generalized treatment programs to performance based contract
- 2003 PGS funding slated for elimination (HB5077 and the rejection of a surtax)
- 2003 Number of Lottery VLTs increases from five to six
- 2003 First annual Problem Gambling Awareness Week (OPGAW) consolidated activities including first art search for PG posters
- 2003 Development of first OPGAW Community Resource Guides

- 2004 Emergency Board restores expenditure authority but budget reduced
- 2005 All Oregon counties receive problem gambling prevention funds
- 2006 Adult Gambling Prevalence Replication Study (Moore)
- 2006 Adult Residential Gambling Treatment Program opened in Marion County.
- 2007 Line games introduces on VLTs
- 2007 RFP issued for the establishment of what would become the Voices of Problem Gambling Recovery
- 2007 Teen gambling video “It’s a Risky Deal” created and distributed
- 2008 First PG Services calendar distributed utilizing artwork from middle school student art search
- 2009 Helpline incorporates live web chat
- 2009 Development of Problem Gambling Prevention Coordinators website
- 2010 Adolescent Gambling Study (Volberg)
- 2010 Implementation of Online Problem Gambling “101” training
- 2011 Prevention Infusion Projects funded
- 2013 DOJ opinion Lottery funding treatment ads not legal
- 2013 HB 4028A Allows Lottery to resume treatment ad funding
- 2013 HB 2355 Stabilizes PGS funding to not go below 7/1/11 baseline
- 2013 HB 2613 Legalized gambling based on historic horse races
- 2014 PGS Office fully staffed
- 2015 Peer support services introduced with the first certification for gamblers
- 2014 Implementation of the Spanish language helpline number – 844-TU VALES
- 2014 Creation of Oregon Problem Gambling Resource web page
- 2014 Oregon Lottery Commission adopts Responsible Gambling Code of Practice
- 2015 Responsible Gambling Code of Practice adopted into statute
- 2015 Peer support services introduced with the first certification for mentors
- 2015 OHA develops 2016 to 2020 System Improvement Plan for Problem Gambling Services
- 2015 Beginning of Positive Cultural Framework Campaign and funding
- 2015 Adult Gambling Behavior Study funded
- 2015 Adolescent Gambling Behavior Study funded
- 2016 Prevention Special Projects funded
- 2016 Implementation of clinical supervisor and clinician online trainings by Lewis & Clark College
- 2017 Motivational messaging incorporated in Helpline services
- 2017 Community Readiness Projects funded
- 2017 Oregon Depart of Corrections partners with PGS to study prevalence of problem gambling in incarcerated populations
- 2019 Replication study of prevalence of problem gambling in incarcerated populations
- 2019 Implementation of Reflect, Resource, Renew prevention campaign.
- 2019 Core Competencies for Problem Gambling Treatment Professionals Meta-analysis completed.
- 2019 Sports betting offered at 2 Oregon Indian Gaming Centers- Chinook Winds and The Mill.
- 2019 Lottery introduces Scorecard, online sports betting app