



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

***GAMBLING PROGRAMS EVALUATION
UPDATE - 2017***

July 1, 2016 - June 30, 2017



Thomas L. Moore, PhD
Herbert & Louis LLC
PO Box 304
Wilsonville, OR 97070-0304
admin@herblou.com

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Questions regarding the evaluation activities may be directed to Dr. Thomas L. Moore, CEO, Herbert & Louis, LLC (503) 685-6100 or tlmoore@herblou.com

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The Prevention section of this report was prepared by Roxann Jones, Problem Gambling Statewide Prevention and Outreach Specialist, Health Systems Division, Oregon Health Authority.

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 2016-2017 (July 1, 2016 through June 30, 2017). Program 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 54 treatment programs representing 42 provider 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.

- ❖ Utilization projections for gamblers enrolling in treatment were set at 1,600 based on current preliminary prevalence data.
 - The number of gambler enrollments across all programs was 973, down approximately 10.0% from last year.
 - 81.4% were enrolled in traditional outpatient programs; 6.3% in residential care; 5.4% in non-traditional home-base care; and, 6.9% in prison based treatment

- ❖ Coordinated statewide gambling prevention efforts were fully integrated with approximately \$1.3 million investment.
 - Goals were met or exceeded
 - Efforts expanded to include adult populations

- ❖ Treatment Availability and Access
 - The lag time from initial call to first available appointment for outpatient treatment was, on average, 3.3 work days and 3.5 calendar days
 - 23.0% of gamblers accessed treatment providers through the Helpline, down slightly from last year
 - 12.4% through previous clients
 - 8.8% through other community health care providers
 - 40.2% reported accessing treatment through a large variety of other sources

- ❖ Treatment System Performance
 - Average length of stay for traditional outpatient was 156.2 days up slightly from 154.3 days
 - Average case cost based on reimbursable treatment services was \$1,363.4, down slightly from \$1,412 for all outpatient programs and \$2,656.3 for those successfully completing their course of treatment – down from \$2,813
 - Average services hours per case was 19.4 hours and for successful completers 41.5 hours
 - Adjusted successful completion rate from outpatient treatment was 37.9%, up from 35.4%

- ❖ Helpline

- Calls for help to the Helpline were down 9.0% over last year
- ❖ Client Demographics
 - The distribution of married clients entering outpatient treatment rose from 26.4% to 28.9%
 - The distribution of females enrolling in outpatient treatment remained relatively stable at 45.3%
 - Average age was 48.2 years with females significantly older
 - The distribution of Whites enrolling remained relatively constant with last year at 80.9%
- ❖ Gambling Behaviors
 - Average age of first gambling experience remained stable at 24.6 years with males reporting significantly younger first experiences
 - Average of onset of gambling problems was 36.9 years essentially unchanged from last year with males reporting significantly younger age of onset
 - Average gambling debt for those reporting a debt (66.2%) was \$24,019. The debt to income ratio was approximately 1:0.8 – down slightly
 - Primary gambling activity remained machine based (VLT/slots) at 88.2% with females being significantly more likely machine-based gambling. Of these Video Poker was more popular (37.9%) than line games (31.6%) although mechanical reel machines were reported by 16.4%
 - Primary gambling location remained Video Lottery Retailers at 73.9% essentially unchanged followed distantly by IGC/Casino 12.8%
 - Average number of diagnostic criteria endorsed by outpatient clients was 7.6 out of 10 possible - unchanged; for residential clients the average was 8.4, up slightly; minimal intervention program (home-based) was 8.3, also up slightly
- ❖ Outcomes
 - 12-month abstinence rate for successful program completers was 53.6% and “much less gambling” was 29.0%
 - 6-month successful completers abstinence rate was 45.8%; and, much less gambling was 40.3%
 - 6-month non-completers abstinence rate was 28.9%; and, much less gambling was 36.7%
 - 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 92.4% at 12-month follow-up

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1. INTRODUCTION

This is an annual report of the Oregon Problem Gambling Services activities for Fiscal Year 2016-2017 (FY 16-17) that included the period July 1, 2016 through June 30, 2017. The purpose of this report is twofold: to document the critical system performance elements of 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 40 county-based programs funded to provide treatment services with five statewide programs including a residential program in Marion County; respite program in Josephine County; home-based minimal intervention program based in Lane County; prison project in Coffee Creek Corrections Facility (Clackamas County); and, a Native American program in Multnomah County. The number of treatment programs has varied over the years due mostly to the regionalization and de-regionalization of treatment efforts in rural counties.

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 abuse prevention efforts at the state 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 the current year, there were attempts to integrate peer services personnel, as discussed below, with supporting billing codes introduced to reimburse agencies employing peer services.

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.

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, the only regulation requirements are only 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.

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

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

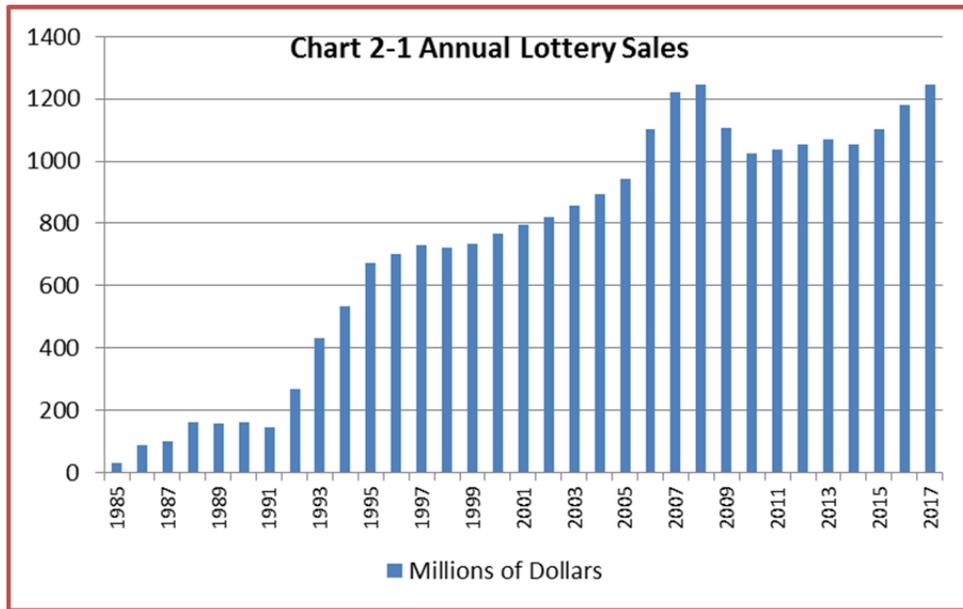
statutory mandate is to “produce the maximum amount of net revenues to benefit the public purpose ...commensurate with the public good.”³ A minimum of 84% of the Lottery’s annual net revenue must be returned to the public in the form of prizes and benefits to the public purpose. The Lottery offers instant 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.

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 3,934 Oregon Lottery Retailers. Of these 1,707 sold only traditional lottery products, 485 sold only video lottery products, and 1,751 offered both traditional and video lottery products. There were 11,817 video lottery terminals active in the state. Total gross Lottery sales for FY 16-17 were approximately \$1.25 billion. Video lottery gross sales this year were reported at approximately \$910 million.

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 along with the economy. (Chart 2.1)

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



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 are currently nine IGCs in the state, one of which is a Class II casino in Coos Bay. The IGC in Burns is currently closed with no apparent plans to re-open. 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 facility in Coos Bay).

It should also be noted that at the time of this report Portland Meadows, a long standing horse racing venue in the Portland metropolitan area with off-track betting for the past several years, was slated to open a poker room (social gaming); over 150 video terminals (Class II machines); and, historical horse racing making the facility one of the larger gambling venues in Oregon. (In the fall, they have live horse racing slated.)

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 Oregon. While the suit was eventually overturned, the unintended consequence was to cut off funding for problem gambling treatment programs in Oregon. 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.

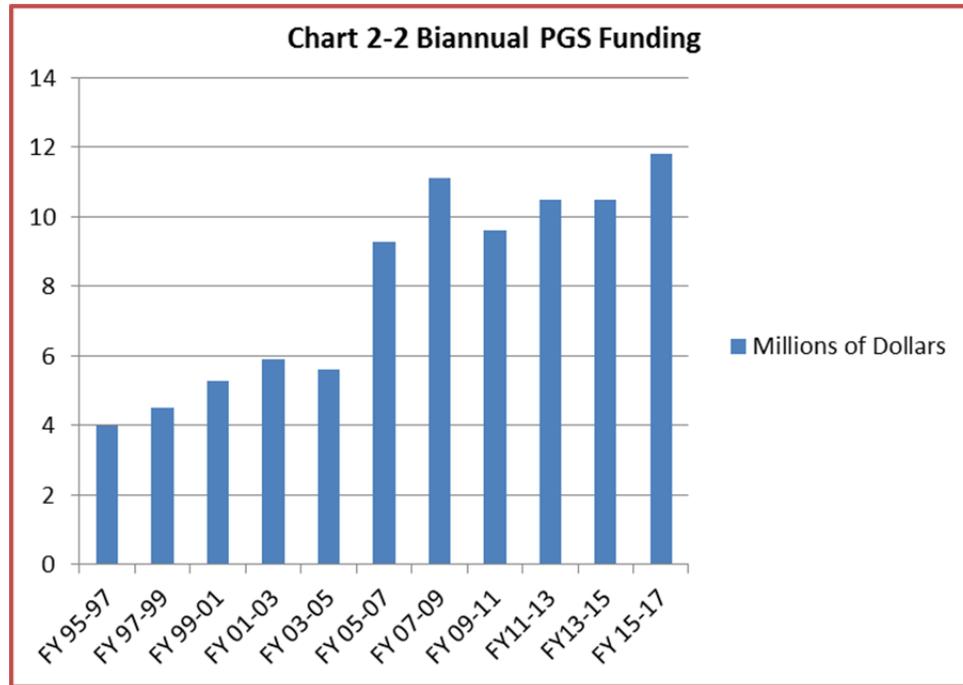
The introduction of Senate Bill (SB) 118, eventually led to the enactment of legislation in 2001 that again tied the funding of problem gambling services to the Lottery proceeds. Oregon Revised Statute (ORS) 409.435 created the Problem Gambling Treatment Fund and ORS 461.549 set aside one percent of 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 taken 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 reflect the set-aside.



Estimating Treatment Needs

In 1997, the Oregon Gambling Addiction Treatment Foundation (OGATF)⁴ commissioned an adult prevalence study of problem and pathological gambling in the State. 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

⁴ The Foundation changed its name to the Oregon Council on Problem Gambling in early calendar 2008.

gamblers to the programs each year should be between 600 and 1,400 individuals. (Volberg, 1997)⁵

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.

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

⁵ Copies of all studies sponsored by OGATF can be downloaded from www.oregoncpg.org

projected enrollments in all programs during the report period was estimated to be approximately 1,600 to 1680⁶ 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).^{7,8} The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals. Nonetheless, a subsequent anecdotal investigation⁹ 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% were problem gamblers and another 4.6% were at risk. (Volberg, R., Hedberg, E., Moore, T., 2008)¹⁰ Preliminary findings from a third adolescent study suggest the prevalence rate had continued to decrease to a combined rate of 1.8%.¹¹

⁶ 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%.

⁷ 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.

⁸ 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.

⁹ 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.

¹⁰ 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.

¹¹ Moore, T. (2016) Unpublished preliminary comparison of rates from the three studies.

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.¹² Agencies applying for state funding¹³ were required to be a state-recognized alcohol and drug (A&D) 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 A&D 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 those that were developed by MH agencies tended to be oriented towards harm reduction (controlled gambling) and a psychodynamic approach to therapy.¹⁴ 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

¹² 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.

¹³ All state funding was directed through the counties. Each agency's contract was with the county in which they operated.

¹⁴ This is arguably a generalization.

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,¹⁵ blossomed within the state, most programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.¹⁶

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. 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 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.

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

¹⁵ 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.

¹⁶ Many programs have specialized treatment efforts for family members that are not contingent upon the gambler being also enrolled.

determinants influencing gambling and health. It incorporates prevention, harm reduction and multiple levels of treatment by placing emphasis on quality of life issues for 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 is 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 them or their families 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.

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.¹⁷ Originally designed as an intervention for those with less severity, the effort has

¹⁷ During the FY 10-11 report period this service was cut due to budget constraints but was re-introduced in FY 11-12.

proven to be utilized by many with severity similar to those entering traditional outpatient programs. Traditional outpatient programs comprise the bulk of the treatment effort with non-English services available in some areas. There is one short-stay respite program located in Southern Oregon 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 ranges 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 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 although it was quickly implemented by a rural program.

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 prevention and outreach programs are directed at avoiding or reducing the emotional, physical, social, legal, and financial consequences of disordered gambling for the gambler, the gambler's family, and the community. Oregon's prevention efforts are guided by the Center for Substance Abuse Prevention's (CSAP) six core prevention strategies. Oregon Problem Gambling Services delivers prevention and outreach services via three separate, yet related, administrative bodies:

Oregon Health Authority (OHA) Problem Gambling Services coordinates actions to prevent gambling-related problems, promote informed and balanced attitudes, and protect vulnerable groups. These actions include promoting healthy public policy, funding regional efforts, and developing collaborative relationships between various stakeholder groups.

County Government. Local governments develop regionally specific prevention plans utilizing the Strategic Prevention Framework model (Appendix A): assessing needs; building capacity; planning; implementation and evaluation. Implementation plans integrate the CSAP six guiding strategies (Appendix B), the Behavioral Health Continuum Care Model (Appendix C), and include measurable goals and objectives.

The Oregon Lottery develops and delivers public awareness and education programs to provide clear and consistent messages regarding healthy and unhealthy gambling

behaviors. The Oregon Lottery campaigns use a variety of media including TV, radio, social media platforms and print to help increase awareness of problem gambling and to encourage Oregonians to utilize the Oregon Problem Gambling Resource (OPGR) website and Problem Gambling Helpline as a resource when seeking help or information.

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 work plans are located at: <http://www.oregonpgs.org/about/2016-2020-oregon-pgs-system-improvement-plan/>.

3. PROBLEM GAMBLING PREVENTION OUTCOMES

As noted above, 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. State and regional efforts focus on exposing Oregonians throughout the lifespan to problem gambling prevention information.¹⁸

Significant Outcomes

The combined prevention and outreach efforts of the state and local jurisdictions have significantly contributed to the following:

- Increased awareness that problem gambling is a significant public health concern at the state and community level;
- Increased awareness regarding the continuous growth in access to, and types of gambling opportunities; and
- Significant advances in incorporating problem gambling into existing behavioral health programs for youth and adults.

Funding

The State of Oregon Problem Gambling Services invested over 1.3 million dollars for problem gambling prevention and outreach services in this reporting period; this represented

¹⁸ The Prevention section of this report was prepared by Roxann Jones, Problem Gambling Statewide Prevention and Outreach Specialist, Health Systems Division, Oregon Health Authority.

an increase over previous years. The vast majority of those funds went directly to local problem gambling prevention and outreach providers. In addition, the Oregon Lottery invested 3.1 million dollars during this reporting period to research and advertisement of responsible and problem gambling outreach (treatment access).

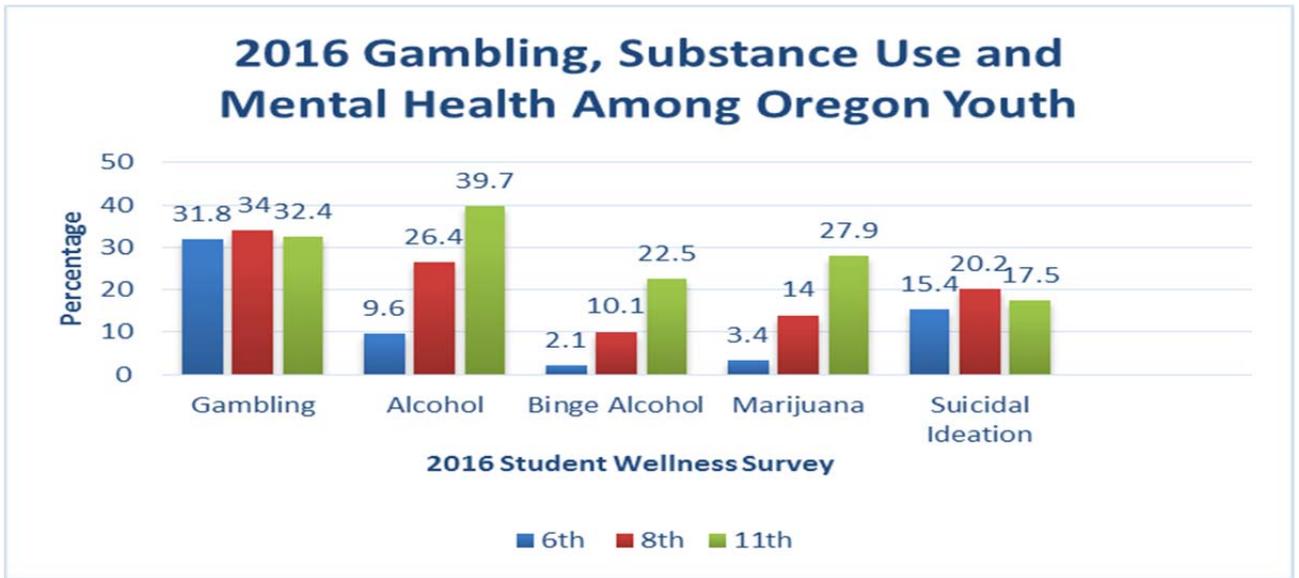
State Office Accomplishments

During this reporting period the Statewide Prevention and Outreach Specialist focused on increasing supports to providers and system development; a few notable accomplishments during this reporting period included:

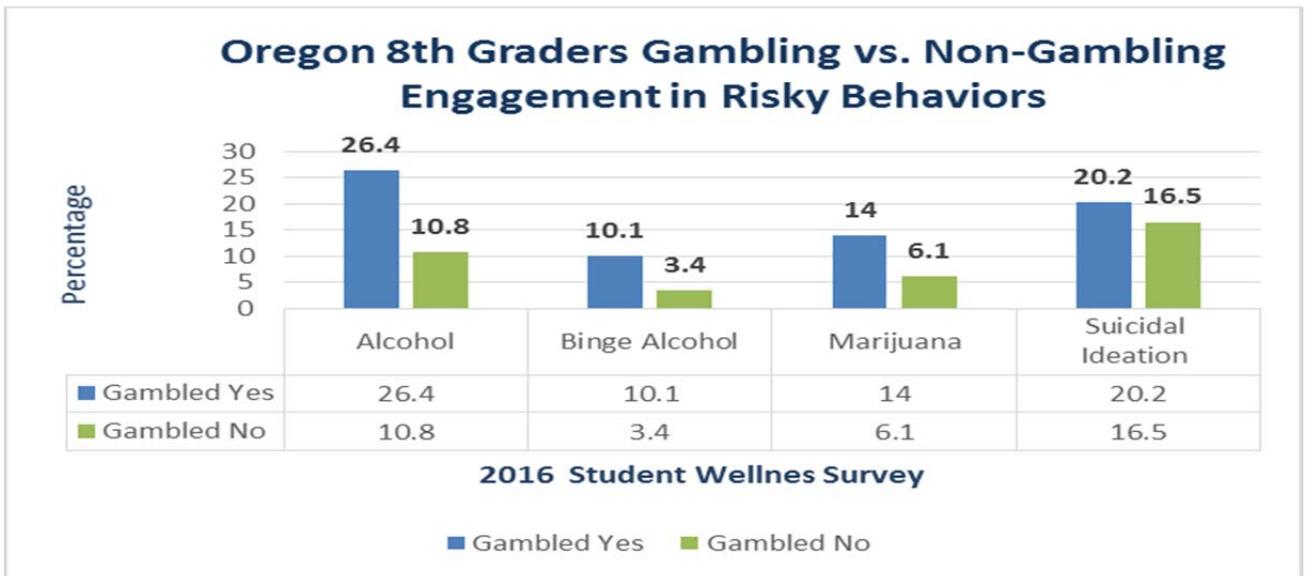
- Annual Problem Gambling Awareness Calendar created and disseminated: 12,000 calendars featuring art from middle schoolers throughout Oregon were created and distributed across the State as well as nationally.
- Creation of Problem Gambling Prevention Advisory Committee (PGPAC) consisting of representation from across the state of Problem Gambling Prevention Coordinators. The mission of the PGPAC is “To Strengthen the Problem Gambling Prevention System” and the purpose is to: 1) ensure community level voice and expertise is included in improving the statewide Problem Gambling Prevention System; and 2) advocacy at the local and statewide level.
- Promotion of the OregonPGS.org as the central repository for information and materials to assist treatment and prevention providers to facilitate sharing of information and resources, and to eliminate duplication of effort.
- Workforce development activities to ensure Problem Gambling Prevention Coordinators are skilled in prevention science and the field of problem gambling. Workforce activities including: 1) Fall Annual Gathering 2) Monthly PGS Prevention

Connect Calls that enhances relationship between state staff and regional providers, while providing a platform for two-way information sharing; and, 3) Co-hosting the 31st National Conference of Problem Gambling, and ensuring quality presentations within a designated prevention track, along with registration scholarships to problem gambling prevention providers.

- Provided additional funding to 17 programs to develop creative and innovative problem gambling outreach strategies aimed to increase awareness of problem gambling in the adult population.
- Partnership with Oregon State Lottery on the development of PSA materials and resources.
- Problem gambling was included in OHA's Student Wellness Survey. A few significant findings are below:
 - More Oregon youth with the exception of 11th grade alcohol use, reported gambling more in the past 30 days than had engaged in other risky behaviors like alcohol, marijuana, binge drinking, and suicidal ideation (SWS 2016), as shown below:



- o Youth who gamble are more likely to engage in other risky behaviors (SWS 2016), as shown below:



- o Additional data available upon request.

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 problem 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; however, a concerted effort has been made in this past reporting period to include the adult population as a focus area. Of the CSAP strategies employed by Oregon providers the following were the most successful:

- Information Dissemination – though significant progress has been made, problem gambling is still working toward being recognized as a concern. Therefore, regional prevention and outreach efforts have typically focused on building community awareness of the potential risks and harm of problem gambling and the availability of treatment for problem gamblers and their families.
- Community-Based Processes – Several regions have come to see the advantages of working with groups and coalitions as a way to increase their ability to share information and strategies regarding problem gambling.

CSAP strategies that are more challenging for Oregon Problem Gambling Prevention providers are:

- Education- True prevention education activities are difficult to achieve in the field of problem gambling because of limited resources, a lack of research on what works in problem gambling prevention, and the generally time-consuming nature of prevention education. Where appropriate, providers have integrated problem gambling education into existing prevention education programs.

- Environmental – This is a more long term and complex strategy which requires significant effort, as well as policy change can be a slowly evolving process.

Future Directions

Problem gambling prevention and outreach efforts in Oregon will build on the positive momentum in place and will focus on the following during the coming year:

- Increasing the local providers' knowledge and skills regarding effective prevention principles and strategies, and training of new providers.
- Increased provision of targeted technical assistance as needed.
- Improving regional web-based problem gambling information.
- Analysis of the 2016 Adolescent Prevalence Study.
- Increased collaboration with partners such as the Oregon Council on Problem Gambling, Voices of Problem Gambling Recovery, and the Oregon Lottery.
- Continuing to support infusion of problem gambling into existing prevention efforts.
- Implementation of Problem Gambling Services System Improvement Plan.

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 effort¹⁹ 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,²⁰ 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 agencies²¹ 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 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.

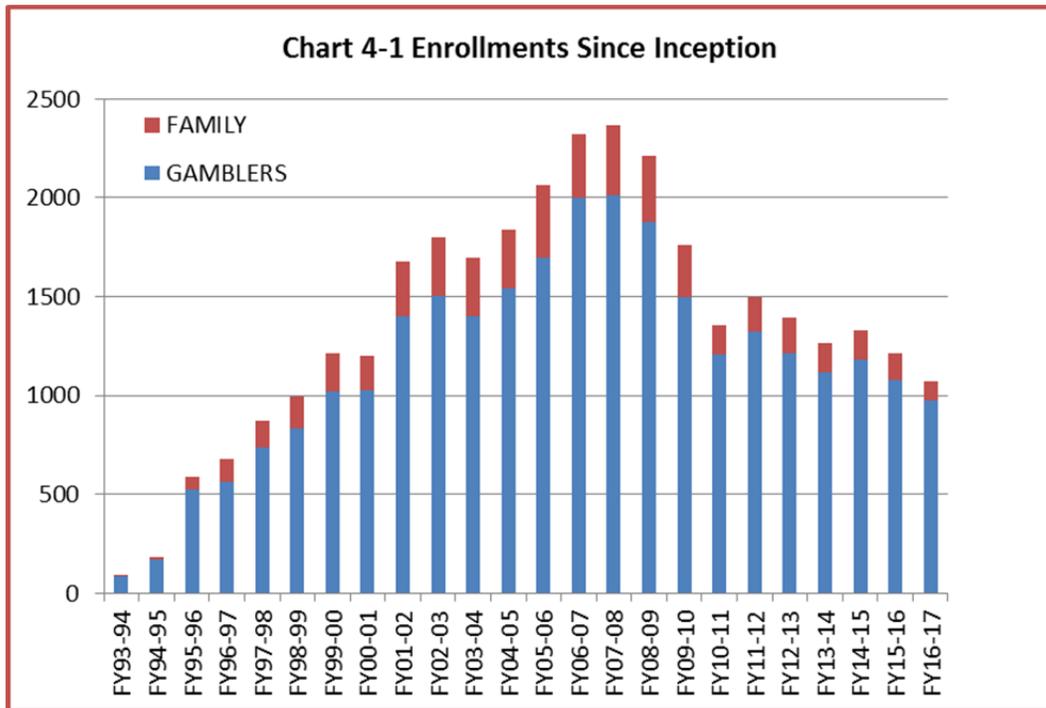
¹⁹ Senate Bill 118

²⁰ 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.

²¹ This conclusion is based on extensive, informal contact by the evaluator with program managers and counselors throughout the state.

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 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 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 continue dropping another 10.0% this reporting 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 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

significant²² 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 reporting²³ was the finding that the annual recidivism rate of gamblers for FY 01-02 was 6.1%, up from 2.4% reported during the previous fiscal year.

Approximately 28.8% 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 episodes of care. Approximately 12.4% (n = 28) 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.

During the current year there were 40 agencies funded with 47 treatment programs including a statewide residential program at Bridgeway in Salem; short-term residential respite program in Grants Pass operated by Options for Southern Oregon; the home-based minimal intervention programs (GEAR) based in Lane County and run by Emergence; and, two prison program based in Clackamas and Multnomah Counties operated by Cascadia Behavioral Care. The reader will note that some programs in the following table reported no enrollments during the period. This is 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)

²² Chi square $P < .01$. Statistical significance is only reported in this document where $p < .05$.

²³ Providers are required to close cases if the client has been inactive for a period greater than 30 days.

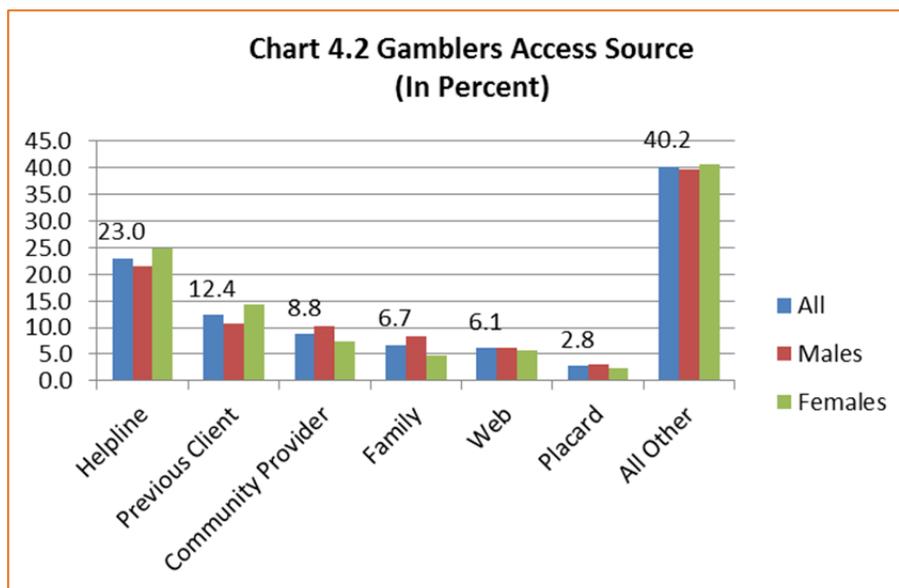
Table 4-1 Treatment Enrollments FY 16-17**Funded Programs**

| County- Agency/Program | Gamblers | Family | Total |
|--|-----------------|---------------|--------------|
| BAKER-NEW DIRECTIONS NORTHWEST | 2 | 0 | 2 |
| CLACKAMAS-CASCADIA CLACKAMAS | 56 | 14 | 70 |
| CLACKAMAS-CASCADIA DOJ OUTPATIENT | 28 | 0 | 28 |
| CLATSOP-CLATSOP COUNTY HEALTH CENTER | 5 | 0 | 5 |
| COLUMBIA-COLUMBIA COMMUNITY CENTER | 1 | 0 | 1 |
| COOS-ADAPT | 21 | 0 | 21 |
| CROOK-CROOK | 7 | 1 | 8 |
| CURRY-CURRY COUNTY | 2 | 0 | 2 |
| DESCHUTES-DESCHUTES BESTCARE | 31 | 1 | 32 |
| DOUGLAS-ADAPT DOUGLAS COUNTY | 26 | 3 | 29 |
| GILLIAM-COMMUNITY COUNSELING SOLUTIONS | 1 | 0 | 1 |
| GRANT-COMMUNITY COUNSELING SOLUTIONS | 0 | 0 | 0 |
| HARNEY-HARNEY COUNTY | 1 | 0 | 1 |
| HOOD RIVER-MID COLUMBIA/HOOD RIVER | 3 | 0 | 3 |
| JACKSON-ARC | 34 | 7 | 41 |
| JACKSON-ON TRACK | 2 | 0 | 2 |
| JEFFERSON-BEST CARE RES-SPANISH | 1 | 0 | 1 |
| JEFFERSON-BEST CARE OUTPATIENT | 3 | 0 | 3 |
| JOSEPHINE-OPTIONS FOR SOUTHERN OREGON | 21 | 0 | 21 |
| KLAMATH-BEST CARE | 12 | 0 | 12 |
| LAKE-LAKE COUNTY | 0 | 0 | 0 |
| LANE-CENTRO LATINO AMERICANO | 0 | 0 | 0 |
| LANE-EMERGENCE | 92 | 15 | 107 |
| LINCOLN-LINCOLN COUNTY | 10 | 3 | 13 |
| LINN/BENTON-LINN COUNTY | 33 | 0 | 33 |
| MALHEUR-LIFEWAYS | 1 | 0 | 1 |
| MARION-BRIDGWAY | 88 | 14 | 102 |
| MORROW-COMMUNITY COUNSELING SOLUTIONS | 3 | 0 | 3 |
| MULTNOMAH-CASCADIA | 110 | 8 | 118 |
| MULTNOMAH-CASCADIA DOJ | 39 | 0 | 39 |
| MULTNOMAH-EMPOWERMENT CLINIC | 13 | 1 | 14 |
| MULTNOMAH-INACT, INC | 32 | 1 | 33 |
| MULTNOMAH-LEWIS AND CLARK COLLEGE | 58 | 19 | 77 |
| POLK-POLK COUNTY | 7 | 0 | 7 |
| SHERMAN-MID COLUMBIA CENTER FOR LIVING | 0 | 0 | 0 |
| TILLAMOOK-TILLAMOOK FAMILY COUNSELING | 9 | 0 | 9 |
| UMATILLA-ALL HEART COUNSELING | 8 | 1 | 9 |

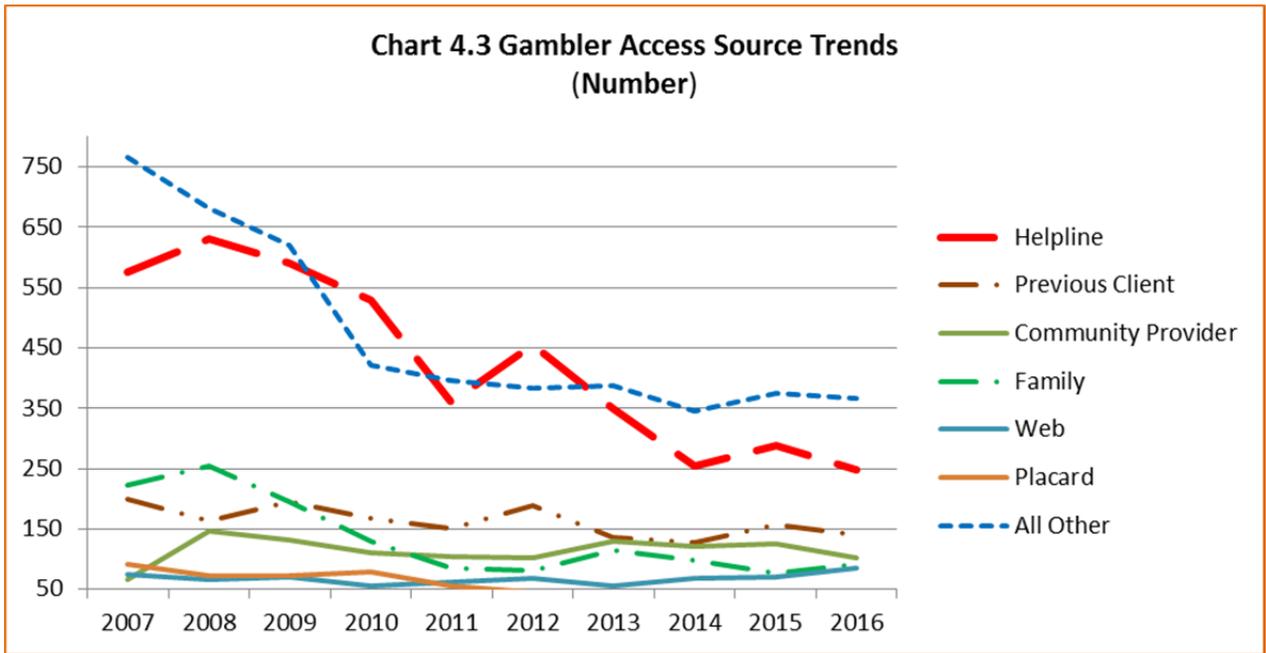
| | | | |
|--|-----|----|------|
| UMATILLA-NEW HORIZON | 3 | 0 | 3 |
| UNION-CENTER FOR HUMAN DEVELOPMENT | 4 | 0 | 4 |
| WASCO-MID COLUMBIA/WASCO CO | 7 | 0 | 7 |
| WASHINGTON-TUALATIN VALLEY CENTERS | 73 | 6 | 79 |
| WHEELER-COMMUNITY COUNSELING SOLUTIONS | 0 | 0 | 0 |
| YAMHILL-YAMHILL COUNTY | 12 | 1 | 13 |
| STATEWIDE-BRIDGEGWAY RESIDENTIAL | 61 | 0 | 61 |
| STATEWIDE-EMERGENCE/GEAR | 53 | 2 | 55 |
| STATEWIDE-OPTIONS FOR SOUTHERN OREGON RESPITE | 0 | 0 | 0 |
| STATEWIDE-NATIVE AMERICAN REHABILITATION ASSOCIATION | 0 | 0 | 0 |
| | 973 | 97 | 1070 |

Of the 973 gambler enrollments system wide, 792 enrolled in traditional outpatient programs and the remainder enrolled in the specialized programs including residential and prison programs, for example.

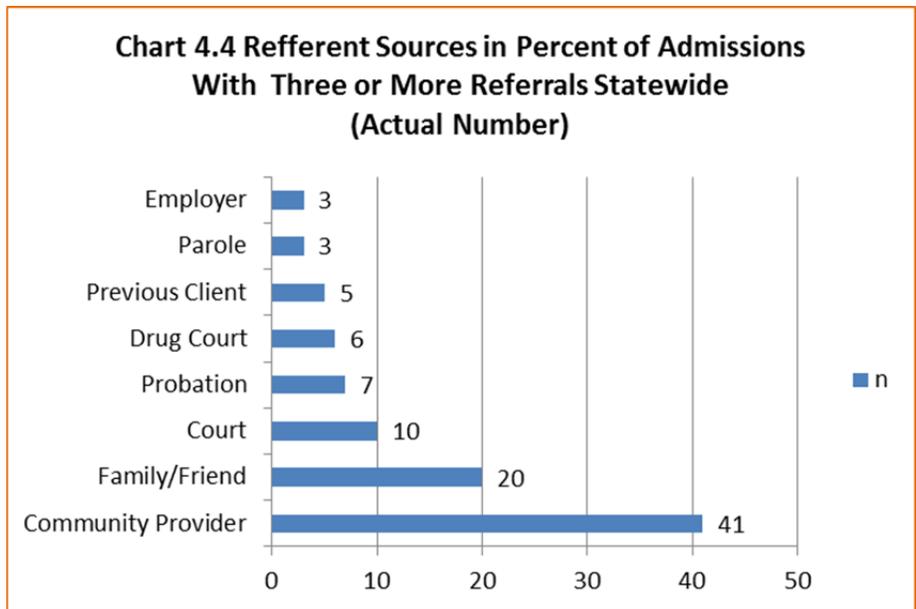
System wide (all programs), and consistent with previous reports, approximately 23.0% (down from 24.0% last year) reported obtaining the treating agency contact information from the Helpline; 12.4% reported receiving the contact information from a current or previous client; 8.8% community provider; 6.7% family member; 6.1% web/internet; and, 2.8% placard . (Chart 4.2)



The actual number of clients reporting the source for the treating agency contact information is provided below: (Chart 4.3)

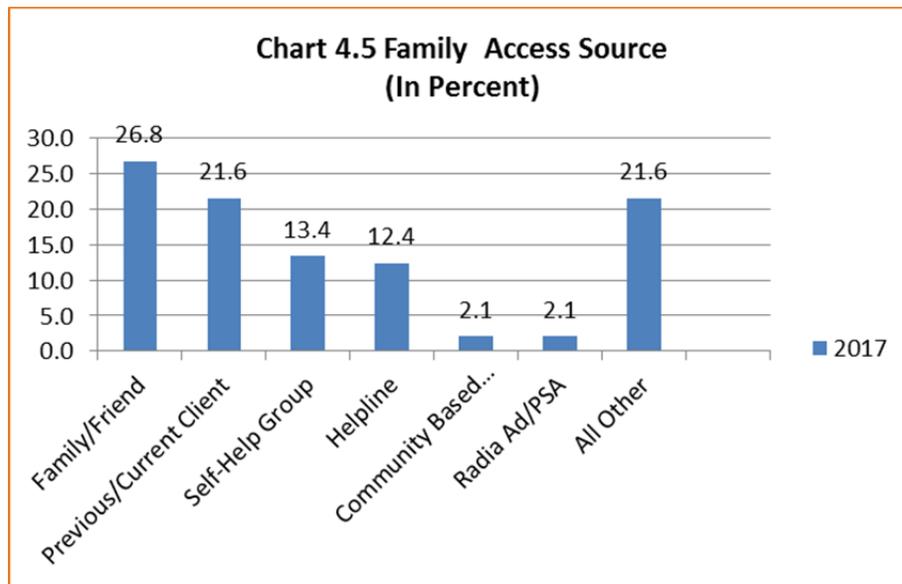


This year saw a slight shifting in the distribution “deliberate” referrals to treatment sources with a drop in referrals from non-community based addictions and mental health providers, but the number was so small as to not significantly alter the findings. Forty-one individuals were reported as being referred by a community-based



treatment provider, 20 by a friend or family member and 26 from court, parole/probation and specialty courts. (Chart 4.4)

As consistently reported, the largest referral source for family member access was a family or friend (26.8%) which would be expected as some agencies send out invitations to family members with the consent of the gambler client. This was followed by information received by previous/current client (21.6%); self-help group (13.4%); and, calls to the helpline (12.4%). Television ads were not reported (0%). (Chart 4.5)



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 (94.9%) significantly²⁴ more often the males. Males continued to be significantly²⁵ more likely to report card games (7.3%) as their primary gambling activity more than females (1.6%). The distributions of the other available games were too small to statistically test. (Table 5.1)

| Game | All | Males | Females |
|-------------|------|-------|---------|
| Machines | 88.2 | 82.4 | 94.9 |
| Cards | 4.5 | 7.3 | 1.6 |
| Traditional | 1.2 | 1.5 | 1.3 |
| Sports | 1.1 | 1.7 | 0.4 |
| Keno | 1 | 1.9 | 0 |
| All Other | 4 | 5.2 | 1.8 |

Also, consistently reported previously, males were more likely to report playing video poker machines (42.6%) than females (37.2%) while females were significantly more likely to report slot machines or video line games than males. (All were $p < .05$) (Table 5.2)

| Game | All | Males | Females |
|----------------------|------|-------|---------|
| Video Poker | 37.9 | 42.6 | 37.2 |
| Video Line Games | 31.6 | 29.3 | 34.1 |
| Slot/Mechanical Reel | 16.4 | 12.8 | 20.5 |

Approximately 96.0% of the clients reported their primary gambling location was in Oregon while 1.2% reported Washington, 0.1% California, and 0.8% Nevada.

| Location | All | Males | Females |
|--------------------------|------|-------|---------|
| Video Lottery Retailer | 73.9 | 72.4 | 75.6 |
| Casino/IGC | 12.8 | 11.5 | 14.4 |
| Restaurant/Bar Non-Video | 5.1 | 4.8 | 5.5 |
| Food/Convenience Store | 1.5 | 1.9 | 1.1 |
| Internet | 1.5 | 2.1 | 0.9 |
| Card Room | 1.2 | 2.1 | 0.2 |
| Track/Off Track | 0.8 | 1.3 | 0.2 |
| Other | 3.2 | 3.9 | 2.1 |

²⁴ $p < .01$

²⁵ $p < .01$

As consistently reported over the years, the primary gambling location was at video lottery retailers (73.9%) followed by casino/IGC (12.8%), and restaurant/bar with no video lottery sales (5.1%). (Table 5.3)

The primary protocol for diagnosing pathological gambling since 1994 has been the clinical criteria found in the Diagnostic and Statistical Manual IV - TR (DSM) published by the American Psychiatric Association (APA). 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.

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 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.

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 7.7 of 10 criteria with males averaging 7.5 items and females 7.8 items.²⁶ 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.

**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.

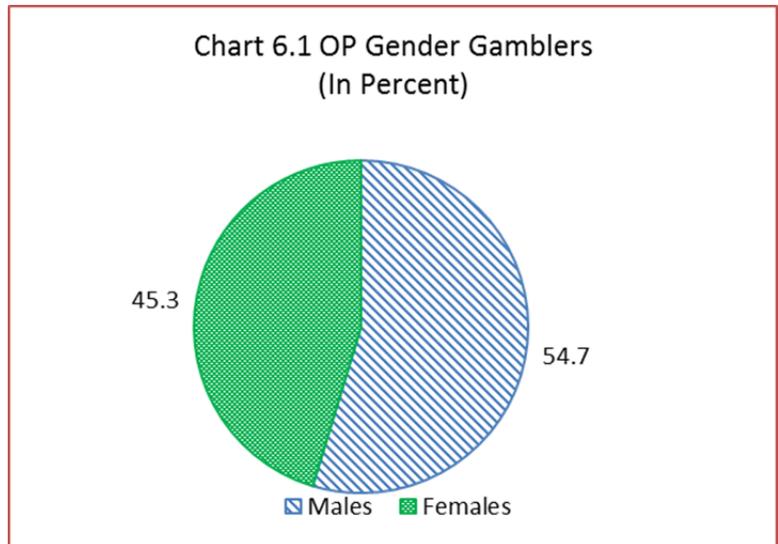
²⁶ Females were significantly ($p < .05$) more likely to endorse a greater number of items than males system wide.

6. TRADITIONAL OUTPATIENT PROGRAMS

Outpatient Demographics

There were 36 agencies providing traditional outpatient (OP) treatment services. In two counties there were multiple agencies, while other agencies provided services for multiple counties. During the report period 792 gambler and 95 family member clients were reported as enrolling in the traditional OP services. This was 9.4% below the number of outpatient gambler enrollments reported last year.

Males were somewhat more likely (54.7%) to enroll in OP again this year than females. Again, essentially unchanged from the past two years. (Chart 6.1)



The average age for OP gamblers was 48.2 years, up slightly from 47.7 years previously reported.

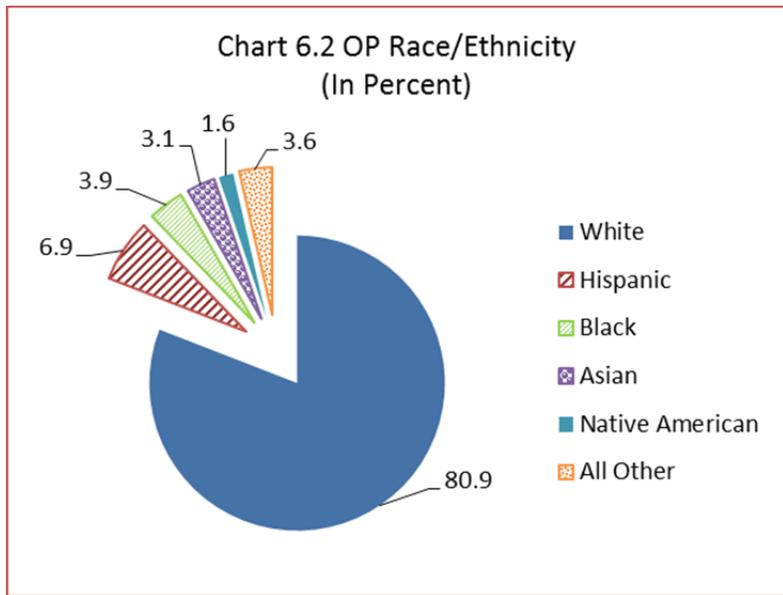
Females were significantly more likely²⁷ to be older (50.0 years) than males. (Table 6.1)

This year, 86 OP gamblers (down slightly from 88) were reported as being 65 years old or older.

| | n | mean | sd |
|---------|-----|------|------|
| All | 791 | 48.2 | 13.7 |
| Males | 432 | 46.6 | 14.1 |
| Females | 359 | 50.0 | 12.8 |

²⁷ p < .01

The distribution of Whites enrolling in the OP programs increased slightly to 80.9% from 80.0% previously reported. Hispanic/Latino decreased from 9.8% to 6.9%, while Asians increased slightly from 2.8% to 3.1%.



The distribution of Black/African American increased from 2.7% to 3.9%, and Native Americans decreased from 1.9% to 1.6%. (Chart 6.2)

| | n | Mean | sd |
|---------|-----|------|-----|
| All | 782 | 13.0 | 2.3 |
| Males | 427 | 13.0 | 2.3 |
| Females | 355 | 13.0 | 2.3 |

The average number of years of formal education was 13.0 for both males and females, essentially unchanged from the last year. (GED included as 12 years). (Table 6.2)

The distribution of married individuals enrolling in OP treatment decreased slightly from 31.1% to 28.3%. There were slight shifts in the other marital categories, but none significant. (Chart 6.3)

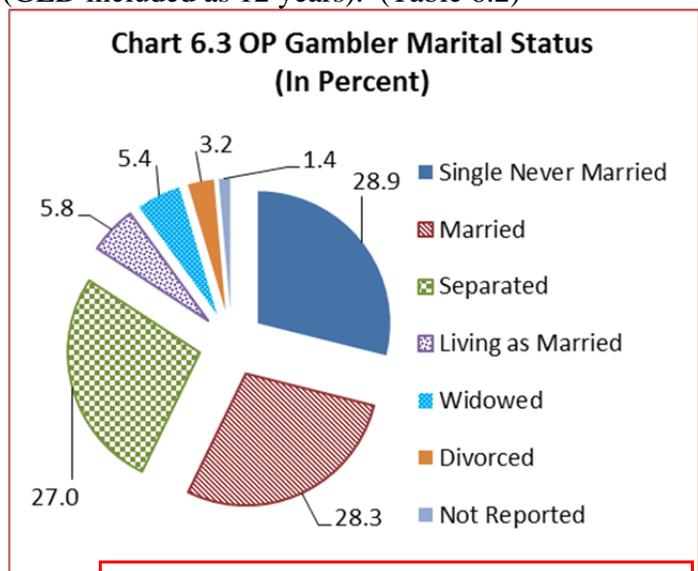
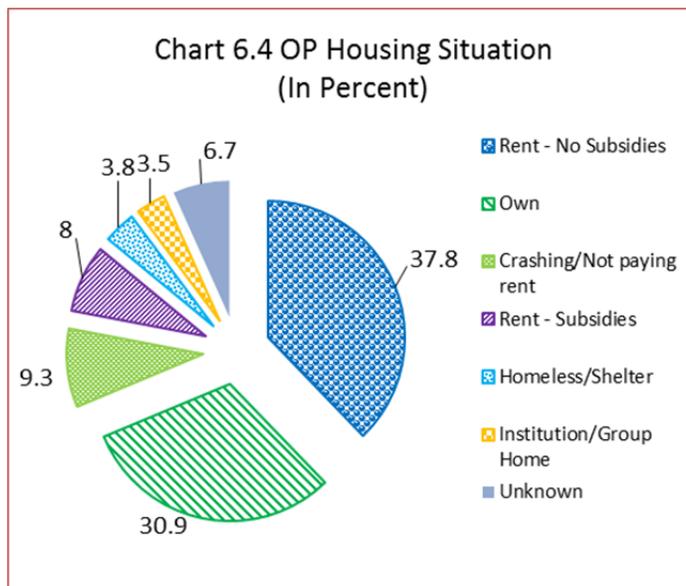


Table 6.3 OP Marital Status

Males were significantly more likely to be single or living as married, and less likely to be separated than females.²⁸ (Table 6.3)

| | (In Percent) | | |
|----------------------|--------------|-------|---------|
| | All | Males | Females |
| Single Never Married | 28.9 | 37.0 | 19.2 |
| Married | 28.3 | 27.5 | 29.2 |
| Separated | 27.0 | 1.6 | 32.3 |
| Living as Married | 5.8 | 22.6 | 6.1 |
| Widowed | 5.4 | 5.5 | 6.4 |
| Divorced | 3.2 | 4.6 | 5.0 |
| Not Reported | 1.4 | 1.2 | 1.8 |

Approximately 37.8% of the OP clients reported living in a rental without subsidies and 30.9% reported living in a home that was owned. These distributions were similar to those seen in the OP population in previous years. The number of individuals reported as crashing, or other situation of not paying rent,



jumped back to previous year levels from 3.9% last year to 9.3% this year. (Chart 6.4)

Females were significantly²⁹ more likely to report living in a home owned (35.1%) than males (27.5%) and subsequently males more likely to be living a non-subsidized rental. (Table 6.4)

²⁸ p < .01

²⁹ p < .05

| | All | Males | Females |
|--------------------------|------|-------|---------|
| Rent - No Subsidies | 37.8 | 40.2 | 34.8 |
| Own | 30.9 | 27.5 | 35.1 |
| Crashing/Not paying rent | 9.3 | 9.9 | 8.6 |
| Rent - Subsidies | 8.0 | 7.2 | 8.9 |
| Homeless/Shelter | 3.8 | 4.6 | 2.8 |
| Institution/Group Home | 3.5 | 0.0 | 3.9 |
| Unknown | 6.7 | 10.6 | 5.9 |

As previously reported, males continued to be significantly³⁰ more likely to be working full-time (44.1%) than females (37.6%). There were only minor differences in the distributions of the other employment categories from last year. (Table 6.5)

| Status | All | Males | Females |
|--------------------------|------|-------|---------|
| Full-Time | 41.4 | 44.1 | 37.6 |
| Part-Time | 11.2 | 7.6 | 11.0 |
| Irregular | 2.5 | 4.0 | 2.5 |
| Unemployed Looking | 10.2 | 12.4 | 12.0 |
| Unemployed - Not Looking | 9.7 | 9.5 | 9.0 |
| Retired | 11.1 | 7.6 | 11.0 |
| Disabled | 11.1 | 12.6 | 14.8 |
| Other/Not Reported | 2.8 | 2.2 | 2.1 |

The average household income for OP clients was reported at \$36,580 up from \$34,143 previously reported and up the last two years. Females reported an average income below that of males but the

| | n | mean | sd |
|---------|-----|----------|----------|
| All | 736 | 36,580.7 | 35,697.7 |
| Males | 399 | 38,237.3 | 36,962.2 |
| Females | 337 | 34,619.2 | 34,035.9 |

difference was not statistically significant. Overall, the median income was \$28,800; \$30,000 for males and \$28,800 for females. There were only slight changes for those median incomes reported last year. (Table 6.6)

³⁰ p < .01

Wages were most frequently (53.5%) cited as the source of the household income followed by other pension (13.1%), disability (10.9%) and other sources (7.0%).

Approximately 11.1% were reported as having no income. Males were significantly more

likely³¹ to report wages as their source of income than females. Females were significantly more likely³² to report their source of income from a pension than males. (Table 6.7)

| | All | Males | Females |
|-------------------|------|-------|---------|
| Wages | 53.5 | 58.9 | 47.1 |
| Pension | 13.1 | 11.3 | 15.3 |
| Disability | 10.9 | 9.2 | 12.8 |
| Other | 7.0 | 6.7 | 8.4 |
| Public Assistance | 4.4 | 3.0 | 6.1 |
| None | 11.1 | 10.9 | 10.3 |

Approximately 87% of clients entering OP were reported as being covered by some form of private or public insurance and approximately 43.7% being covered by some form of public coverage. It must be noted that all treatment is paid for by the state regardless of insurance coverage. (Table 6.8)

| | All | Males | Females |
|--------------|------|-------|---------|
| Private | 34.1 | 34.2 | 34.0 |
| MEDICAID/OHP | 30.4 | 27.7 | 33.7 |
| MEDICARE | 13.3 | 12.0 | 14.8 |
| VA | 4.0 | 5.5 | 2.2 |
| Other | 3.5 | 3.5 | 3.7 |
| None | 12.9 | 15.5 | 9.7 |
| Not Reported | 1.8 | 1.6 | 1.9 |

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 | 790 | 3.5 | 3.3 |
| Work Days | 792 | 3.3 | 2.4 |

average number of work days to the first available appointment was 3.3 days, down from 3.8

³¹ p < .01

³² p < .05

days reported last year. The average number of calendar days from the prospective client’s first call to the program and the first available appointment was 3.5 days down from 4.3 days previously reported. The average lag from first call to admission in the outpatient programs was 6.3 calendar days accounting for client delays and the same as last year. There were no significant gender differences in the lag time to first available appointment or to first seen this year. (Table 6.9)

The average length of stay (LOS) in the OP programs was 156.2 days up slightly from 154.3 days previously reported. Although females were more likely to remain enrolled longer (169.9 days) than males (145.2 days) the difference was not significant. (Table 6.10a)

| | n | Mean | sd |
|---------|----------|-------------|-----------|
| All | 725 | 156.2 | 193.7 |
| Males | 402 | 145.2 | 182.1 |
| Females | 323 | 169.9 | 206.4 |

Individuals who were reported as successfully completing treatment remained, as expected, significantly³³ longer (296.4 days) than

| | n | Mean | sd |
|---------|----------|-------------|-----------|
| All | 208 | 296.4 | 211.0 |
| Males | 111 | 260.6 | 187.9 |
| Females | 97 | 337.4 | 227.9 |

those who left for other reasons. Females successfully completing treatment remained significantly³⁴ longer in treatment (337.4 days) than males (260.6 days). (Table 6.10b)

The unadjusted program completion rate for the OP programs was 28.7%, down slightly from 29.1%. Using the state adjustment formula that only includes successful completers, those who stopped coming against staff advice, and those who were discharged for not following program rules, the overall rate was 37.9%, up from 35.4% previously

³³ p < .001

³⁴ p < .01

reported. Although females were somewhat more likely to complete using the adjusted rate (40.5%) the difference between genders was not significant. (Table 6.11)

| Status | All | Males | Females |
|--------------------------------------|------------|--------------|----------------|
| Adjusted Successful Completion Rate* | 37.9 | 35.8 | 40.5 |
| Stopped Attending ASA* | 46.9 | 49.3 | 44.0 |
| Successful Completion* | 28.7 | 27.6 | 30.0 |
| Evaluation Only | 7.4 | 7.7 | 7.1 |
| Refused Service | 3.7 | 3.0 | 4.6 |
| Moved from Catchment Area | 2.8 | 2.5 | 3.1 |
| Further Treatment Not Appropriate | 2.6 | 2.2 | 3.1 |
| Conflicting Hours | 2.1 | 1.2 | 3.1 |
| Program Closure - Non Cap | 2.1 | 2.2 | 1.9 |
| Physical/Mental Illness | 1.1 | 0.2 | 2.2 |
| No Transportation | 0.3 | 0.5 | 0.0 |
| Non-Compliance With Rules* | 0.1 | 0.2 | 0.0 |
| Incarcerated | 0.1 | 0.2 | 0.0 |
| Other | 2.1 | 3.2 | 0.9 |
| *Used for Adjustment | | | |

The average number of OP treatment encounters for those discharged during the report period was 19.4, down from 21.7 previously reported. The average number of treatment encounters for those successfully completing treatment was 41.5, down from 46.0. The

| | n | mean | sd |
|-----------------------|----------|-------------|-----------|
| Encounters | | | |
| All Gamblers | 700 | 19.4 | 33.5 |
| Successful Completers | 208 | 41.5 | 48.2 |
| Dollars | | | |
| All Gamblers | 700 | 1,362.4 | 1,890.2 |
| Successful Completers | 208 | 2,656.3 | 2,498.8 |

average case cost for all gamblers was \$1,362.4, down from \$1,412.0. Successful completer case cost was \$2,656.3, down from \$2,813.4 this year. (Table 6.12)

Outpatient Gambler Activities and Consequences

The average age of the first gambling experience for the outpatient clients was 24.6 years, essentially the same as previously reported. Males continued to report their first gambling experience at a significantly³⁵ younger age (22.2 years) than females (27.4 years). (Table 6.13)

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 766 | 24.6 | 12.6 |
| Males | 420 | 22.2 | 11.6 |
| Females | 346 | 27.4 | 13.1 |

Similarly, males reported a significantly³⁶ earlier age (34.7 years) of the onset of problems with gambling than females (39.5 years) and the overall average age was 36.9 years essentially the same as previously reported. (Table 6.14)

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 753 | 36.9 | 14 |
| Males | 411 | 34.7 | 14.1 |
| Females | 342 | 39.5 | 13.5 |

The average number of years between age first gambled and the onset of problems with gambling was approximately 14.9 years overall. There was no significant difference between genders.

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

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 775 | 7.6 | 2 |
| Males | 422 | 7.5 | 2 |
| Females | 353 | 7.7 | 2 |

consistency across two decades of data. The average number of items endorsed by those enrolling in the outpatient programs was 7.6 items, essentially the same as previously reported with no significant difference between genders. (Table 6.15)

³⁵ p < .01

³⁶ p < .01

An item analysis revealed no statistically significant differences in the likelihood that there were differences in the distribution of responses to the 10 DSM criteria based on gender.

| | All | Males | Females |
|-------------------------------|------|-------|---------|
| Unsuccessful attempts to stop | 92.4 | 92.2 | 92.6 |
| Preoccupation | 91.6 | 90.8 | 92.6 |
| Returning to get even | 86.3 | 86.5 | 86.1 |
| Escaping | 86.1 | 82.7 | 90.1 |
| Lying | 85.0 | 84.8 | 85.3 |
| Increasing size of bets | 84.6 | 83.4 | 86.1 |
| Restlessness | 81.7 | 80.1 | 83.6 |
| Jeopardized relationship/job | 66.3 | 66.6 | 66.0 |
| Relies on others for money | 63.2 | 63.7 | 62.6 |
| Committed illegal acts | 24.8 | 22.3 | 27.8 |

Interestingly nonetheless, was finding that unsuccessful attempts to stop rose to the most frequently cited criteria. This may be due to the recidivism rate over time. (Table 6.16)

Approximately one-quarter of those enrolling in the outpatient programs reported to their counselors of having thoughts of suicide in the past six months. About 2.4% reported making suicidal threats, 1.8% reported

| | All | Males | Females |
|----------|------|-------|---------|
| Thoughts | 25.1 | 23.6 | 27.0 |
| Threat | 2.4 | 1.9 | 3.1 |
| Plan | 1.8 | 1.9 | 1.7 |
| Action | 2.2 | 2.1 | 2.2 |

having a plan, and 2.2% indicated they had attempted to commit suicide. Females were somewhat more like than males to report suicidal tendencies. (Table 6.17)

Approximately 51.0% reported experiencing significant relationship problems, 16.1% reported problems at work, 10.5% legal problems, and 9.1% reported having filed, or planned to file, for bankruptcy in the past six months. (Table 6.18)

| | All | Males | Females |
|---------------|------|-------|---------|
| Relationships | 51.0 | 50.2 | 52.0 |
| Job | 16.1 | 16.5 | 15.5 |
| Legal | 10.5 | 11.5 | 9.2 |
| Bankruptcy | 9.1 | 9.6 | 8.5 |

Approximately 5.1% reported on their survey experiencing physical violence in the six months prior to enrollment; 23.9% reported verbal, emotional, or psychological abuse; and,

21.3% reported feeling controlled or trapped in a relationship. These distributions were similar to previous years with females being more likely to report these types of violence. (Table 6.19)

| | All | Males | Females |
|--------------------|------|-------|---------|
| Physical | 5.1 | 3.5 | 7.4 |
| Non-Physical | 23.9 | 19.9 | 29.7 |
| Controlled/Trapped | 21.3 | 19.2 | 24.0 |

Approximately 66.2% of the clients reported having a gambling related debt at enrollment. The average amount owed was \$24,019.2 up from \$23,373. The average debt to income ratio was also down from approximately 1:0.89 to 1:0.78. Although males reported a larger average debt than females, the difference was not statistically significant.³⁷(Table 6.20)

| | All | mean | sd |
|---------|-----|----------|----------|
| All | 524 | 24,019.2 | 54,389.0 |
| Males | 287 | 24,488.3 | 58,830.8 |
| Females | 237 | 23,451.1 | 48,462.2 |

Approximately 33.2%, down again slightly this year from 34.6%, reported having any prior substance related (A&D) treatment episodes of care. The average number of prior A&D treatments was 2.6. For the data point, episodes of care include both residential/inpatient and outpatient but excluded self-help activities. (Table 6.21)

| | n | mean | sd |
|---------|-----|------|-----|
| All | 263 | 2.6 | 2.6 |
| Males | 159 | 2.2 | 1.8 |
| Females | 104 | 3.3 | 3.4 |

Approximately 36.6%, down from 38.7%, of the clients were reported as having prior mental health (MH) episodes of care. For these individuals, the average number of MH episodes was 3.0. As

| | n | mean | sd |
|---------|-----|------|-----|
| All | 290 | 3.0 | 3.0 |
| Males | 145 | 2.9 | 3.1 |
| Females | 145 | 3.0 | 2.9 |

³⁷ Four individuals were reported as having a gambling related debt of over \$250,000 including one with a \$6.5 million debt. The latter figure was omitted from these calculations.

with the A&D, MH episodes of care included both inpatient and outpatient and excluded self-help. (Table 6.22)

Approximately 14.0% were reported as being concurrently enrolled in A&D treatment at the time of enrollment with 8.8% enrolled at the same agency. Approximately 4.4% were reported as being enrolled in another publically funded agency and less than one percent in a private treatment program. Concurrent enrollment in a mental health program was

| <i>Location</i> | <i>All</i> | <i>Males</i> | <i>Females</i> |
|--------------------------|-------------|--------------|----------------|
| A&D Treatment | | | |
| Same Agency | 8.8 | 7.4 | 10.6 |
| Other Public Agency | 4.4 | 3.9 | 5.0 |
| Other Private Agency | 0.8 | 1.2 | 0.3 |
| <i>Total</i> | <i>14.0</i> | <i>12.5</i> | <i>15.9</i> |
| MH Treatment | | | |
| Same Agency | 7.6 | 6.7 | 8.6 |
| Other Public Agency | 7.3 | 6.0 | 8.9 |
| Other Private Agency | 5.3 | 9.7 | 6.7 |
| <i>Total</i> | <i>20.2</i> | <i>22.5</i> | <i>24.2</i> |

reported for 20.2% of the gamblers. These concurrent enrollments were nearly evenly spread across the same agency, other public funded agency, and private program. (Table 6.23)

Of those enrolling in the outpatient programs, 39.0% were reported as having prior gambling treatment enrollments, essentially the same rate as previously reported. The average number of prior enrollments was reported as 1.8. (It should be noted that this rate is much higher than the rate discussed above which reported recidivism in the same program.) (Table 6.24)

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 309 | 1.8 | 1.4 |
| Males | 148 | 2.0 | 1.6 |
| Females | 161 | 1.7 | 1.1 |

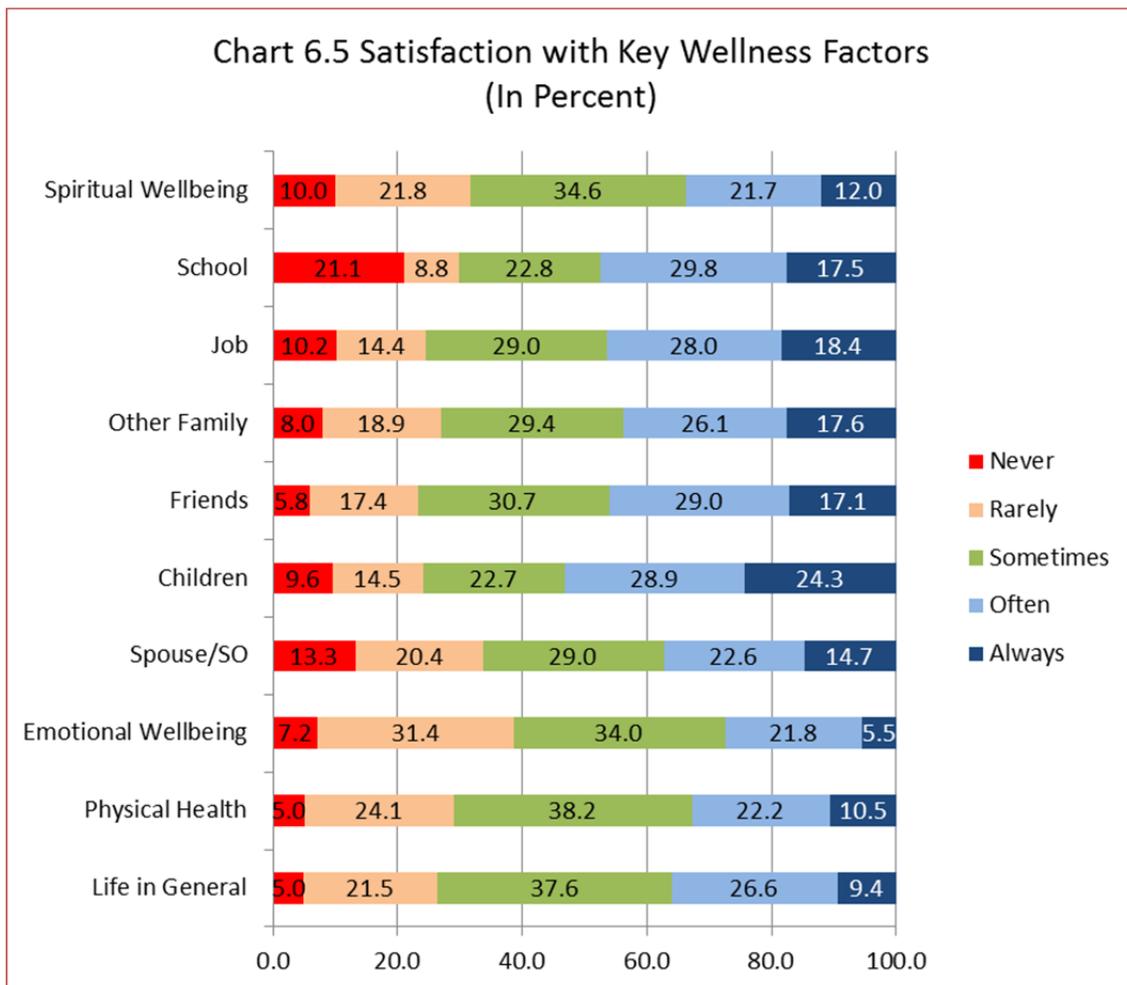
At the time of enrollment, approximately 6.1% reported they were currently active in self-

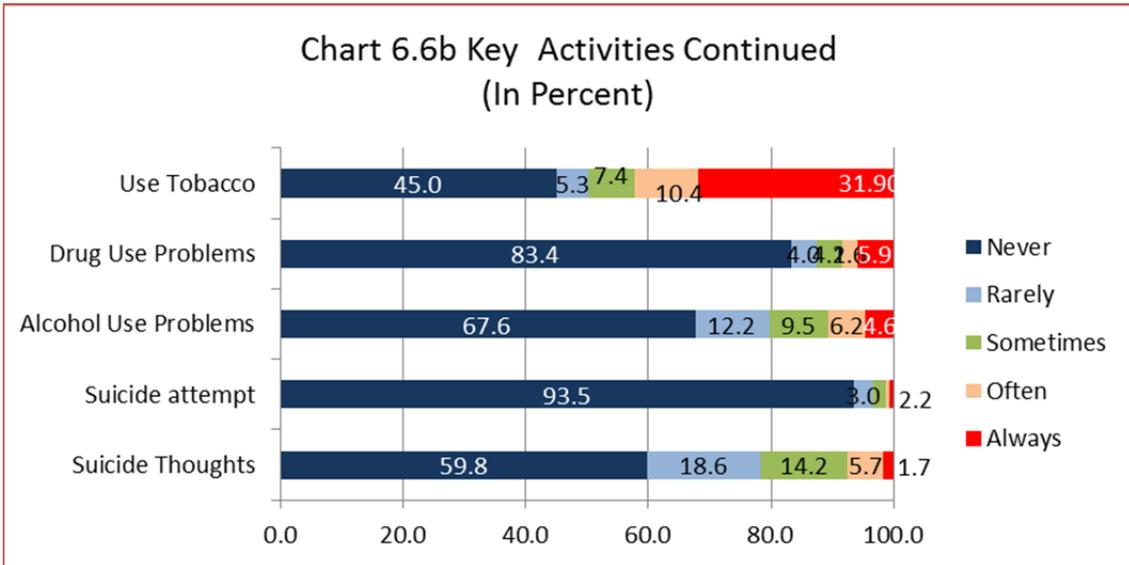
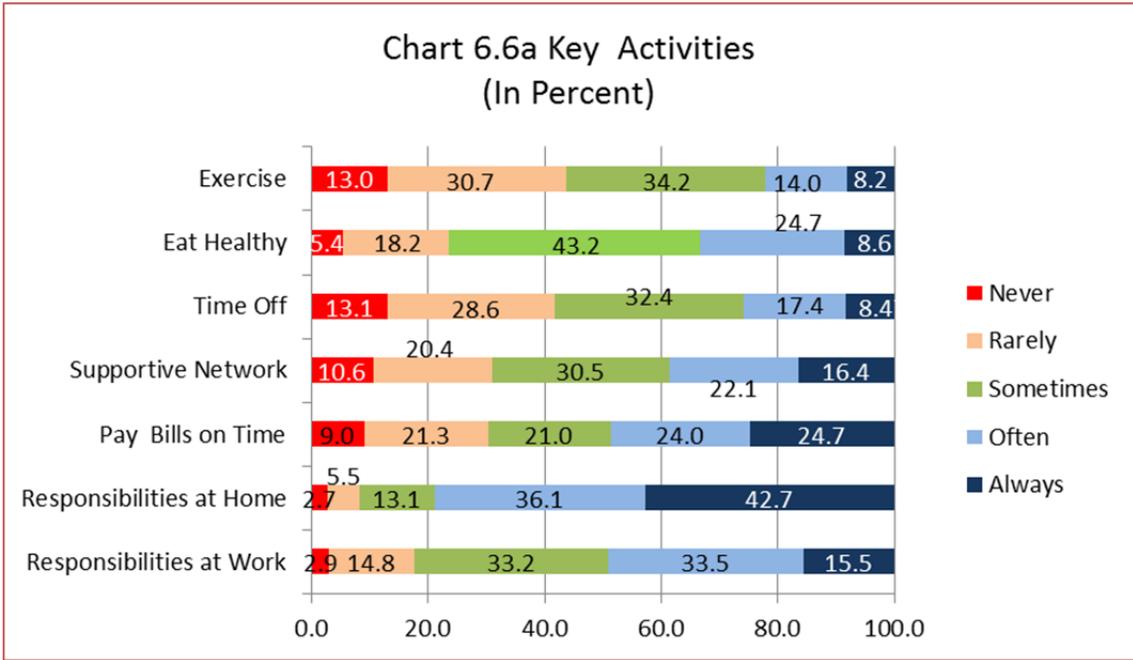
| | Previous | Current |
|---------|-----------------|----------------|
| All | 16.8 | 6.1 |
| Males | 13.4 | 6.5 |
| Females | 20.9 | 5.9 |

help, down for 9.5% previously reported, while 16.8% reported they had previously been involved with self-help. (Table 6.25)

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. (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, 53.6% of the participants reported abstinence

since enrolling in the program compared with 59.2% previously reported. Another 29.0% reported gambling much less than before enrollment. Again, only program completers are tracked at 12 months post discharge.

At six months the abstinence rate for program completers was 45.8% and 40.3% reported gambling much less compared with 56.3% and 33.3% last year. For those who did not successfully complete treatment their reported abstinence was 28.9%, down from 37.4% previously reported. (Table 6.26)

| | None | Much Less | Less | Same | More | Much More |
|------------------------|-------------|----------------------|-------------|-------------|-------------|----------------------|
| 12-Month Completers | 53.6 | 29.0 | 2.9 | 7.2 | 2.9 | 4.3 |
| 6-Month Completer | 45.8 | 40.3 | 9.7 | 2.8 | 0.0 | 1.4 |
| 6-Month Non-Completers | 28.9 | 36.7 | 15.6 | 11.1 | 5.6 | 2.2 |

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 endorsements. (Table 6.27)

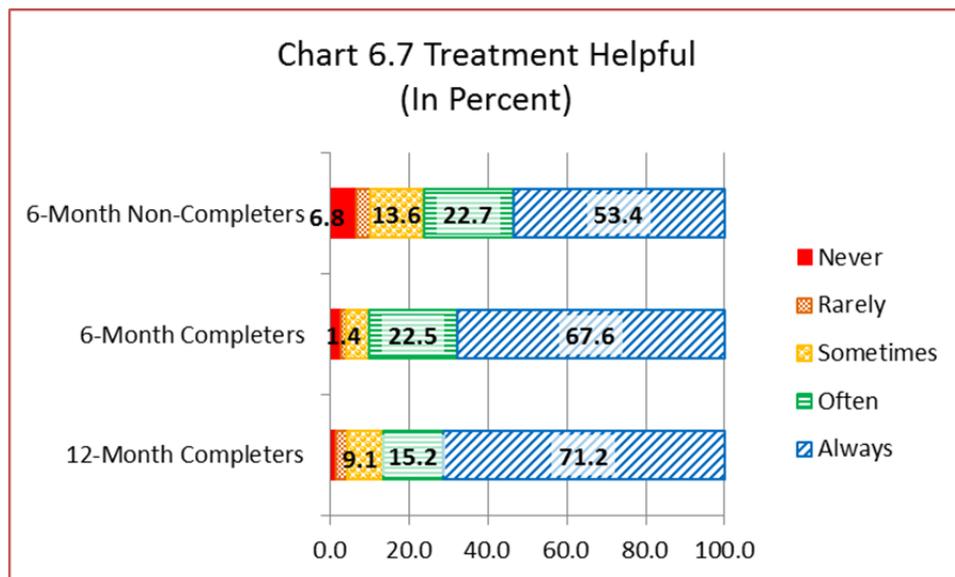
All three samples demonstrated significant improvement in their level of satisfaction with life in general. Completers also demonstrated significant improvement in the emotional well-being, maintaining supportive relationships, and attending GA or other community supports. Those at twelve months additionally demonstrated improved satisfaction with their physical health, job, spiritual well-being, ability to pay bills on time, and taking time off.

Table 6.27 OP ANOVA Pre/Post Survey

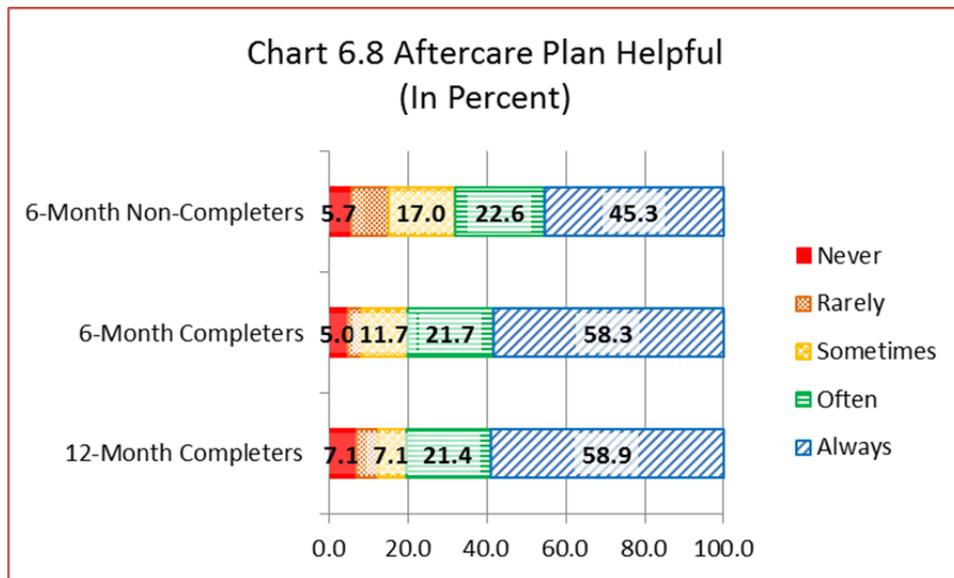
| | Six-Month Completers | Six-Month Non- Completers | Twelve Month Completers |
|--|---------------------------------|--|--|
| Satisfaction With | | | |
| Life in General | ↑ p < .01 | ↑ p < .05 | ↑ p < .05 |
| Physical Health | ↔ ns | ↔ ns | ↑ p < .05 |
| Emotional Wellbeing | ↑ p < .01 | ↔ ns | ↑ p < .01 |
| Relationship with Spouse/SO | ↑ p < .01 | ↔ ns | ↔ ns |
| Relationship with Children | ↔ ns | ↔ ns | ↔ ns |
| Relationship with Friends | ↔ ns | ↔ ns | ↔ ns |
| Relationship with other Family | ↔ ns | ↔ ns | ↔ ns |
| Job | ↔ ns | ↔ ns | ↑ p < .05 |
| School | ↔ ns | ↔ ns | ↔ ns |
| Spiritual Wellbeing | ↔ ns | ↔ ns | ↑ p < .05 |
| Activities | | | |
| Accomplish Responsibility at Home | ↔ ns | ↔ ns | ↔ ns |
| Accomplish Responsibility at Work | ↔ ns | ↔ ns | ↔ ns |
| Pay Bills | ↔ ns | ↔ ns | ↑ p < .01 |
| Thoughts of Suicide | ↔ ns | ↔ 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 | ↑ p < .01 | ↔ ns | ↑ p < .01 |
| Take off Time to Rest/Relax | ↔ ns | ↔ ns | ↑ p < .05 |
| Eat Health Foods | ↔ ns | ↔ ns | ↔ ns |
| Exercise | ↔ ns | ↔ ns | ↔ ns |
| Attend GA/Community Support | ↑ p < .05 | ↔ ns | ↑ p < .01 |
| DSM Criteria | | | |
| Thinking about gambling | ↑ p < .01 | ↑ p < .01 | ↑ 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 < .05 | ↑ p < .05 |
| Borrowed from others | ↑ p < .01 | ↑ p < .01 | ↑ p < .01 |
| Key: ↑ Improvement; ↓ Regression; ↔ No Change | | | |

This year, non-completers demonstrated fewer statistically significant improvements than have been previously reported. (Table 6.27)

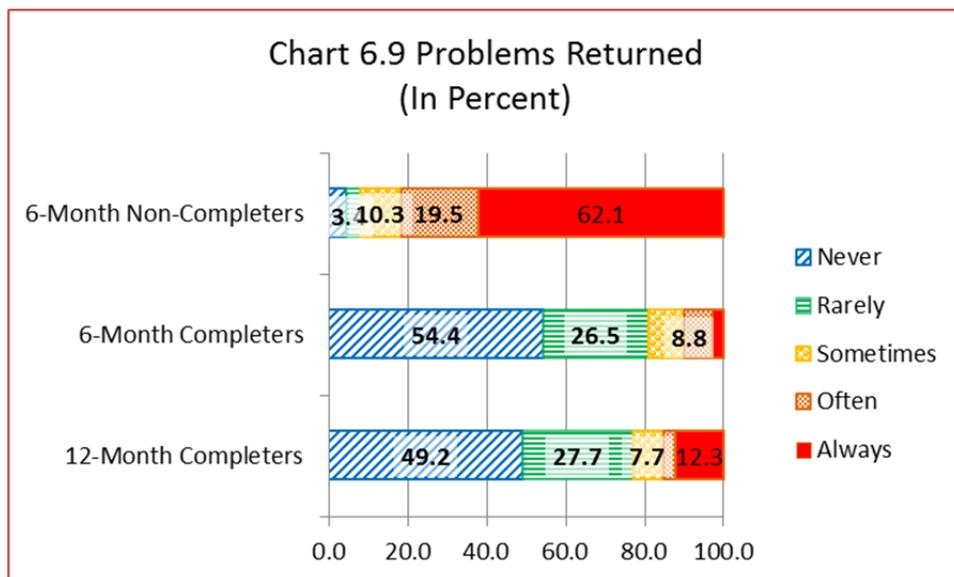
Care should be taken in interpreting the ANOVA findings as the findings are not from a controlled study and intervening variables, such as higher levels of satisfaction in the key wellness and recovery domains at enrollment for example, preclude the opportunity to numerically demonstrate improvement 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 data regarding changes from six to twelve months.



Individuals who completed treatment were again this year positive regarding the helpfulness of their treatment experience. Nearly 86.4% of those in the 12-month sample were positive (71.2% always; 15.2% often) and 92.1% of the six month successful completer sample reported positive satisfaction. Approximately 76.1% of the non-completers endorsed this item as often or always. (Chart 6.7)

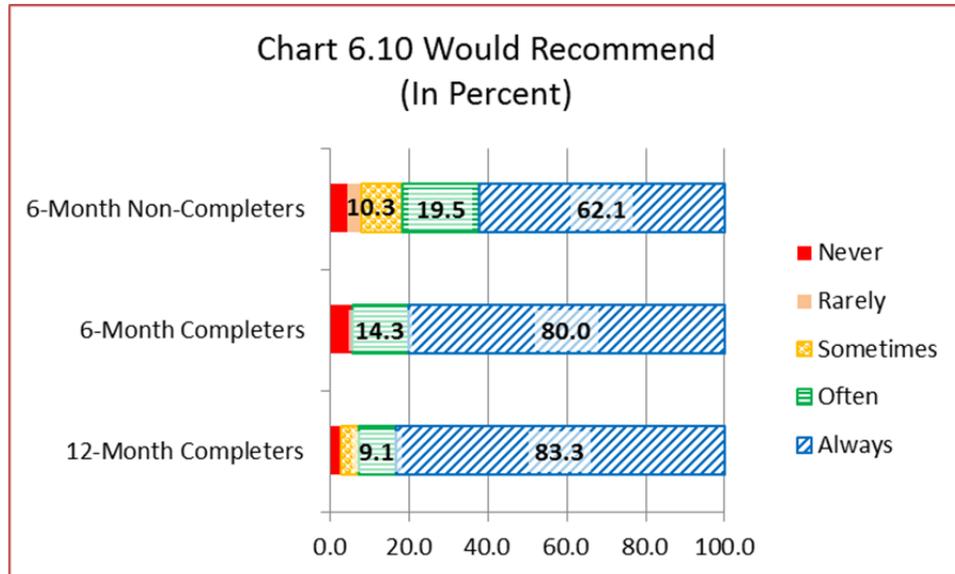


Approximately 80.3% of the twelve month sample and 80.0% of the six month reported positive satisfaction with the helpfulness of their aftercare/continuing care plan compared with only 45.3% of the non-completers who also reported less success with abstinence. (Chart 6.8)



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 81.6% reporting always or often.

As expected the six month sample was somewhat more positive than the twelve month sample with would be expected. (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 92.4% (83.3% always and 9.1% often). Similarly, the six month sample demonstrated a 94.3% positive endorsement. As expected, those who did not successfully complete the programs reported a lower endorsement rate of 81.6% that is still considered good for those who left the program prior to completion. (Chart 6.10)

7. RESIDENTIAL CARE

The 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.

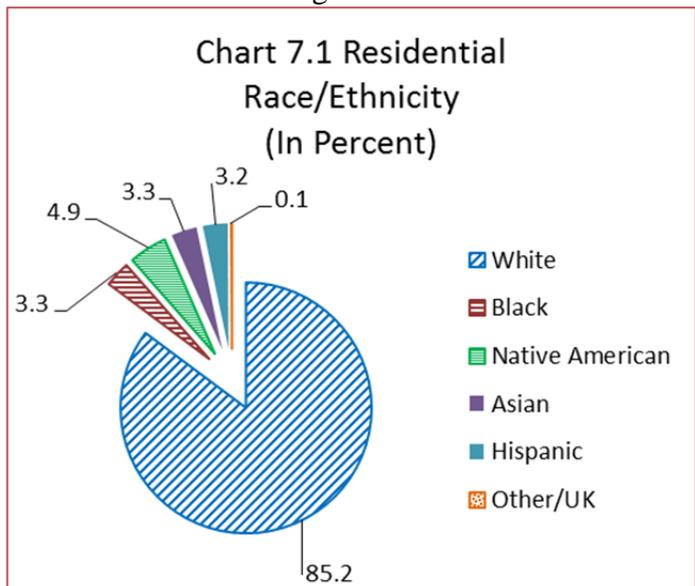
In order for individuals to be eligible for residential or respite care they normally need to have a referral from a state-approved gambling treatment program and are expected to be referred back to that outpatient program following treatment. During the period, 61 individuals, up from 52 reported last year, were enrolled. Approximately 13.1% of the clients had received prior treatment at the program since 2009 and 3.3% had been readmitted during the report year.

| | n | mean | sd |
|---------|----|------|------|
| All | 61 | 48.5 | 12.0 |
| Males | 28 | 46.7 | 14.1 |
| Females | 33 | 50.0 | 9.7 |

The average age of clients in the residential program was 48.5 years up again somewhat from 47.7 years previously reported. 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.

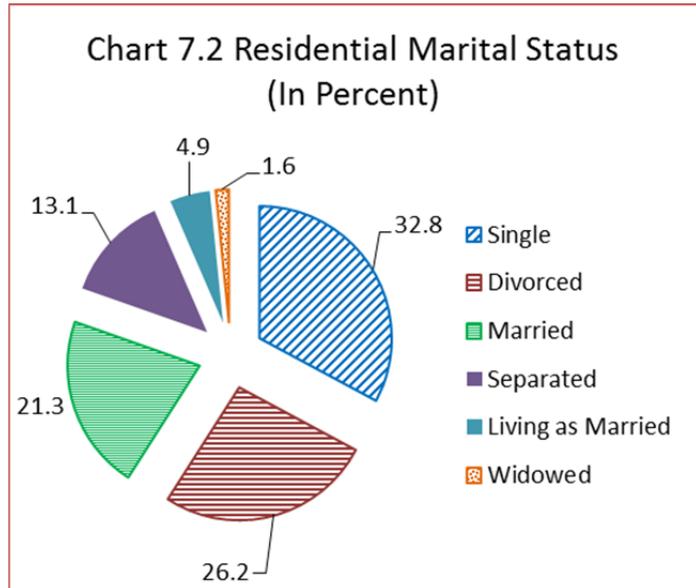
This year, approximately 60.5% of the clients were females compared with only 44.2% last year. (Table 7.1)

Approximately 85.2% of the clients were reported as white, down from 90.4% reported last year. Small



increases were noted in the other groups but were not statistically significant. (Chart 7.1)

Approximately 32.8% of those enrolling were reported as being single, 26.2% divorced, 21.3% married, 13.1% separated, 4.9% living as married, and 1.6% widowed. As has been seen previously, there was shifting of the distributions with fewer single, more divorced, and fewer living as married. (Chart 7.2)



| | n | mean | sd |
|---------|----|----------|----------|
| All | 59 | 24,420.2 | 35,787.5 |
| Males | 26 | 27,048.5 | 42,926.0 |
| Females | 33 | 22,349.5 | 28,780.3 |

The average annual household income was reported as \$24,420.2, and was significantly³⁸ lower than the \$34,896.3 previously reported. The median income was \$18,000 (down from \$21,600 reported last year). Males reported a higher income than

females but the difference was not statistically significant. (Table 7.2)

The average gambling related debt, for those who reported a gambling debt (82.0%), was approximately \$63,833.6. This average debt was

| | n | mean | sd |
|---------|----|-----------|-----------|
| All | 50 | 63,833.6 | 169,312.0 |
| Males | 21 | 101,799.0 | 250,602.0 |
| Females | 29 | 36,341.4 | 46,353.6 |

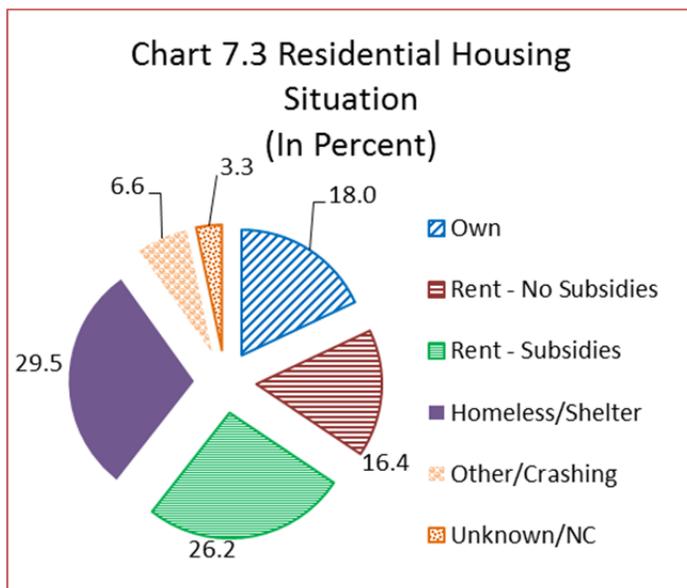
extremely high and was skewed by one male reporting a debt of \$1.2 million and two other individuals reporting debts of \$200,000 each. Removing the one outlier reduced the average

³⁸ p < .05

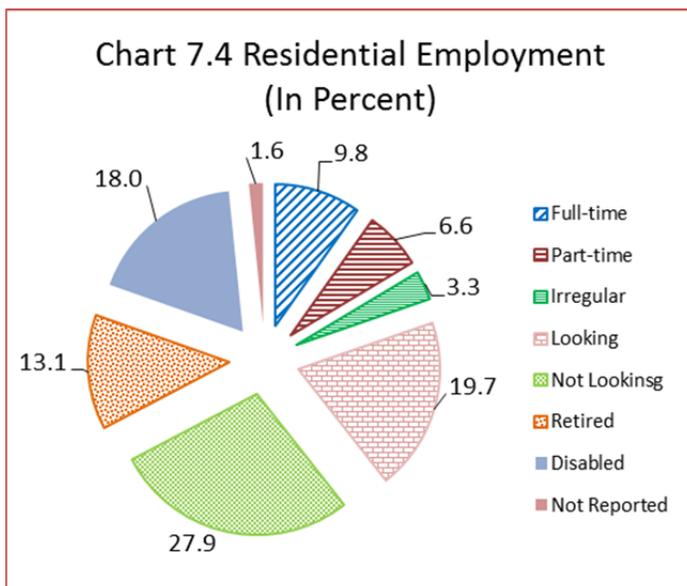
to \$33,194.67 and removing all three of the outliers the average was reduced to \$27,442.8, \$18,595, down from \$34,202 previously reported. Nonetheless, nearly 15% of the clients reported debts of \$100,000 or more. (Table 7.3)

The average number of years of education was 12.9 years with males having slightly more years with 13.1 years compared with 12.7 years – essentially unchanged from last year.

Approximately 26.2% reported living in a subsidy supported rental, 18.0% in a home owned by them or their family, and another 16.4% were reported as living in a market rental. Approximately 29.5% were reported as homeless and another 6.6% “crashing” essentially raising the homeless rate to 36.1% by federal definition. (Chart 7.3)



There was a substantial difference in the distributions relating to employment status this year. Full-time employment was 9.8%, down from 17.3%; part-time was 6.6% down from 7.7%; unemployed and looking for work was 19.7% down



from 26.9%; unemployed and not looking for work was 27.9% up from 15.4%; retired was 13.1% up from 5.8%; and, disabled was 18.0% down from 23.1%. These differences could be due to having more females enrolled than males this year and employment characteristic do tend to be different for females. (Chart 7.4)

The primary gambling activity of residential clients was machine-based (42.6% video poker, 14.8% video line games and 36.1% slot/reel machines). Cards were reported by 4.9% of the clients (all males). Females only reported machine-based activities: video line games (48.5%), video poker (36.4%), and slot/reel 15.2%. Approximately 80.4% reported primarily gambling at a lottery retailer (bar/pub) and 16.4% at a casino/IGC.

The average age of first gambling experience was 21.1 years. Males reported 18.0 years old and females 23.7 years. The average age of onset of problem gambling was reported as 35.8 years with males younger (29.9 years) than females (40.8 years). These findings were similar to those previously reported.

The average number of DSM IV criteria endorsed by the residential clients was 8.4. This was significantly³⁹ higher than the average reported for the general outpatient population reported above. There 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 7.4)

| | |
|-------------------------------|-------|
| Unsuccessful attempts to stop | 100.0 |
| Lying | 100.0 |
| Preoccupation | 96.4 |
| Increasing size of bets | 92.9 |
| Escaping | 92.9 |
| Jeopardized relationship/job | 92.9 |
| Returning to get even | 89.3 |
| Restlessness | 82.1 |
| Relies on others for money | 67.9 |
| Committed illegal acts | 17.9 |

³⁹ p < .01

Approximately 37.7% of the residential clients reported having thoughts of suicide, none reported threatening suicide, 3.3% reported having a plan, and 6.6% reported making an attempt at suicide in the past six months. These findings are similar to last year however with an increase in the number individuals reporting attempting suicide. (Table 7.5)

| | |
|----------|------|
| Thoughts | 37.7 |
| Threat | 0.0 |
| Plan | 3.3 |
| Action | 6.6 |

Approximately 50.0% reported having employment problems and 83.3% reported relationship problems related to their gambling. Approximately 25.4% reported having legal problems and 8.3% reported filing, or planning to file, for bankruptcy.

Lag time from initial call to first availability of a bed was 15.5 days, up from 12.4 calendar days reported last year. Males were somewhat more likely to experience a longer delay than females. The average number of work days to first available was 11.7 work days. The average lag time from first call to first seen was 15.9 days with males (19.4% days) experiencing a significantly⁴⁰ longer delay than females (12.8 days). (Table 7.6)

| | n | mean | sd |
|---------|----|------|------|
| All | 61 | 15.5 | 13.3 |
| Males | 28 | 18.9 | 14.5 |
| Females | 33 | 12.6 | 11.5 |

The average length of stay (LOS) at residential treatment was 37.1 days, up slightly from 35.6 days previously reported. For those successfully completing treatment, the average number of days enrolled was 50.8 days. (Table 7.7)

| | n | mean | sd |
|---------|----|------|------|
| All | 57 | 37.1 | 23.9 |
| Males | 26 | 35.1 | 25.5 |
| Females | 31 | 38.8 | 22.4 |

The unadjusted successful completion rate was 57.9% essentially the same as previously reported. The adjusted completion rate was 62.3%. Approximately 35.1% were

⁴⁰ p < .05

reported as refusing treatment and leaving against staff advice.

Although there is an expectation that, upon graduation, residential clients are referred back to the outpatient program in their area for follow-up outpatient/aftercare, there was little evidence of this based on data submitted by the residential program or outpatient programs.

Short-term respite service was also available during the year through Options for Southern Oregon in Josephine County. Eligibility for this service is the same as for residential service. Interestingly, there were no enrollments reported for this service.

8. MINIMAL INTERVENTION PROGRAM (GEAR)

The demonstration minimal intervention treatment program was initially placed in the field 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 pathological gamblers. A secondary purpose of the demonstration was to serve pathological 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

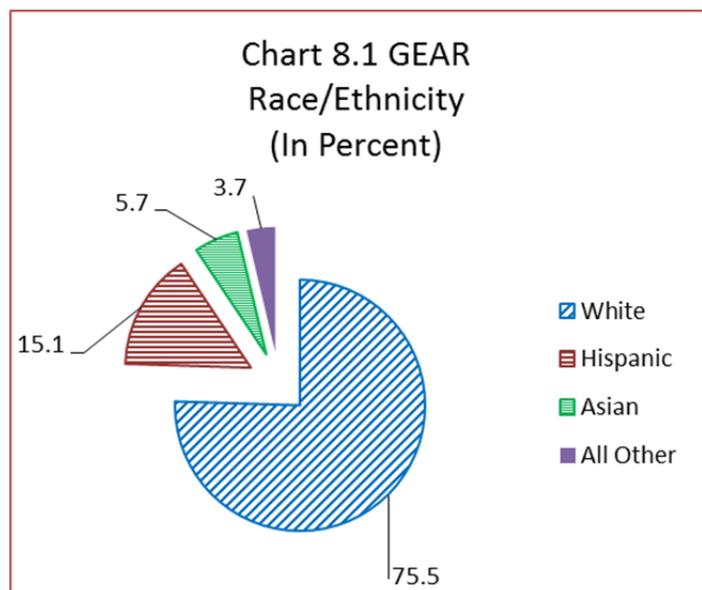
problems with gambling, and had been diagnosed as disordered gamblers. Due to funding shortages and lack of extensive utilization, the program was temporarily closed in FY 10-11 and refunded for a partial period of FY 11-12.

The total number of gamblers reported this year was 53 up from 44 last year. This year two family clients were enrolled, down from four 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 49.3 years, down significantly⁴¹ from 55.0 years reported last year, up from 49.0 years previously reported. Females were again significantly⁴² older than males and were somewhat more likely than males to enroll in the GEAR program than as in the outpatient programs. (Table 8.1)

| | n | mean | sd |
|---------|----|------|------|
| All | 53 | 49.3 | 12.4 |
| Males | 22 | 45.5 | 13.8 |
| Females | 31 | 51.9 | 10.4 |

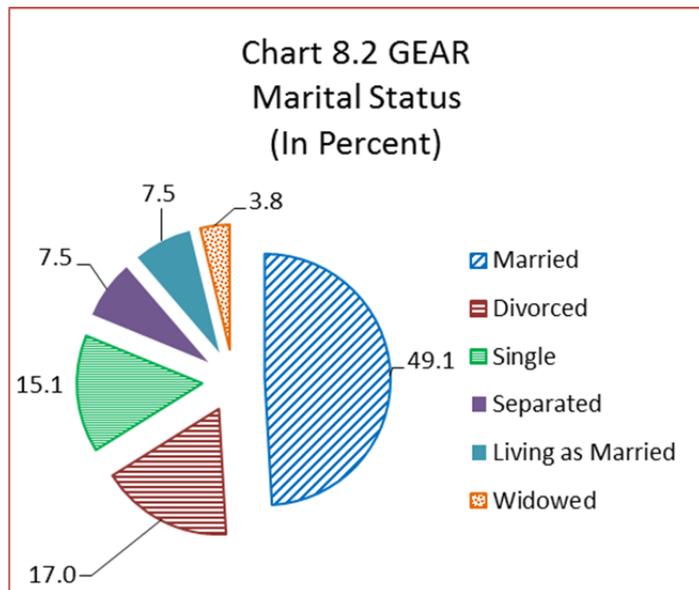
Approximately 75.5% were reported as White, down from 90.0% previously reported. Approximately 15.1% were reported as Hispanic, up from 2.5%; and 5.7% Asian, up from zero percent last year. (Chart 8.1)



⁴¹ p < .05

⁴² p < .05

Approximately 49.1% of those enrolling in GEAR reported being married, up from 22.5% previously reported. Seventeen percent were reported as divorced and 15.1% as single, down from 25.0%. These distributions are different from those previously



reported but the differences were not significant due to the small sample size. (Chart 8.2)

The average annual household income for the GEAR clients was \$59,471.3 up from \$47,055.8. The median income was \$48,000 up from \$42,000. The average income was significantly⁴³ higher than the outpatient clients' and there was no statistically significant difference between the genders. (Table 8.2)

| | n | mean | sd |
|---------|----|----------|----------|
| All | 49 | 59,471.3 | 41,186.8 |
| Males | 19 | 64,899.8 | 38,490.3 |
| Females | 30 | 56,033.2 | 42,449.3 |

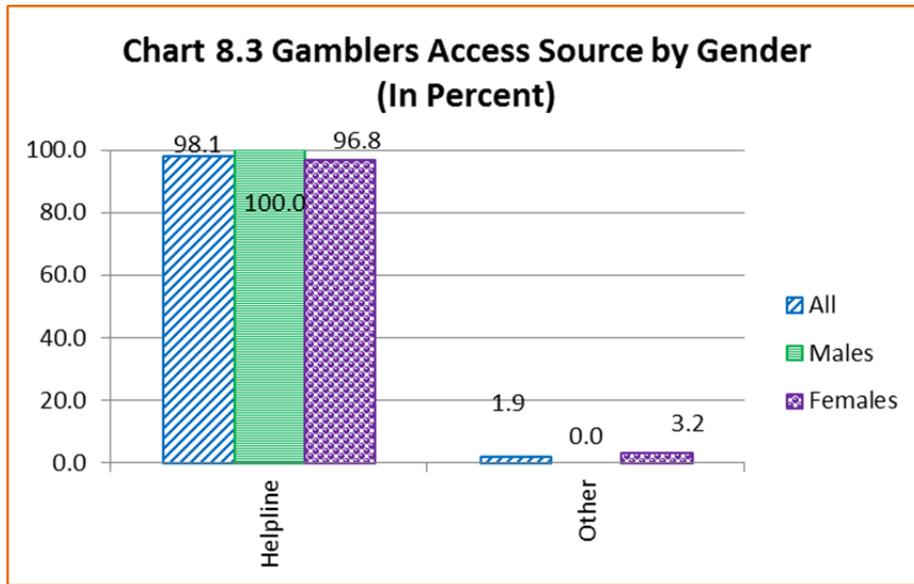
The average numbers of years of education completed was 13.5 the same as previously reported. (Table 8.3)

| | n | Mean | sd |
|---------|----|------|-----|
| All | 53 | 13.5 | 2.8 |
| Males | 22 | 13.2 | 3.3 |
| Females | 31 | 13.7 | 2.3 |

A majority of the clients (98.1%) reported accessing the GEAR program through the Helpline⁴⁴ and 1.9% reported learning of the program from another source. (Chart 8.3)

⁴³ p < .05

⁴⁴ It should be noted that the same agency operates the Helpline and GEAR.



As previously reported, the primary gambling activity for both males and females were machines (video poker, slots, line games) with video poker being the more frequently reported game. (Table 8.4)

| | All | Males | Females |
|-----------|------|-------|---------|
| Machines | 94.3 | 86.4 | 100.0 |
| All Other | 5.7 | 13.6 | 0.0 |

Approximately 77.4% reported video lottery retailers as the primary location followed by casino/IGG 17.0% and internet 3.8%. Males and females reported lottery retailers as the primary location; nonetheless, males reported the internet second at 9.1% while females reported casino/IGC as second at 25.8%.

The reported lag time from initial call to first available was reported as 11.5 calendar days, up from 10.5 calendar days. There was essentially no difference between males and females. The lag from initial call to first clinical contact was reported as 14.3 day, up from 12.4 days (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 26.0, down somewhat from 28.6 years previously reported. Females reported an older age (29.9 years) of their first gambling experience than males (19.9 years) and the difference was significant.⁴⁵ (Table 8.5)

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 51 | 26.0 | 12.7 |
| Males | 20 | 19.9 | 7.6 |
| Females | 31 | 29.9 | 13.8 |

The average age of onset was 38.1 years, down from 43.6 years previously reported. Females reported a significantly⁴⁶ older age than males. (Tables 8.6)

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 51 | 38.1 | 13.8 |
| Males | 20 | 32.1 | 11.8 |
| Females | 31 | 42.0 | 13.6 |

The average number of DSM IV criteria endorsed was 8.3, up slightly from 8.0 previously reported. This average was significantly⁴⁷ greater than the average for the outpatient population which was 7.6, and not significantly different from the residential clients with an average of 8.4 items endorsed.

One female and one male were reported as having had thoughts of suicide in the past six months prior to enrollment. None reported making a threat, plan, or attempt. (Table 8.7)

| | (%) |
|----------|------------|
| Thoughts | 3.7 |
| Threat | 0.0 |
| Plan | 0.0 |
| Action | 0.0 |

Five males and one female were reported as having employment related problems due to their gambling; two females reported planning, or

⁴⁵ p < .01

⁴⁶ p < .01

⁴⁷ p < .01

recently filing, for bankruptcy; and, four males and one female reported relationship problems. Two females reported bankruptcy actions and one female reported legal problems associated with their gambling.

The average length of time reported being enrolled in GEAR was 294.0, up from 217.2 days previously reported and there were no differences in length of stay for males and females. (Table 8.8)

| | n | Mean | sd |
|---------|----------|-------------|-----------|
| All | 51 | 294.0 | 267.3 |
| Males | 21 | 273.6 | 226.9 |
| Females | 30 | 308.3 | 291.4 |

The average length of enrollment for those who were reported as successfully completing the program was 344.1 with females remaining significantly longer.⁴⁸ (Table 8.9)

The unadjusted successful completion rate was 56.9% up from 48% previously reported.

| | n | Mean | sd |
|---------|----------|-------------|-----------|
| All | 29 | 344.1 | 206.2 |
| Males | 17 | 259.6 | 124.2 |
| Females | 12 | 463.8 | 237.6 |

⁴⁸ p < .01

9. CORRECTIONAL 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 OHA and the Department of Corrections (DOC) implemented an “out-patient” based treatment service for those identified with gambling problems that was briefly discussed in the previous report.

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 A&D treatment communities including Turning Point, LIFT, and Westcare.

GRIP is a 12-session 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.

During the report period 39 male participants were enrolled at CRCI and 28 female participants at CCCF. For these programs a much abbreviated dataset was utilized.⁴⁹

⁴⁹ Due to special request for corrections personnel some questions were not asked of these individuals during the intake process.

The average age of the CRCI participants was 33.8 years and that for the CCCF participants the average age was 33.7 years. Both groups were significantly younger than their counterparts in the traditional outpatient programs. (Table 9.1)

| | n | mean | sd |
|--------------|----|------|-----|
| CRCI Males | 38 | 33.8 | 8.0 |
| CCCF Females | 28 | 33.7 | 7.8 |

As with the traditional programs, White/Caucasian was the largest racial/ethnic group in both programs. As can be seen in the accompanying table, there were difference in the distributions but due to small cell sizes no tests for statistical significance were conducted. (Table 9.2)

| | CRCI | CCCF |
|-----------------|------|------|
| White | 69.2 | 71.4 |
| Hispanic | 10.3 | 10.7 |
| Native American | 7.7 | 10.7 |
| Black | 5.1 | 3.6 |
| Asian | 2.6 | 0.0 |
| All Other | 5.1 | 3.6 |

The average number of years of education for both programs was 11.6 years. (Table 9.3)

| | n | mean | sd |
|------|----|------|-----|
| CRCI | 37 | 11.6 | 1.4 |
| CCCF | 28 | 11.6 | 2.1 |

| | CRCI | CCCF |
|----------------------|------|------|
| Single Never Married | 69.2 | 67.9 |
| Married | 17.9 | 10.7 |
| Divorced | 5.1 | 7.1 |
| Separated | 2.6 | 7.1 |
| Widowed | 0.0 | 0.0 |
| Living as Married | 0.0 | 7.1 |
| Not Reported | 5.1 | 0.0 |

Males were somewhat more likely to be married than females. (Table 9.4)

The average age of first gambling experience was reported by males as 15.6 years and females as 20.4 years – both significantly⁵⁰ younger than their traditional outpatient counterparts. (Table 9.5)

| | n | mean | sd |
|------|----------|-------------|-----------|
| CRCI | 39 | 15.6 | 5.9 |
| CCCF | 28 | 20.4 | 5.8 |

The average age of onset of problems related to gambling was 23.9 years for males and 27.0 years for females – also significantly⁵¹ younger than their traditional outpatient counterparts. (Table 9.6)

| | n | mean | sd |
|------|----------|-------------|-----------|
| CRCI | 36 | 23.9 | 7.3 |
| CCCF | 28 | 27.0 | 7.7 |

The average number of DSM criteria endorsed by the males was 5.9, significantly⁵² less than the 8.1 average for the females and the 7.5 for the traditional outpatient males. Although the females’ 8.1 average score was higher than their traditional outpatient counterparts, the difference was not significant. (Table 9.7)

| | n | mean | sd |
|------|----------|-------------|-----------|
| CRCI | 39 | 5.9 | 2.8 |
| CCCF | 28 | 8.1 | 1.7 |

Approximately one-third of the males and three-quarters of the females report a debt related to gambling. Although the average debt for males of \$13,958 was higher than that for the

| | All | mean | sd |
|------|------------|-------------|-----------|
| CRCI | 12 | 13,958.3 | 14,635.1 |
| CCCF | 22 | 8,281.8 | 16,084.3 |

females (\$8,281.8) the difference was not significant. Nonetheless, both were significantly⁵³ lower than that reported for the traditional outpatient counterparts. (Table 9.8)

During the report period 80 cases were closed with 73 (91.3%) reported as successful completions (88.7% of the males and 96.4% of the females).

⁵⁰ p < .05

⁵¹ p < .05

⁵² P < .01

⁵³ p < .05

The average number of encounters overall was 9.4 with 9.9 for those reported as successfully completing their course of treatment. The average case cost overall was \$372.9 and for the successful completers it was \$392.3. (Table 9.9)

| | n | mean | sd |
|-----------------------|----------|-------------|-----------|
| Encounters | | | |
| All Gamblers | 80 | 9.4 | 3.2 |
| Successful Completers | 73 | 9.9 | 2.7 |
| Dollars | | | |
| All Gamblers | 80 | 372.9 | 127.0 |
| Successful Completers | 73 | 392.3 | 106.2 |

10. PEER SUPPORT SERVICES

Peer Delivered Services is defined as any services 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 addictions services. There are additional requirements regarding length of abstinence required as specified by the state.⁵⁴

Prior to the issuance of the billing codes for peer services, Voices of Problem Gambling Recovery (VPGR)⁵⁵ working closely with the Addiction Counselor Certification Board of Oregon (ACCBO) took the initiative to develop and implement a training curricula that would meet the certification standards of ACCBO and be consistent with standards associated with peer support in mental health and other addictions.⁵⁶ The terminology utilized by ACCBO is Certified Gambling Recovery Mentor (CGRM).⁵⁷

⁵⁴ Extracted from Oregon PGS Procedure Codes and Rates 2015-16

⁵⁵ A consumer-based 501 (c) 3 funded by PGS and based in Portland, Oregon

⁵⁶ ACCBO is affiliated with the International Certification & Reciprocity Consortium

⁵⁷ 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 ACCBO 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 was first used in October 2014; and, since initiation, only six agencies reported any peer mentor encounters and only three for the current report period (Best Care [Bend], Polk County, and Yamhill County). Several other agencies have accessed these services from Voices and that activity is reported below.

Twenty-six outpatient clients received direct peer services this year, down from 77 receiving services last year. Only 195 encounters were reported, down from 712 with a total cost of \$6,753, down from \$24,390 previously reported. (Table 10.1)

| | |
|---------------------------|---------|
| Total Clients Served | 26 |
| Total Encounters Reported | 195 |
| Total Cost of Services | \$6,753 |

The average age of clients was 49.7 with no significant difference between genders. Females were somewhat more likely to be served by a mentor. (Table 10.2)

| | n | mean | sd |
|---------|----|------|------|
| All | 26 | 49.7 | 12.0 |
| Males | 11 | 50.6 | 12.8 |
| Females | 15 | 49.1 | 11.3 |

Of the 26 outpatient clients who received mentoring services during the period, 14 were discharged from their outpatient program with 78.6% of them reported as successfully completing. Again, although promising, this finding is very coarse and may or may not be replicable in a rigorously controlled study due the large number of intervening variables.

In addition to the traditional treatment program-based peer services, VPGR made application to 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,⁵⁸ 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 76 individuals have been enrolled. During the report period a total of 31 clients were enrolled and their average age was 49.7

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 31 | 49.7 | 10.3 |
| Males | 11 | 50.3 | 11.4 |
| Females | 20 | 49.3 | 9.7 |

years, somewhat older than the outpatient clients. Females were somewhat younger than males. (Table 10.3)

During the report period, clients were reported as coming from five state-funded agencies, GA, and the community. Approximately 84.5% were from the state-funded agencies, 12.5% from the community (not associated with any state-funded program), and 3.1% from GA. (Table 10.4)

| | |
|-----------------------|------|
| Lewis & Clark | 40.6 |
| Cascadia Multnomah | 18.8 |
| Cascadia Clackamas | 9.4 |
| VOA INACT | 9.4 |
| Bridgeway Residential | 6.3 |
| GA | 3.1 |
| Community | 12.5 |

During the report period, 19 cases were closed with a 15.8% successful closing rate. Over the life of the project the evaluation team was able to match 45 mentor clients with their outpatient

| | |
|----------------------------|----------|
| Total Clients Served | 59 |
| Total Direct Service Hours | 3,784.50 |

⁵⁸ This was state PGS funding that was not used for the established treatment programs in the County.

treatment program data. Of these, 33 had been discharged from the outpatient program with 45.5% being reported as successful.

Encounter data was submitted for 59 VPGR clients with approximately 3,784.50 direct service hours. The program is grant funded (not a fee for service model) so it is difficult to determine case costs. (Table 10.5)

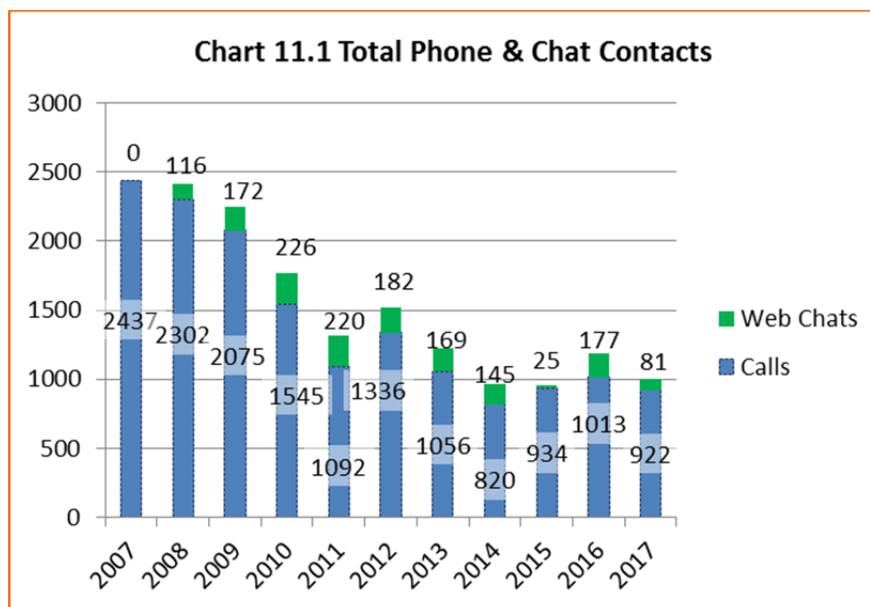
During the year, one participant received, on average, 7.4 hours per week of direct services and three others averaged over five service hours per week for the year. Overall the average number of contact hours was 0.9 hours per week and the median contact time was approximately 0.6 hours per week. (These figures were not adjusted for length of enrollment.)

There were four mentors actively providing services during the year. Their level of effort averaged approximately 0.5 FTE, although two were engaged at an approximate 0.75 FTE. Approximately 73.0% of their effort was devoted to direct services, approximately 9.2% for outreach, 2.9% for supervision, and 15% travel time.

| | |
|-----------------------|-----------------|
| Individual Counseling | 3,177.50 |
| Case Management | 17.75 |
| Supervision | 126.00 |
| Travel Time | 657.50 |
| Outreach | 404.00 |
| Total | 4,382.75 |

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 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.



Over the last seven years contact with the Helpline has remain depressed with some fluctuations. This year 922 calls for assistance were reported to the evaluation team along with 81 chat sessions. (Chart 11.1)

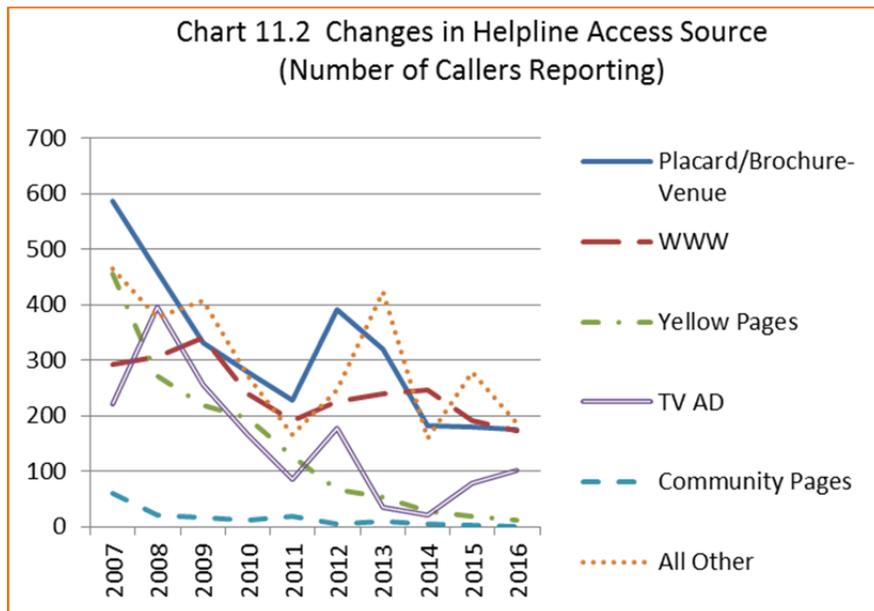
Tracking Spanish language calls was initiated for the previous report period where 68 (6.7%) of all the calls were reported as Spanish speaking callers. This year 109 (11.8%) Spanish Language calls were reported.

After callers 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.

When video lottery machines were introduced, a requirement was made that each machine has the toll-free number conspicuously placed where users could see it when playing. From the onset of the Helpline, the majority of callers reported accessing the number from the placard, or from brochures, at the gambling venue. Over the years that has remained the primary source callers report. For several years the Oregon Lottery provided extensive treatment orientated advertising and that became the second most frequently cited source for accessing the Helpline.

Early on, the use of Yellow Pages was documented to also be a reliable source for callers to acquire the Helpline contact information. As preferences for information sources have changed, Yellow and White Pages are no longer used and the internet has experienced an increase in reported use to find the Helpline. As can be seen in the accompanying table, sources for the phone number have fluctuated extensively. This is due to a plethora of intervening variables. (Chart 11.2)⁵⁹

⁵⁹ Due to extensive missing data for this data point the chart was not updated for the current year.

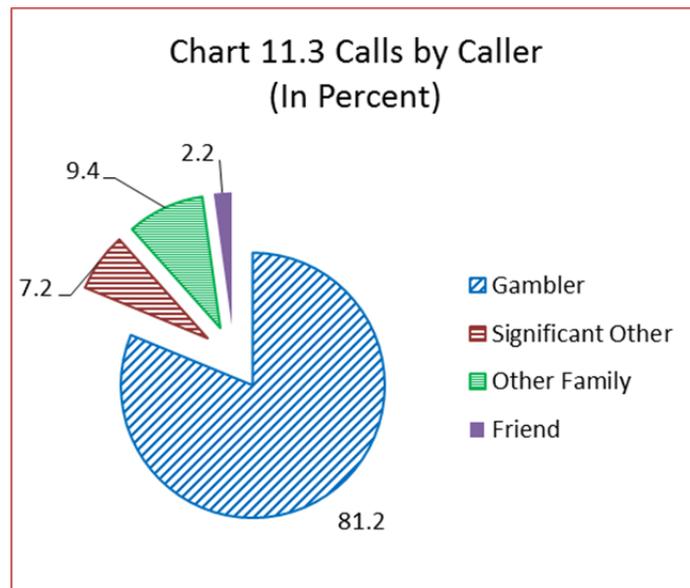


Of the 928 calls that were reported to the evaluator, approximately 56.4% were made during normal working hours; 28.7% were made on workdays but after normal work hours; and 15.0% were reported as being made during the weekends.

| | |
|-------------------|------|
| Normal Work Hours | 56.4 |
| After Hours | 28.7 |
| Weekend | 15.0 |

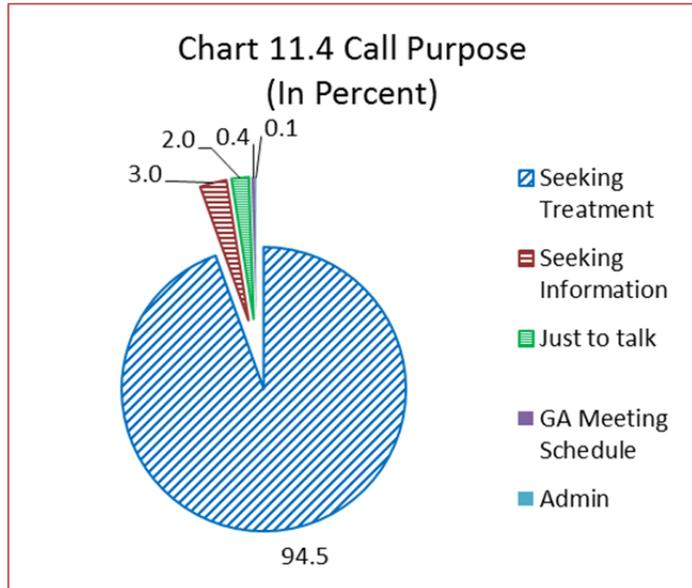
These distributions were similar to those previously reported. (Table 11.1)

Approximately 81.2% of the calls for assistance or information were reported as coming from the individual who was experiencing the gambling problems. Approximately 7.2% came from a spouse or significant other and another 9.4% from other family members. Approximately 2.2% of the calls were reported as coming from a concerned friend or



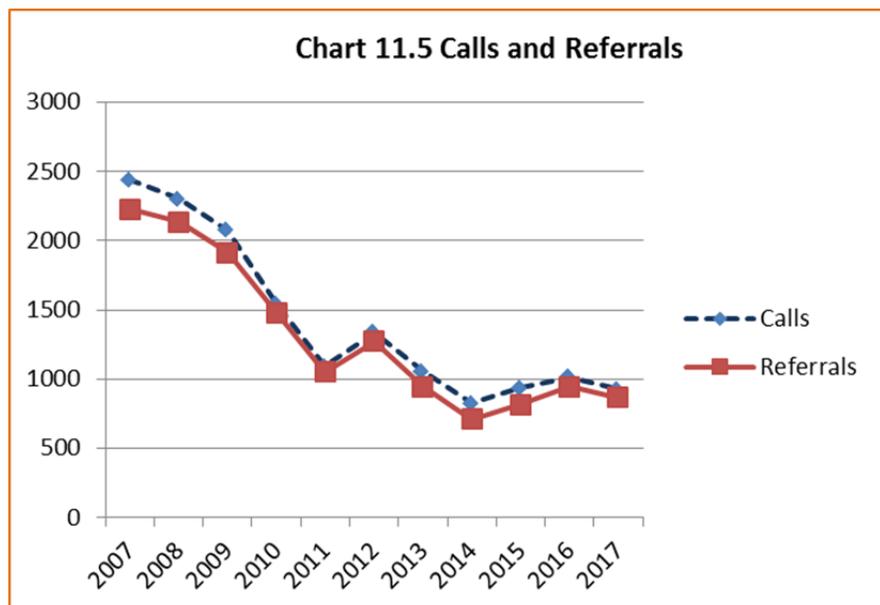
co-worker. This distribution of callers has remained fairly constant over the years. (Chart 11.3)

The majority of the calls (94.5%), as expected, were reported to be by individuals seeking treatment followed distantly by those seeking information (3.0%), the opportunity to speak with a counselor for support (2.0%), and those looking for recovery support and GA meeting schedules (0.4%). (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 182 direct referrals were reported, down from 186 previously reported.

Most calls do result in a referral to one of the numerous treatment agencies as can be seen in the accompanying chart. Of the 928 calls, 865



(93.2%), were referred to a treating agency. (Chart 11.5)

Four individuals were reported as experiencing suicidal ideation, two additional individuals having a plan but no means, and two more with plan and means to carry out the plan. (Table 11.2)

| | |
|-----------------|----|
| Ideation | 4 |
| Plan/Means | 2 |
| Plan/No Means | 2 |
| Recent Attempts | 01 |

A total of 81 chat sessions were reported to the

| Type | n | Purpose of Chat | | | | |
|-------------------|----|-------------------|------------------|-------------|--------------|-------|
| | | Seeking Treatment | Information Only | GA Meetings | Just to Chat | Admin |
| Gambler | 64 | 53 | 3 | 2 | 1 | 5 |
| Significant Other | 8 | 8 | 0 | 0 | 0 | 0 |
| Other Family | 8 | 5 | 3 | 0 | 0 | 0 |
| Friend | 1 | 0 | 0 | 0 | 1 | 0 |

evaluation team. Approximately 79.0% were with a gambler, and 9.9% each with significant others and other family members. Approximately 81.5% of these contacts were regarding getting treatment. (Table 11.3)

12. Family Client Demographics

In 1995, when the pilot programs were consolidated, 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 97, down from 118 and the lowest level of family enrollments since 1995-96. Females were much more likely⁶⁰ to be enrolled (64.9%, down from 71.8% previously reported) than males and they were somewhat more likely to be younger than the male family clients. (Table 12.1)

The majority (69.4%, up from

| | n | mean | sd |
|---------|----------|-------------|-----------|
| All | 94 | 48.8 | 13.5 |
| Males | 33 | 52.0 | 12.9 |
| Females | 61 | 47.1 | 13.4 |

| | All | Males | Females |
|-------------------|------------|--------------|----------------|
| Spouse/SO | 69.4 | 55.6 | 77.8 |
| Parent | 4.2 | 7.4 | 2.2 |
| Child | 16.7 | 29.6 | 8.9 |
| Sibling | 8.3 | 7.4 | 8.9 |
| Other Family | 0.0 | 0.0 | 0.0 |
| Co-Worker/Friend | 1.4 | 0.0 | 2.2 |
| Employee/Employer | 0.0 | 0.0 | 0.0 |
| Other | 0.0 | 0.0 | 0.0 |

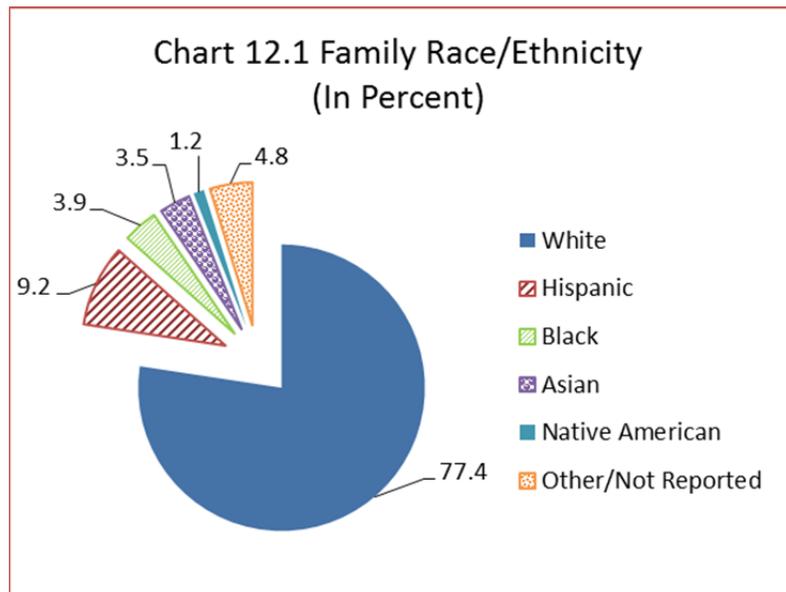
⁶⁰ p < .05

65.6%) of family clients were the spouse or significant other (SO) of a gambler. Following distantly were children (16.7%), siblings (8.3%), and parents (4.2%, down considerably from 18.3% previously reported). (Table 12.2)

Approximately 51.6% of the family members were reported as having a family member enrolled in treatment. Male gamblers were significantly⁶¹ more likely to have a female family member attending treatment than females. Again this year, gamblers successfully completing treatment during the year were significantly⁶² more likely to have a family member enrolled in treatment. (Table 12.3)

| | |
|--------------------------------|------|
| Gambler Male - Family Male | 12.0 |
| Gambler Male - Family Female | 54.0 |
| Gambler Female - Family Male | 24.0 |
| Gambler Female - Family Female | 10.0 |

Family client race/ethnicity somewhat mirrored that of the overall gambler population as would be expected. The majority were reported as White (77.4%, down from 80.7 and the second year in a row to see this decline), followed by

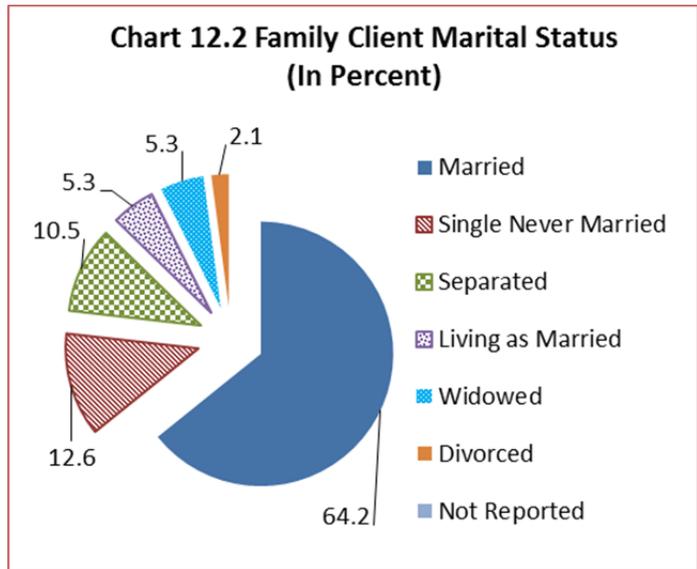


Hispanic (9.2% - same as last year), (3.5% - up from 1.6%), Black/African American (3.9%), and Native American 1.2%). (Chart 12.1)

⁶¹ p < .01

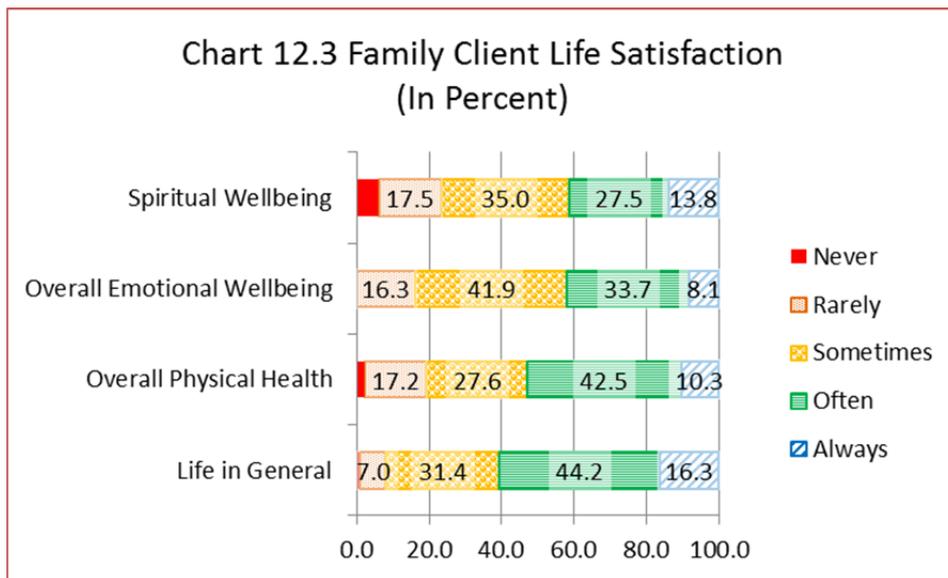
⁶² p < .01

Approximately 64.2% (up from 60.5%) of the family clients were married, 12.6% were reported as single - never married, 10.5% separated, 5.3% widowed, and 2.1% divorced. (Chart 12.2)

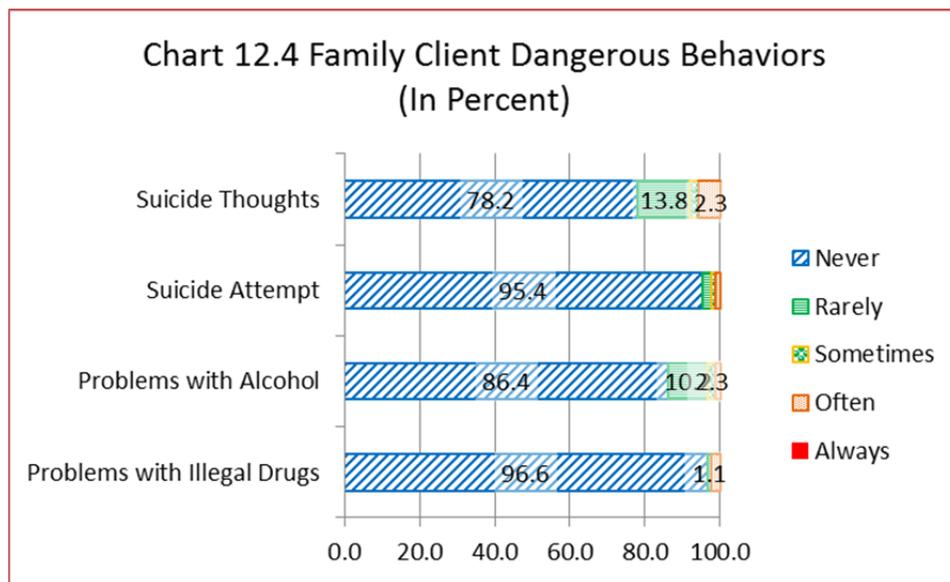


At enrollment, family clients, in the past six months, were only

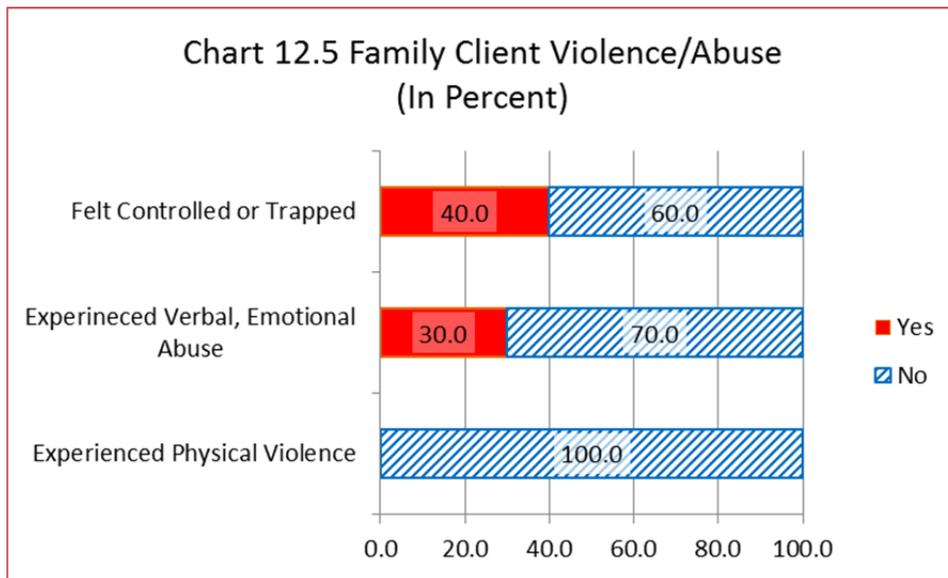
moderately satisfied with their life in general and overall physical health. Satisfaction with spiritual and emotional wellbeing was low similar to last year. (Chart 12.3)



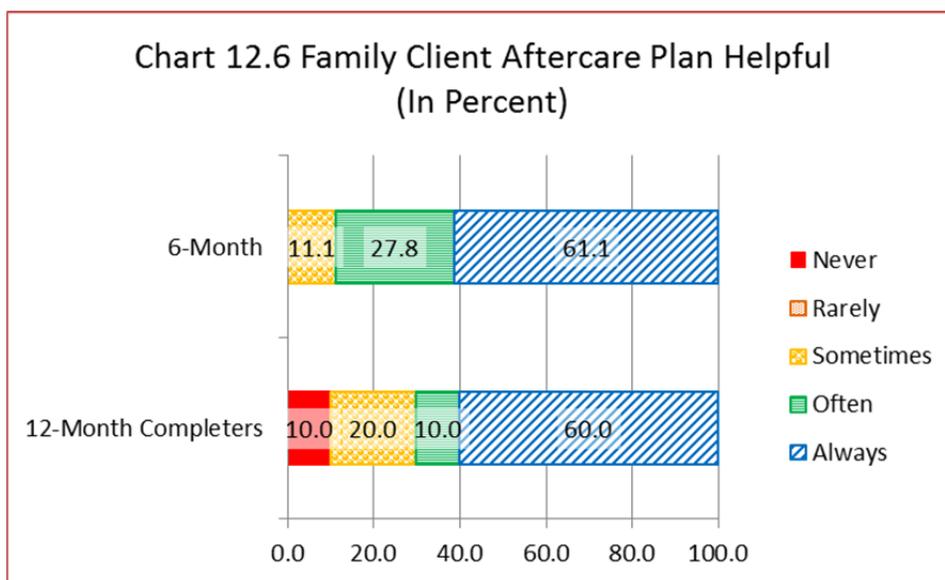
Approximately 21.8% (down from 23.5%) of the family members reported having any thought of suicide in the past six months with 5.7% reporting often. Approximately 6.6% reported attempting suicide rarely or sometimes. Having any problems with alcohol were endorsed by 13.6% (down from 19.4%) of the family clients and 3.4% (down from 7.8%) reported having any problems with drugs. (Chart 12.4)



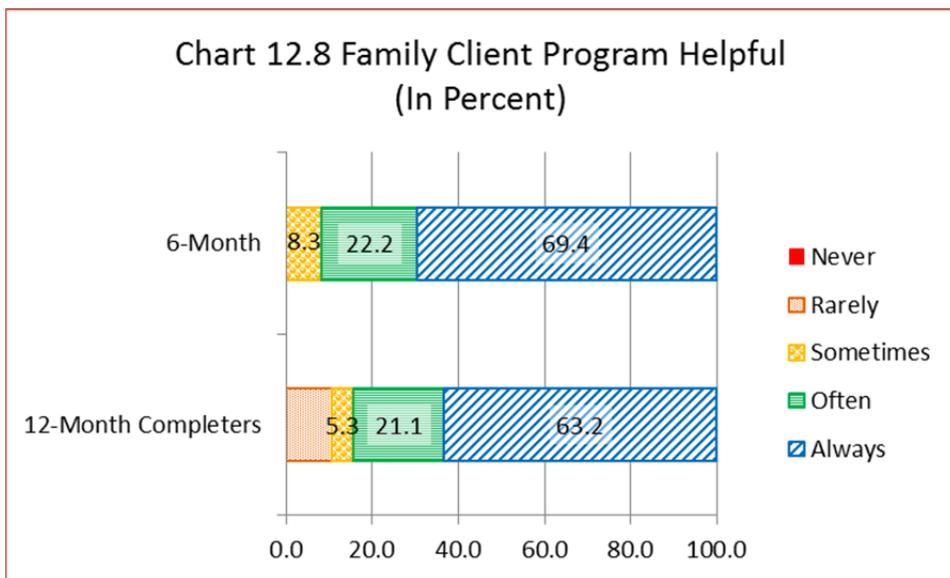
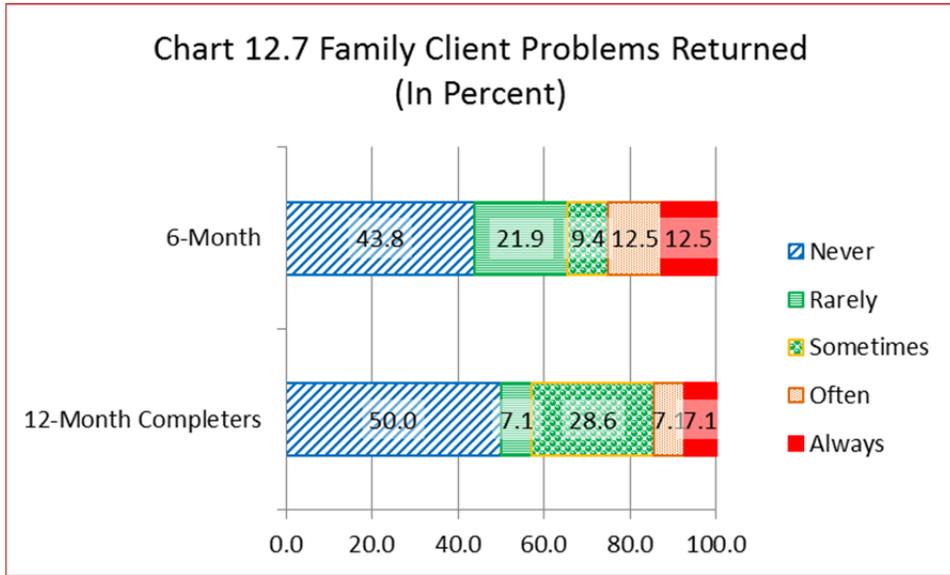
None of the family clients reported experiencing any physical violence in the previous six months while 30% reported experiencing verbal or emotional abuse and 40% reported feeling controlled or trapped in their relationship. These findings are similar to those previously reported. (Chart 12.5)



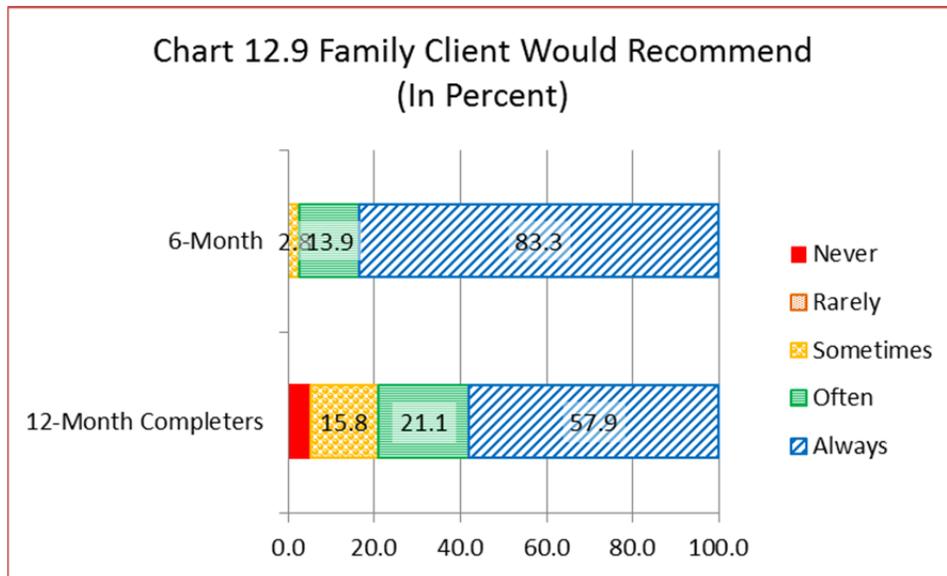
Family clients reported moderate helpfulness of their aftercare plans at both the six and twelve-month follow-up. It should be noted that family treatment encompasses an extremely broad range of care – from simple short-duration education to in depth, long term therapy – based on the needs of the individual. 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)



Approximately 50.0% of the twelve-month sample and 43.8% of the six-month sample reported no return of that brought them to the program. On the other end of the scale, 14.2% of the twelve-month sample reported the problems returned “always” or “often,” while 25% of the six-month sample so reported. (Chart 12.7)



Approximately 91.6% in the six-month follow-up reported the program was helpful “always” or “often” while 84.3% of the twelve month sample so reported. (Chart 12.8)



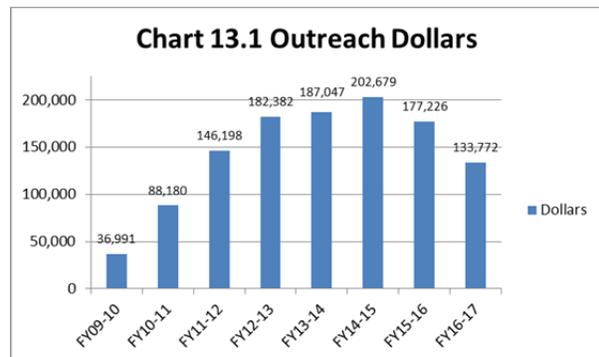
A very strong endorsement of the willingness of the six-month follow-up sample was reported with 97.2% indicating “always” or “often.” The twelve-month sample was less positive with 79.0% so reporting. It should be noted that willingness to recommend tends to diminish the longer away from the experience and that the six and twelve month samples are comprised of different participants. (Chart 12.9)

13. COMMENTS AND SUMMARY

The most perplexing finding reported was the continued drop in enrollments down 10.0% from last year and down approximately 51.7% from the highest year of FY 07-08. Adjusting for the current 28.8% outpatient recidivism rate, the adjusted enrollment rate was the lowest seen since FY 96-97. Adult prevalence studies conducted in Oregon since that time 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.

Initially, the plunge from FY 07-08 to FY 10-11 was hypothesized to have been influenced by the severe economic recession which may have encourage individuals to avoid treatment due to fear of losing a job or simply taking time off from a job. If this had been true, the expectation would have been that only individuals with the most severe symptomology would take the risk to enter treatment. In fact, based on the DSM criteria, those entering treatment during this report period were only slightly more severe than the average reported in FY 07-08 and the difference was not statistically significant.

In an effort curb the declining enrollments PGS authorized expenditure of funds to enable agencies to allow clinical staff to conduct community outreach activities. The first activities occurred in July 2009 with approximately \$37,000 being expended by agencies across the state that year.



By FY 14-15 that expenditure had increased to approximately \$203,000 and then began declining the following two years. A cursory comparison of these investments with the enrollments for FY 09-10 through FY 14-15 suggest a potential inverse relationship but with all the intervening variables there was more likely no effect. (Chart 13.1)

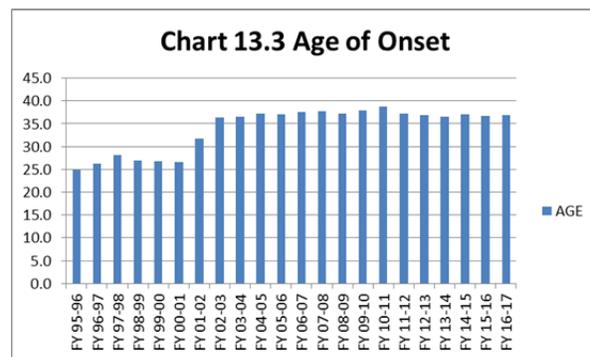
As noted above, the Oregon Lottery has an extensive history of promoting responsible gambling as well as access to treatment. Over the last five fiscal years the amount of that investment has risen



from approximately \$0.7 million to nearly \$2.9 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 preventative impact. (Chart 13.2)

In the first decade of treatment availability the age of onset of problem gambling rose significantly⁶³ 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 did not continue over the

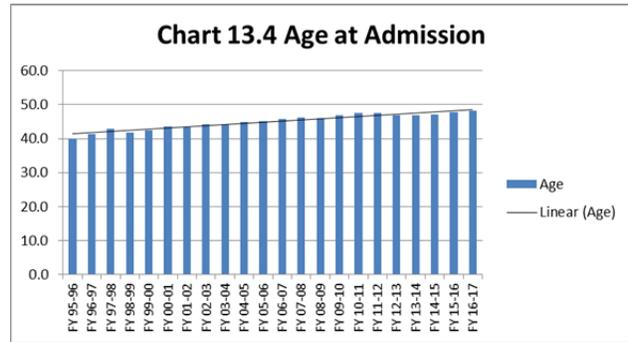
following 14 years. That initial jump was hypothesized to be related to an increased number of relatively older people participating in gambling for the first time with the relative “newness” of the



availability and subsequently experiencing problems at an older age. (Chart 13.3)

⁶³ p < .01

Further analysis of the available historic data did find an interesting trend in the average age at the time of enrollment. This age has increased relatively consistently from an average age of 40.0



years for FY 95-96 to a significantly⁶⁴ older average age of 48.2 years this year.

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 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 introduced in two prisons where previous educational and awareness interventions were highly successful, and at the time of this writing two other prisons have been identified for similar interventions.

As discussed in Section 6, approximately one-third of the outpatient gamblers were reported as having prior mental health treatment or A&D 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

⁶⁴ p < .001

relatively large portion of the mental health and addictions patients could benefit from problem gambling specific treatment.

APPENDIX A: 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 – Applying the Strategic Prevention Framework (SPF). (<http://www.samhsa.gov/capt/applying-strategic-prevention-framework>)

APPENDIX B: CENTER FOR SUBSTANCE ABUSE PREVENTION STRATEGIES

The US Center for Substance Abuse Prevention (CSAP) delineates six core strategies that included in the state's prevention efforts. These strategies include:

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.

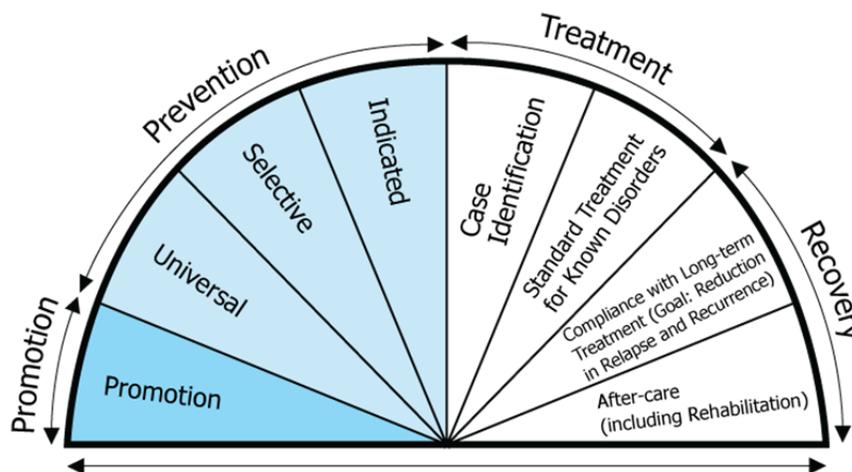
Reference: Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies. (2002). Best and Promising Practices for Substance Abuse Prevention (3rd ed.). Also available online: <http://www.unr.edu/westcapt/bestpractices/bpcsap.htm>

APPENDIX C: 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:

- 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.

Behavioral Health Continuum of Care



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

APPENDIX D: OREGON PREVALENCE CITATIONS

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APPENDIX E: 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 okays 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 (OCMHP)
- 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)
- 2002 Etiology of Pathological Study (Moore)
- 2003 PGS funding slated for elimination (HB5077 and the rejection of a surtax)
- 2003 Number of Lottery VLTs increases from five to six
- 2004 Emergency Board restores expenditure authority but budget reduced
- 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
- 2009 Helpline incorporates live web chat
- 2010 Adolescent Gambling Study (Volberg)
- 2013 DOJ opinion Lottery funding treatment ads not legal
- 2013 HB 4028 A 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
- 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 Adult Gambling Behavior Study funded
- 2015 Adolescent Gambling Behavior Study funded
- 2017 Motivational messaging incorporated in Helpline services