



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

***GAMBLING PROGRAMS EVALUATION  
UPDATE - 2018***

**July 1, 2017 - June 30, 2018**



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

## EXECUTIVE SUMMARY

This is the annual report of the statewide problem gambling services for Fiscal Year 2017-2018 (July 1, 2017 through June 30, 2018). Problem gambling services have been funded statewide through proceeds from Oregon Lottery since 1995 and are currently coordinated through the Problem Gambling Services (PGS) that is part of the Health Systems Division (HSD) of the Oregon Health Authority (OHA). There were a total of 51 treatment programs provided by 35 agencies funded during the fiscal year. These included traditional outpatient, residential, respite, home-based, and prison-based programs as well as a full-service help line. Additionally, extensive prevention activities were also funded to cover every county in the State.

- ❖ 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 947, down approximately 2.7% from last year.
  - 79.0% were enrolled in traditional outpatient programs, down from 81.4%; 5.9% in residential care, down from 6.3%; 5.1%, down from 5.4%, in non-traditional home-base care; and, 10.0%, up from 6.9%, in prison based treatment interventions
  
- ❖ Coordinated statewide gambling prevention efforts were integrated into existing prevention programming or as stand-alone strategies with over \$1.3 million investment.
  - Progress was made toward identified goals, and in many cases either meeting or exceeding the goal
  - Efforts to include populations across the lifespan were expanded to ensure information was available across the stages of lifespan from youth to older adults
  
- ❖ Treatment Availability and Access
  - The lag time from initial call to first available appointment for outpatient treatment was, on average, 3.6 work days and 3.5 calendar days
  - 22.3% of gamblers accessed treatment providers through the Helpline, down slightly from last year
  - 11.2% through previous clients
  - 10.7% through other community health care providers
  - 40.5% reported accessing treatment through a large variety of other sources
  
- ❖ Treatment System Performance
  - Average length of stay for traditional outpatient was 176.3 days, up from 156.2 days

- Average case cost, based on reimbursable treatment services, was \$1,706 for all outpatient programs; and, \$3,139 for those successfully completing their course of treatment
  - Average number of service encounters was 20.3, up from 17.2 and for successful completers 38.3, up from 33.7 encounters
  - Adjusted successful completion rate from outpatient treatment was 34.6%, down from 37.9%
- ❖ Helpline
- Calls for help to the Helpline were up slightly from 922 to 1021
- ❖ Outpatient Client Demographics
- The distribution of married clients entering outpatient treatment rose slightly from 28.9% to 29.8%
  - The distribution of females enrolling in outpatient treatment increased slightly from 45.3% to 47.9%
  - Average age was 48.1 years with females significantly older
  - The distribution of Whites enrolling remained relatively constant with last year at 77.6%
- ❖ Gambling Behaviors
- Average age of first gambling experience remained stable at 24.9 years with males reporting significantly younger first experiences
  - Average age of onset of gambling problems was 37.1 years essentially unchanged from last year
  - Average gambling debt was \$25,403. The debt to income ratio was approximately 1:1
  - Primary gambling activity remained machine based (VLT/slots) at 89.5% with females being significantly more likely to report machine-based gambling. Of these, Video Poker was slightly more popular (37.2%) than line games (34.5%)
  - Primary gambling location remained Video Lottery Retailers at 71.5% essentially unchanged and followed distantly by IGC/Casino 16.1%
  - Average number of diagnostic criteria endorsed by outpatient clients was 7.7 out of 10 possible; for residential clients the average was 8.6; and, the average for the minimal intervention program (home-based) was 8.3 – all relatively unchanged
- ❖ Outcomes
- 12-month abstinence rate for successful outpatient program completers was 39.7%, down from 53.6%; and, “much less gambling” was 38.1%, up from 29.0%
  - 6-month successful completers abstinence rate was 51.1%, up from 45.8%; and, much less gambling was 37.8%, down from 40.3%
  - 6-month non-completers abstinence rate was 21.0%, down from 28.9%; and, much less gambling was 25.8%, down from 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 95.4% at 12-month follow-up
  -
  
- ❖ Approximately 17% of the males and 6.3% of the females were reported as having current or prior military experience.
  - 6.8% of the males and 1.8% of the females were reported to have been deployed in a combat zone
  - 0.8% of the males were disabled with combat experience and 0.2% of the females

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## **1. INTRODUCTION**

This is an annual report of the Oregon Problem Gambling Services activities for Fiscal Year 2017-2018 (FY 17-18) that included the period July 1, 2017 through June 30, 2018. 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)<sup>1</sup> under the direction of the Problem Gambling Services Manager.

During the current year there were 51 treatment programs funded through 35 provider agencies. Five of the funded programs were statewide assets including a residential program in Marion County; one respite program in Josephine County; home-based minimal intervention program based in Lane County; prison projects in three state prisons; 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 and expansion of culturally specific treatment programs.

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

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<sup>1</sup> 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 gambling<sup>2</sup> since statehood was achieved. In 1933 the State passed legislation that allowed for pari-mutuel wagering on horses and dogs. From the mid-1950's through 1991, various modifications and new rules were adopted covering pari-mutuel wagering and in 1987 off-track betting was legalized. Since legalization, pari-mutuel wagering has been governed by the Oregon Racing Commission, now primarily focused on off-track wagering.

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

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

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

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<sup>2</sup> 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.”<sup>3</sup> A minimum of 84% of the Lottery’s annual net revenue must be returned to the public in the form of prizes and benefits to the public purpose. The Lottery offers instant tickets (Scratch-Its ® were first available in 1985), Megabucks® (1985), Multi-State Lotteries – (Lotto America® from 1989 to 1992 and Powerball® from 1992), Sports Action® (1989) the first and only state lottery game based on the outcome of professional sporting events (discontinued by 2005 legislative action), Keno® (1991), video poker (1992), Pick 4 ® (2000), and Win for Life® (2001). Video Lottery Terminals (VLT) were converted in 2007 to add line games to the video poker games to be played at all Lottery Retailer locations having the VLTs. With the recent legalization of sports betting there appears to be movement in the state to embrace this as an additional source of income.

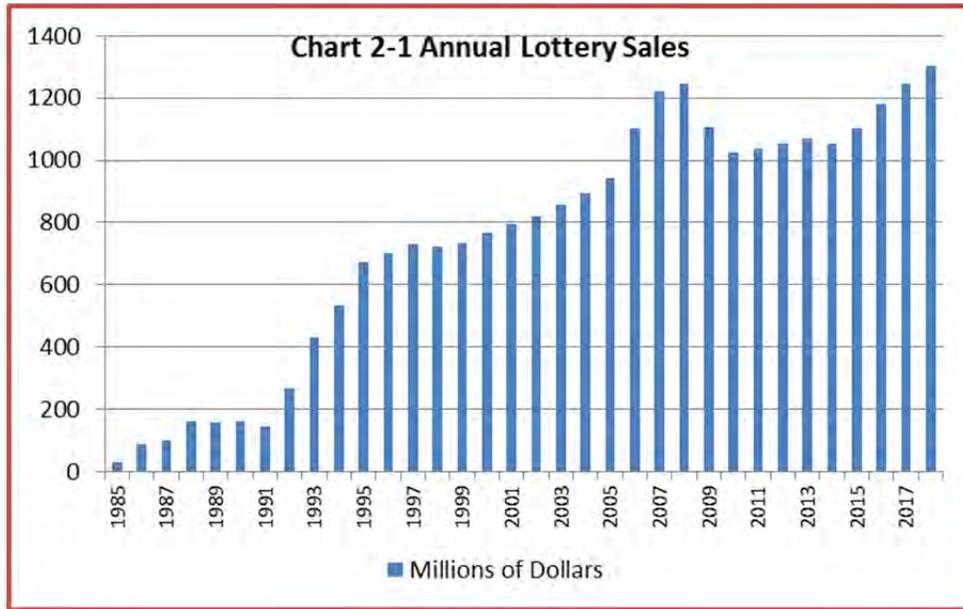
During the 2003 legislative session, the Lottery was authorized to allow retailers to place an additional VLT in their establishments, bringing the total number of machines allowed to six in each establishment.

At the time of this report there were approximately 3,934 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 17-18 were approximately \$1.30 billion.

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

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)



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

Portland Meadows, a long standing horse racing venue in the Portland metropolitan area with off-track betting for the past several years, opened a poker room (social gaming); installed 150 video terminals (Class II machines); historical horse racing; and in the fall live horse racing making the facility one of the larger gambling venues in Oregon.

## **Program Funding**

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

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

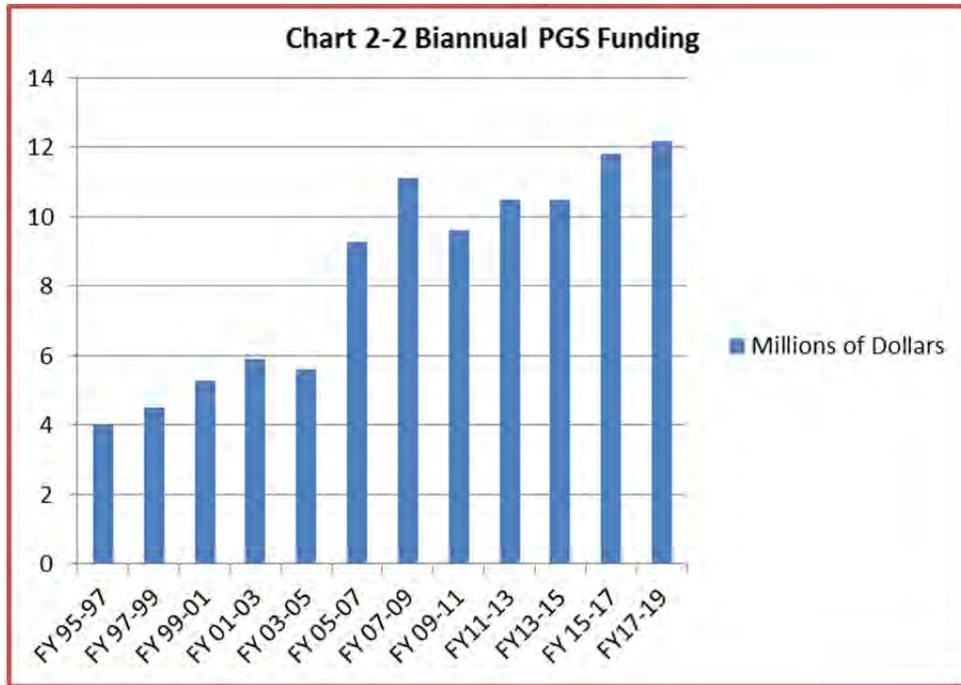
The introduction of Senate Bill (SB) 118, eventually led to the enactment of legislation in 2001 that again tied the funding of problem gambling services to the Lottery proceeds. Oregon Revised Statute (ORS) 409.435 created the Problem Gambling Treatment Fund and ORS 461.549 set aside one percent of the net lottery proceeds annually. These funds were to be transferred from the Administrative Services Economic Development Fund

to the problem gambling fund. This transfer was to occur on a quarterly basis and unused funds were to accrue interest. Enactment of this bill also moved administration of the Problem Gambling Services from the Department of Administrative Services to the Department of Human Services (now Oregon Health Authority).

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

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

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



## Estimating Treatment Needs

In 1997, the Oregon Gambling Addiction Treatment Foundation (OGATF)<sup>4</sup> commissioned an adult prevalence study of problem and pathological gambling<sup>5</sup> 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

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

<sup>5</sup> Terminology in use at the time of the study.

gamblers to the programs each year should be between 600 and 1,400 individuals. (Volberg, 1997)<sup>6</sup>

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

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<sup>6</sup> Copies of all studies sponsored by OGATF can be downloaded from [www.oregoncpg.org](http://www.oregoncpg.org)

Oregon, the projected enrollments in all programs during the report period was estimated to be approximately 1,600 to 1680<sup>7</sup> 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).<sup>8,9</sup> The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals. Nonetheless, a subsequent anecdotal investigation<sup>10</sup> 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)<sup>11</sup> Preliminary findings from a 2016 adolescent study suggest the prevalence rate had continued to decrease to a combined rate of 1.8%.<sup>12</sup>

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<sup>7</sup> 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%.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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.

<sup>12</sup> 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.<sup>13</sup> Agencies applying for state funding<sup>14</sup> were required to be a state-recognized substance use disorder (SUD) treatment provider or a community mental health (MH) provider to streamline the approval and implementation process. Nearly all programs were developed within an overarching framework of their sponsoring agency's philosophical approach. Programs that emerged from within an SUD agency tended to adhere to an abstinence-based social treatment model (self-help oriented along the lines of Alcoholics Anonymous {AA} and Gamblers Anonymous {GA}); while those that were developed by MH agencies tended to be oriented towards harm reduction (controlled gambling) and a psychodynamic approach to therapy.<sup>15</sup> 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

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<sup>13</sup> 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.

<sup>14</sup> All state funding was directed through the counties. Each agency's contract was with the county in which they operated.

<sup>15</sup> 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,<sup>16</sup> blossomed within the state, most programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.<sup>17</sup>

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.<sup>18</sup> 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

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<sup>16</sup> 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.

<sup>17</sup> A few programs have specialized treatment efforts for family members that are not contingent upon the gambler being also enrolled.

<sup>18</sup>

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

Historically, the most frequent access point to treatment was a call made to the state's Problem Gambling Helpline (877-MY LIMIT) that was established in 1995. The Helpline is staffed 24 hours every day of the year by professional counselors with problem gambling expertise. Callers are informed that problem gambling treatment services in Oregon are at no cost to the gambler, their families or others impacted by the gambling and are confidential. When appropriate, counselors conduct brief assessments and motivational interviews with callers. The counselor then makes referrals based on screening information, clinical judgment, and available resources. To facilitate a successful referral, Helpline counselors can use three-way calling to place the caller in contact with the referral agency and offer follow-up calls to provide further support. In 2009 a web-based, real-time chat capability was introduced and is maintained by the helpline staff.

Over the past few years some programs have advertised their agency's phone number so that interested individuals can call the agency directly.

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.<sup>19</sup> Originally designed as an intervention for those with less severity, the effort has proven to be utilized by many with severity similar to those entering traditional outpatient programs. 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. Lengths of stays at this facility typically range from 30 to 40 days. Transportation to and from both the respite and residential programs can be paid by problem gambling funds.

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

## **Prevention Efforts**

Prior to the summer of 2001, the Oregon Lottery and two local programs were the

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<sup>19</sup> During the FY 10-11 report period this service was cut due to budget constraints but was re-introduced in FY 11-12.

primary efforts in the state for prevention and outreach, although earlier agreements from the state with the counties called for the treatment programs to also conduct outreach, early intervention, and prevention.

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

### **Problem Gambling Services Strategic System Improvement Initiatives**

Starting in October of 2014, the state office embarked on the endeavor to create a strategic plan to guide improvements within the problem gambling service system. Through the help of a consultant, over the year, in-person and telephone semi-structured interviews were conducted, and reports and program documents were reviewed in order to identify program strengths and challenges. This information was then taken to community forums of problem gambling providers and partners to assist with the prioritization of critical issues and development of possible solutions.

In December 2015 the Problem Gambling in Oregon 2016-2020 System Improvement Plan was published. The 5 year system improvement plan outlines goals, current activities and initiatives for the advancement of an effective problem gambling prevention, treatment, and recovery system. Oregon state PGS staff have developed work plans designed to implement the System Improvement Plan. The System Improvement Plan and associated updated work

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

At the time of this report several advancements had been made in implementing the plan including:

- Development of treatment provider technical assistant visit protocols and process
- Development of prevention technical assistant visit protocols and process
- Researched structure and outcomes from other types of helplines and made modification to our helpline services, adding motivational texting
- Incorporated Trauma Informed language within Contract/Service Element language
- Development of infographics
- Creation of OPGR Facebook page
- Reviewed funding and allocations of system, which led to 2.5 increase in all provider allocations and increase in reimbursement level in July 2017
- Development of additional flex codes in 2017
- Awarded Community Awareness Grants- Special Project Prevention Funds
- Contracted for Positive Cultural Framework Campaign development
- Development of additional Respite Service- Baker County
- Reinstatement of Problem Gambling Treatment and Recovery Specialist position
- Development of prevention advisory committee
- Development of treatment WFD advisory committee
- Conducted WFD survey of prevention and treatment providers
- Created new data collection system for prevention and reporting tool.

- Developed policy option package to request additional 2% of lottery revenue from Legislature - did not move to out of OHA to legislative session

### **3. PROBLEM GAMBLING PREVENTION OUTCOMES**

#### **Overview<sup>20</sup>**

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. The design of these efforts utilizes community-based strategies intended to provide activities and messaging across the Social Ecological Model (Appendix A).

#### **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;
- Significant advances in incorporating problem gambling into existing behavioral health programs for youth and adults.

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<sup>20</sup> This section of the annual report was prepared, with our thanks, by Roxann Jones, OHA PGS Statewide Prevention Coordinator.

## **Funding**

The State of Oregon Problem Gambling Services invested over 1.4 million dollars for problem gambling prevention and outreach services in this reporting period; this represented 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 devoted over 3 million dollars statewide during this reporting period to responsible gaming and problem gambling awareness campaigns.

## **Problem Gambling Prevention Overview**

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.

### **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:

- Development of the Problem Gambling Prevention Quarterly Reporting tool that captures progress toward the goals indicated in the regional Problem Gambling Implementation Plans from providers. The new tool allows PGS the flexibility to modify data collection to meet the prevention system's needs.
- 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.
- Problem Gambling Prevention Advisory Committee (PGPAC) consisting of Problem Gambling Prevention Coordinator representation from across the state. This committee informed the problem gambling prevention system in the development of a technical assistance tool and workforce development needs. The mission of the PGPAC is “To strengthen the Problem Gambling Prevention System” with the purpose to: 1) ensure

community level voice and expertise is included in improving the statewide Problem Gambling Prevention System; and 2) advocate at the local and statewide level.

- Implementation of the associated workplans from the Problem Gambling in Oregon 2016-2020 System Improvement Plan. Some highlights that have been accomplished are: 1) developed prevention technical assistance visit protocols and process; 2) incorporated Trauma Informed language within contractual/service elements; 3) Community Readiness Assessment Project special grants to 22 regional providers; and 4) working with contractor for the development of Positive Cultural Framework campaign toolkit. The System Improvement Plan and associated work plans are located at:

<http://www.oregonpgs.org/about/2016-2020-oregon-pgs-system-improvement-plan/>

- Workforce development activities to ensure Problem Gambling Prevention Coordinators are skilled in prevention science and the field of problem gambling. Workforce activities included: 1) Oregon specific breakout session on the Social Ecology for prevention at Focus on the Future Conference; 2) Monthly PGS Prevention Connect Calls that enhances a relationship between state staff and regional providers while providing a platform for two-way information sharing; 3) hosting a Prevention Ethics Training; and 4) Positive Cultural Framework specific webinars addressing topics such as communication, stigma, and data collection results.

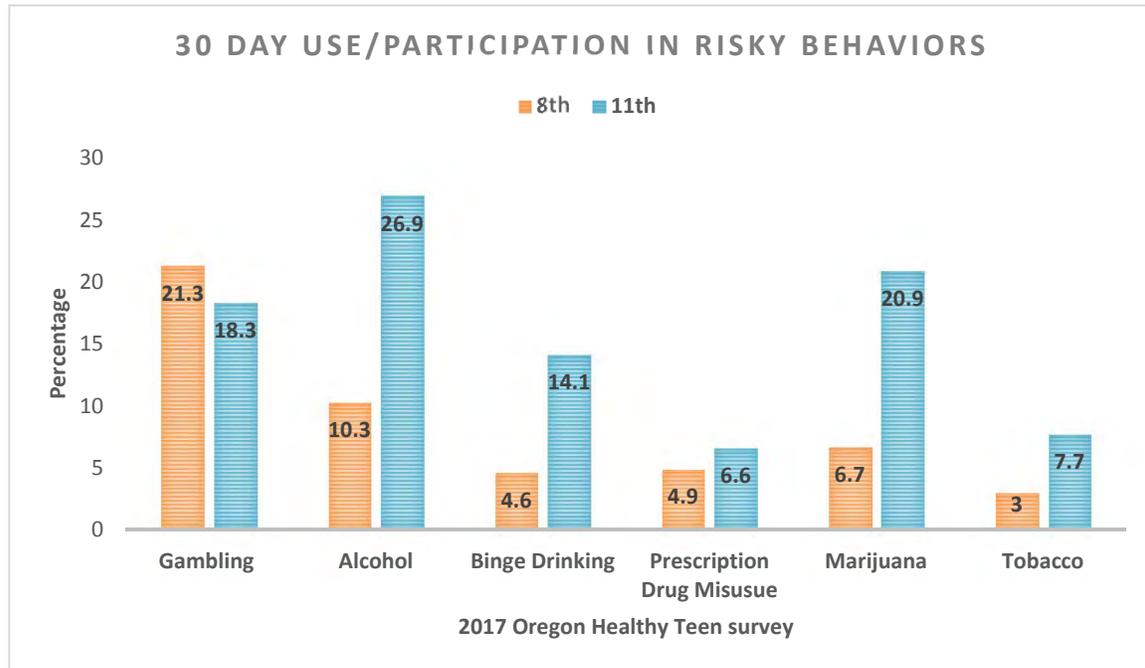
- Preliminary data available from the 2016 Adolescent Prevalence Study revealed a decrease in the estimated Problem/Disordered Gambling Rates reflecting that adolescents at-risk of developing a problem with gambling decreasing from 5.2% in 2008 to 2%. While adolescents who meet the criteria for a problem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

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

- Partnership with The Oregon Lottery on the development of PSA materials and resources and style guide for OPGR.

- Problem gambling was included in OHA’s Oregon Healthy Teen Survey. Further analysis of the data will be conducted this year and results shared with regional problem gambling prevention coordinators. Available data reflects:

- Oregon 8<sup>th</sup> grade youth reported gambling more in the past 30 days than other risky behaviors such as alcohol, prescription drug misuse, and tobacco. With the exception of 11<sup>th</sup> grade alcohol and marijuana use, youth reported gambling more in the past 30 days than had engaged in other risky behaviors (OHT 2017), as shown below:



### Local Regions’ Accomplishments

Oregon Problem Gambling Services has directed its regional prevention/outreach providers to utilize the Center for Substance Abuse Prevention (CSAP) strategies as a research-based framework for implementing problem 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 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 focal 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 an issue. Therefore, regional

prevention and outreach efforts have typically focused on building community awareness and 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 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 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 longer 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 currently in place and will focus on the following during the coming year:

- Strategically increasing the local providers' knowledge and skills regarding effective prevention principles and strategies, and training of new providers through implementation of the Oregon Problem Gambling Services Workforce Development Plan.
- Development of prevention strategies to increase awareness of risk and prevention of problems related to sports betting.

- Increased provision of targeted technical assistance utilizing the Problem Gambling Prevention Technical Assistance Model.
- Data analysis from Phase I Community Readiness Assessment and strategy development at the regional and state level.
- Development of Adolescent Fact Sheet based on 2016 Adolescent Prevalence Study.
- Increased collaboration with partners such as the Oregon Council on Problem Gambling, Public Health and the Oregon Lottery.
- Developing collaborative partnerships with the Oregon Department of Education and Oregon Department of Human Services.
- Continuing to support infusion of problem gambling into existing prevention efforts.
- Continuing 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 prevention 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 effort<sup>21</sup> 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,<sup>22</sup> 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 agencies<sup>23</sup> 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

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<sup>21</sup> Senate Bill 118

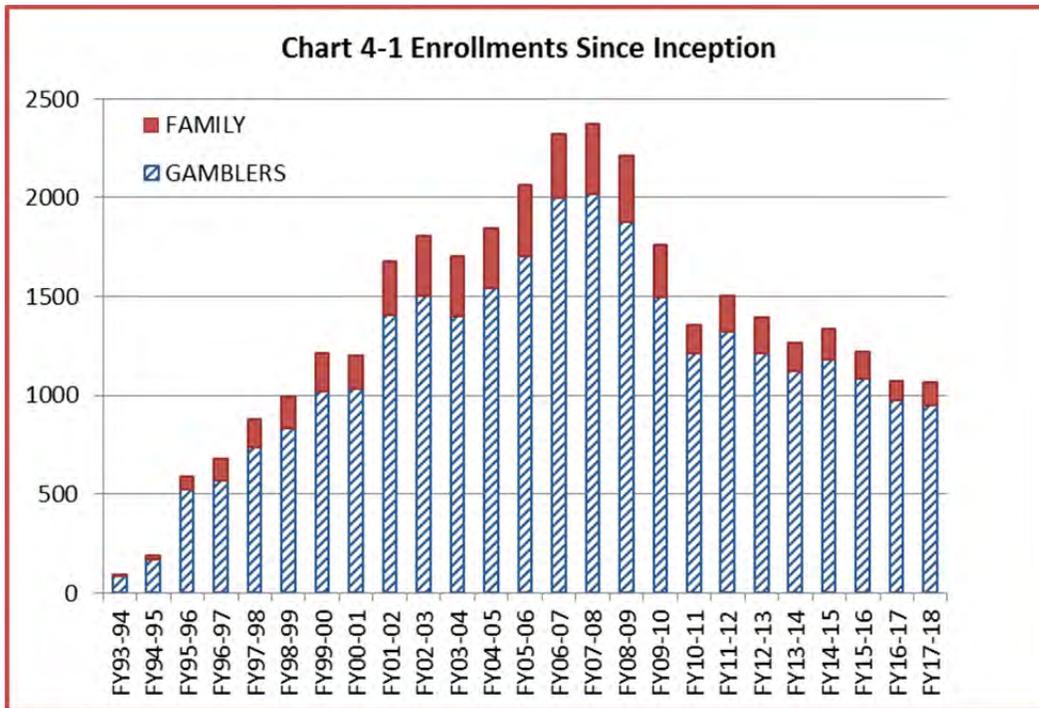
<sup>22</sup> AOCMHP is a membership organization, comprised mainly of county mental health directors within the state with focus on activist and lobbying activities to support the advancement of mental health care in the state.

<sup>23</sup> This conclusion is based on extensive, informal contact by the evaluator with program managers and counselors throughout the state.

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

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

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



Over the next three years, enrollments increased by an average of 12.6% each year. In FY 07-08 the economy began another rapid descent and enrollments dropped nearly 42% from FY 07-08 through FY 10-11. The following year enrollments came back 9.3% (essentially back to FY 01-02 levels) and then dropped 8.1% in FY 12-13 and another 7.8% in FY 13-14. Total enrollments then rose 5.6% in FY 14-15 and subsequently descended 8.5% for FY 15-16 and another 10.0% for FY 16-17. This reporting year enrollments flattened realizing a 2.7% decrease from the previous year. (Chart 4-1)

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

revealed a statistically significant<sup>24</sup> 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 reporting<sup>25</sup> 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 28.2% of the outpatient gamblers enrolling this year had at least one prior enrollment at the same outpatient program. This rate has been fairly consistent over the past few years. For those with more than one enrollment, the average number of enrollments was 1.5. Approximately 13.6% (n = 29) of those with multiple enrollments had five or more enrollments in the same agency. This data excludes enrollments in the specialty respite, residential, minimal intervention, and prisons programs that would be duplicative for re-enrollments.

As noted above, during the current year there were 35 agencies funded with 51 treatment programs funded (not all reported admissions) including the statewide residential program in Marion County; short-term respite program in Josephine County; the home-based minimal intervention programs (GEAR) based in Lane County; and, three prison program based in Clackamas, Multnomah, and Marion Counties. Eight of the programs were funded but did not report enrollments. This was due to efforts in the more rural counties to provide minimal funding since approximately 2009 in an effort to provide outreach and a minimal services base while maintaining critical system infrastructure. (Table 4-1)

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<sup>24</sup> Chi square  $P < .01$ . Statistical significance is only reported in this document where  $p < .05$ .

<sup>25</sup> Providers are required to close cases if the client has been inactive for a period greater than 30 days.

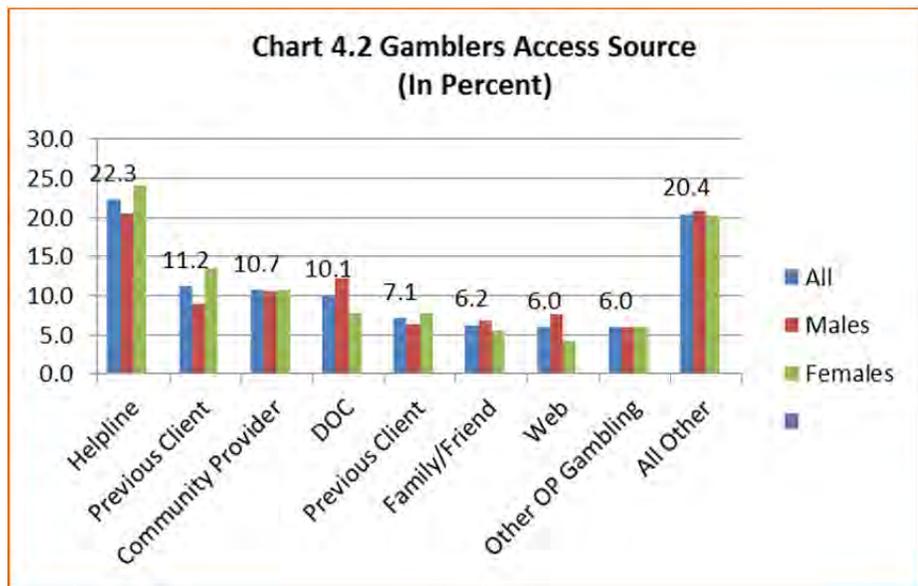
**Table 4-1 Treatment Enrollments FY 17-18****Funded Programs**

<b>County- Agency/Program</b>	<b>Gamblers</b>	<b>Family</b>	<b>Total</b>
BAKER-NEW DIRECTIONS NORTHWEST	5	0	5
CLACKAMAS-CASCADIA CLACKAMAS	57	7	64
CLACKAMAS-CASCADIA DOC OUTPATIENT	34	0	34
COLUMBIA-COLUMBIA COMMUNITY CENTER	3	0	3
COOS-ADAPT	12	2	14
CROOK-LUTHERAN COMMUNITY SERVICES	4	0	4
CURRY-CURRY COUNTY	4	0	4
DESCHUTES-DESCHUTES BESTCARE	19	2	21
DOUGLAS-ADAPT DOUGLAS COUNTY	23	2	25
GILLIAM-COMMUNITY COUNSELING SOLUTIONS	1	0	1
GRANT-COMMUNITY COUNSELING SOLUTIONS	2	0	2
HARNEY-HARNEY COUNTY	1	0	1
HOOD RIVER-MID COLUMBIA/HOOD RIVER	2	0	2
JACKSON-ARC	36	3	39
JEFFERSON COUNTY	0	0	0
JOSEPHINE-OPTIONS FOR SOUTHERN OREGON	24	1	25
KLAMATH-BEST CARE	3	1	4
LAKE COUNTY	0	0	0
LANE-CENTRO LATINO AMERICANO	1	0	1
LANE-EMERGENCE	93	14	107
LEWIS & CLARK COLLEGE-SPANISH CLACKAMAS	1	3	4
LEWIS & CLARK COLLEGE-SPANISH MULTNOMAH	13	8	21
LEWIS & CLARK COLLEGE-SPANISH WASHINGTON	5	2	7
LINCOLN-LINCOLN COUNTRY	19	2	21
LINN/BENTON-LINN COUNTY	42	2	44
MALHEUR LIFEWAYS	0	0	0
MARION-BRIDGEWAY	77	6	83
MORROW-COMMUNITY COUNSELING SOLUTIONS	1	0	1
MULTI-CULTURAL CONSULTANTS	24	0	24
MULTNOMAH-CASCADIA	78	10	88
MULTNOMAH-CASCADIA DOC	37	0	37
MULTNOMAH-EMPOWERMENT CLINIC	4	0	4
MULTNOMAH-VOA	36	4	40
MULTNOMAH-LEWIS AND CLARK COLLEGE	58	37	95
POLK-POLK COUNTY	8	0	8
SHERMAN-MID COLUMBIA	0	0	0
TILLAMOOK-TILLAMOOK FAMILY COUNSELING	12	0	12

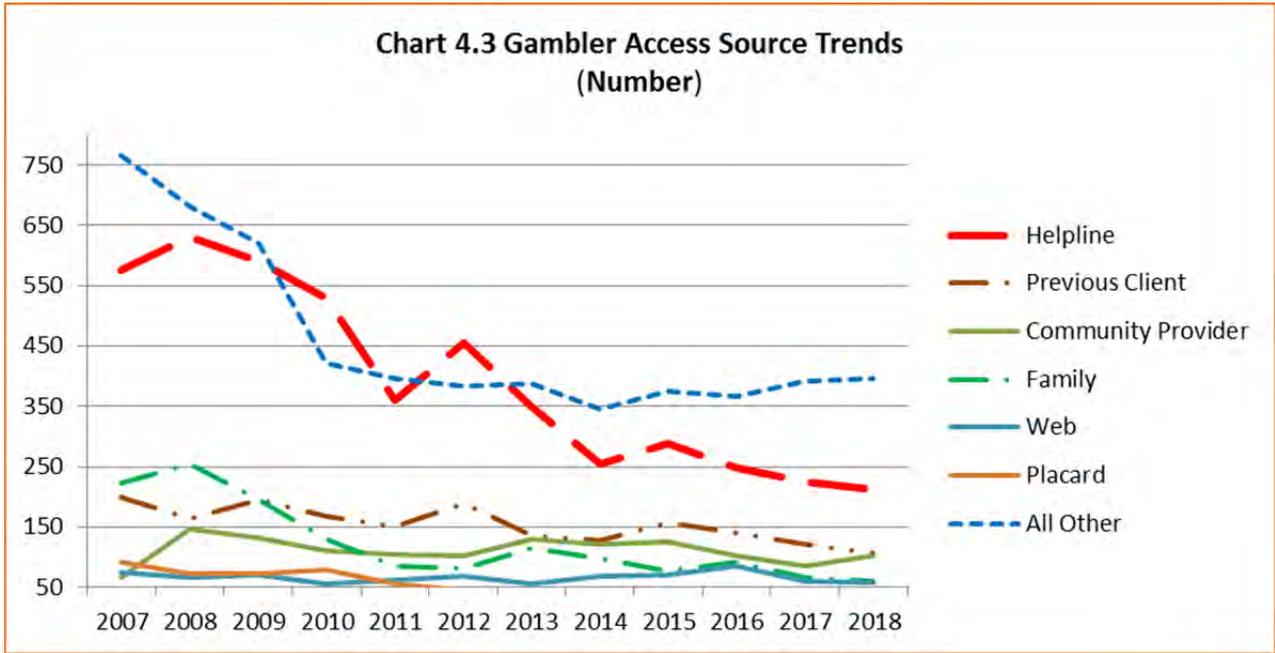
UMATILLA-UMATILLA COUNTY	2	0	2
UMATILLA-NEW HORIZONS	0	0	0
UNION-CENTER FOR HUMAN DEVELOPMENT	3	0	3
WALLOWA-WALLOWA VALLEY CENTER FOR WELLNESS	1	0	1
WASCO-MID COLUMBIA/WASCO CO	3	0	3
WASHINGTON-EMPOWERMENT CLINIC	9	0	9
WASHINGTON-LIFEWORKS NORTHWEST	68	4	72
WHEELER-COMMUNITY COUNSELING SOLUTIONS	0	0	0
YAMHILL-YAMHILL COUNTY	10	2	12
STATEWIDE-BRIDGEMAN RESIDENTIAL	55	0	55
STATEWIDE-JEFFERSON RESIDENTIAL	0	0	0
STATEWIDE-EMERGENCY/GEAR	48	5	53
STATEWIDE-NARA	8	0	8
STATEWIDE-OSO-RESPIRE	1	0	1
	947	117	1064

Of the 947 gambler enrollments system wide, 791 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 22.3% reported accessing the treating agency contact information from the Helpline; 11.2% reported receiving the contact information from a current or previous client; 10.7% community provider; 7.1% previous client; 6.2% family member; 6.0% web/internet; and, 6.0% from another OP gambling treatment program.

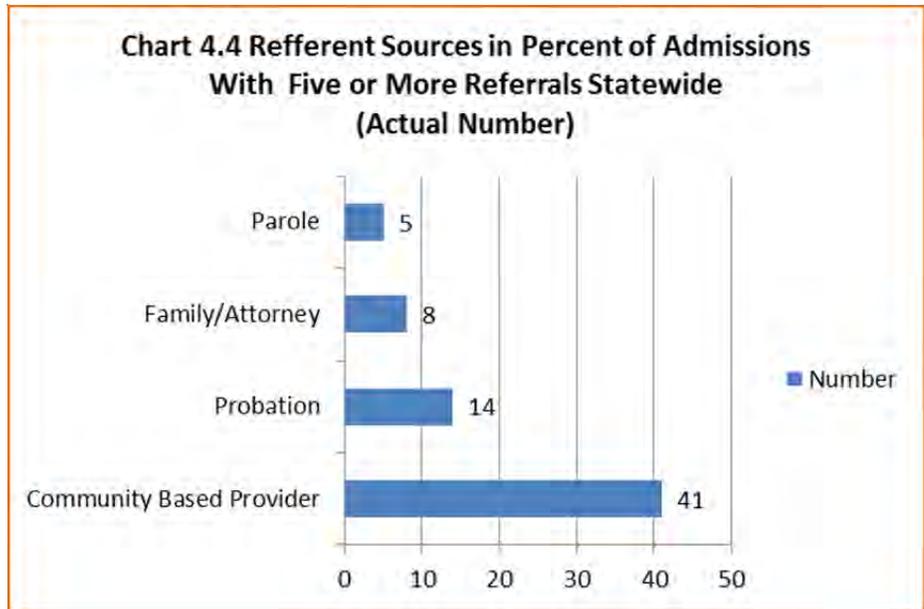


Only 1.9% reported obtaining the helpline number from a placard on an Oregon Lottery VLT. Interestingly, only one gambling client was reported as coming to a program from a Mentor Program referral. (Chart 4.2)



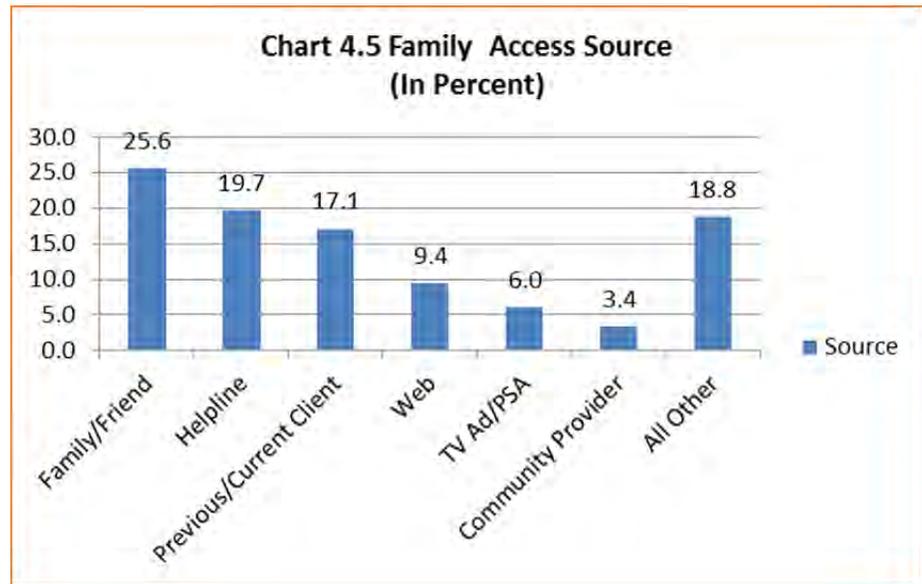
The actual number of clients reporting the source for the treating agency contact information is provided in the accompanying chart. (Chart 4.3)

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



treatment programs. Forty-one were reported as receiving a referral from a community based substance use disorder or mental health treatment provider; 14 from probation and 8 from a family, friend, or attorney. (Chart 4.4)

As consistently reported, the largest referral sources for family member access was a family or friend (25.6%) and previous, or



current, client of the program (17.1%) which would be expected as some agencies send out invitations to family members with the consent of the gambler client. Calls to the Helpline (19.7%) were followed by web/internet (9.4%), and TV ad/PSA. Interestingly, last year approximately 13.4% were reported coming from self-help groups and only 1.7% were so reported this year. (Chart 4.5)

Approximately 11.9% of those enrolling in any program were reported as having some veteran status. For males, it

Status	All	Males	Females
Active Duty Never Deployed to Combat	0.9	1.4	0.4
Active Duty Previously Deployed to Combat	1.2	1.4	0.9
Veteran Never Deployed to Combat	5.4	7.2	3.3
Veteran Deployed to Combat	2.7	4.6	0.7
Disable Veteran Never Deployed to Combat	1.2	1.6	0.7
Disabled Veteran Deployed to Combat	0.5	0.8	0.2
Total	11.9	17.0	6.3

was 17.0% and for females 6.3%. Approximately 4.4% overall were reported as having combat experience. Some estimates suggest that seven to eight percent of Americans have served, or are serving in the US military. (Table 4.2)

## 5. GENERAL GAMBLING ACTIVITIES & CONSEQUENCES

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

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

primary game of choice. Females continue to report choosing machine games as their primary activity (95.1%) significantly<sup>26</sup> more often the males. They were also more likely to report video line games more frequently than video poker.<sup>27</sup> Males continued to be significantly<sup>28</sup> more likely to report card games (7.6%) as their primary gambling activity more than females (2.2%). The distributions of the other available games were too small to statistically test. (Table 5.1)

This year, and uncharacteristically, females and males were statistically similar in the distribution of reporting video poker as their primary game. Nonetheless, females continued to be significantly more

Game	All	Males	Females
Machines	89.5	84.6	95.1
Cards	5.1	7.6	2.2
Traditional	1.0	1.0	0.9
Sports	0.8	1.6	0
Keno	0.8	1.6	0
All Other	2.8	3.6	1.8

Game	All	Males	Females
Video Poker	37.2	38.7	35.5
Video Line Games	34.5	30.1	39.5
Slot/Mechanical Reel	17.8	15.8	20.1

<sup>26</sup> p < .01

<sup>27</sup> p < .02

<sup>28</sup> p < .01

likely<sup>29</sup> to report video line games. They were also more likely to report slot/mechanical reel type machine but the level of significance was not as strong as the other indicators.<sup>30</sup> (Table 5.2)

Approximately 96.1% of the clients reported their primary gambling location was in Oregon while 1.5% reported Washington, 0.6% California, and 0.5% Nevada.

As consistently reported over the years, the primary gambling location was at video lottery retailers (71.5%), followed by casino/IGC (16.1%), and restaurant/bar with no video lottery sales (4.8%). There was a small decrease in the distribution of those reporting video lottery retailers and a commensurate increase in those reporting primary gambling in a casino.

Females were only slightly more likely to report either video lottery retailer or casino. Of note, the distribution for those reporting internet (2.3%) was slightly more than double that previously reported (1.1%).<sup>31</sup> (Table 5.3)

<b>Location</b>	<b>All</b>	<b>Males</b>	<b>Females</b>
Video Lottery Retailer	71.5	70.1	73.0
Casino/IGC	16.1	14.2	18.1
Restaurant/Bar Non-Video	4.8	5.2	4.2
Internet	2.3	2.8	1.8
Food/Convenience Store	1.3	1.4	1.1
Card Room	1.2	2.0	0.2
All Other	2.8	4.3	1.6

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

<sup>29</sup> p < .01

<sup>30</sup> p < .10

<sup>31</sup> The subsample was too small to test for statistical significance.

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”

**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.

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 7.9 items<sup>32</sup> - essentially unchanged from the previous report. The relative severity of gambling related problems is more thoroughly discussed in each of the following section so the reader will have the opportunity to see the difference between outpatient, residential, and minimal intervention programs.

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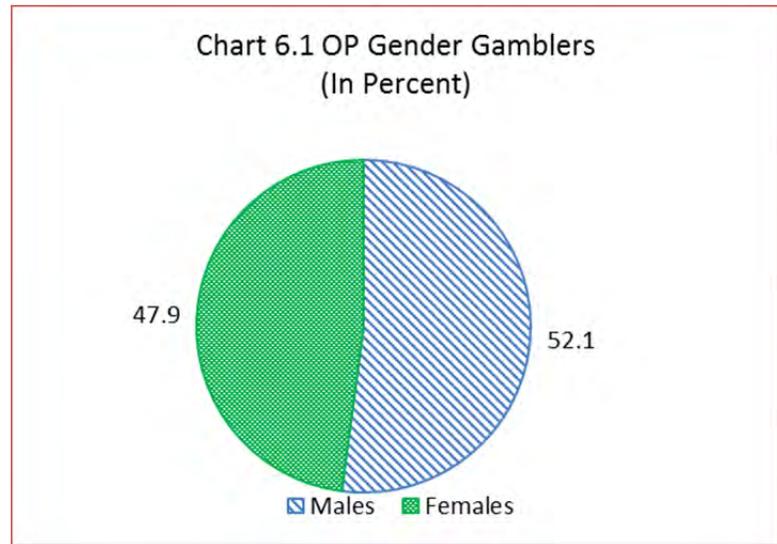
<sup>32</sup> Females were significantly ( $p < .05$ ) more likely to endorse a greater number of items than males system wide.

## 6. TRADITIONAL OUTPATIENT PROGRAMS

### Outpatient Demographics

There were 37 programs that reported enrollments in their traditional outpatient (OP) treatment services. In two counties there were multiple agencies, while other agencies provided services for multiple counties. During the report period 749 gambler and 112 family member clients were reported as enrolling in the traditional OP services. This was approximately 5.3% below the number of outpatient gambler enrollments reported last year.

Males (52.1%) were significantly<sup>33</sup> more likely to enroll in OP programs than females when compared with the general adult population of the state. (Chart 6.1)



The average age for OP gamblers was 48.1 years, essentially the same as last year. Females were again significantly more likely<sup>34</sup> to be older (50.6 years) than males. (Table 6.1)

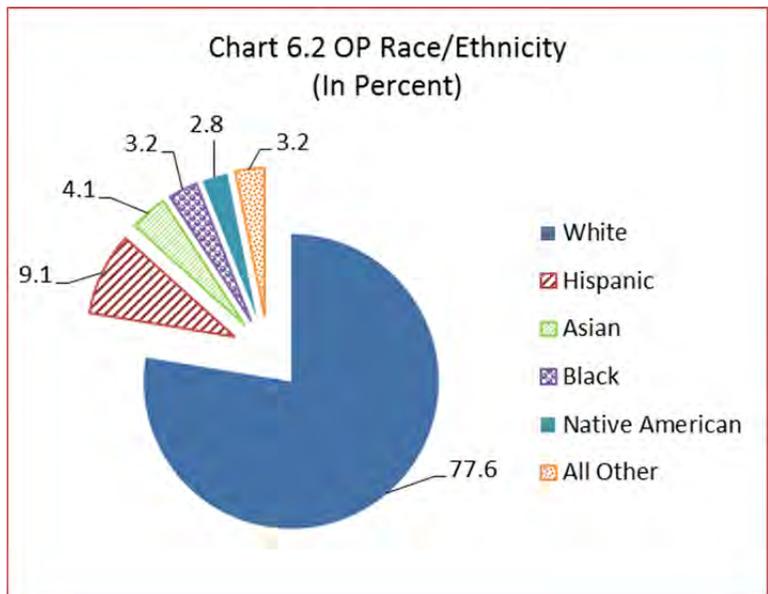
This year, 94 OP gambler clients (up from 86) were reported as being 65 years old or older. The youngest was 17.5 years and the oldest 85.3 years with the median age of 47.8 years.

	n	mean	sd
All	749	48.1	13.8
Males	390	45.8	14.1
Females	359	50.6	13.0

<sup>33</sup> p < .05

<sup>34</sup> p < .01

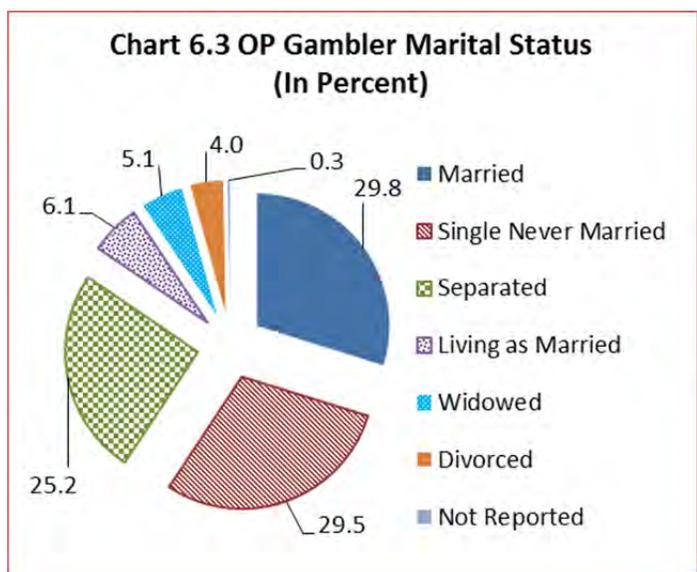
The distribution of Whites enrolling in the OP programs decreased somewhat to 77.6% from 80.9%. Hispanic/Latino increased from 6.9% to 9.1%, while Asians increased to 4.1% from 3.1%.



The distribution of Black/African American decreased from 3.9% to 3.2%, and Native Americans increased to 2.8% from 1.6%. This shifting from year to year is typical and not statistically significant. (Chart 6.2)

	n	Mean	sd
All	739	13.0	2.4
Males	387	12.7	2.6
Females	352	13.3	2.3

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



The distribution of married individuals enrolling in OP treatment

continues to fluctuate slightly from 28.3% to 29.8% this year. There were slight shifts in the other marital categories with the distribution of never married females moving from 19.2% to 23.1% although the distribution of married females was not changed at 29.2%. (Chart 6.3)

Males were significantly<sup>35</sup> more likely to be single (never married) and less likely to be separated than females as previously reported.<sup>36</sup> (Table 6.3)

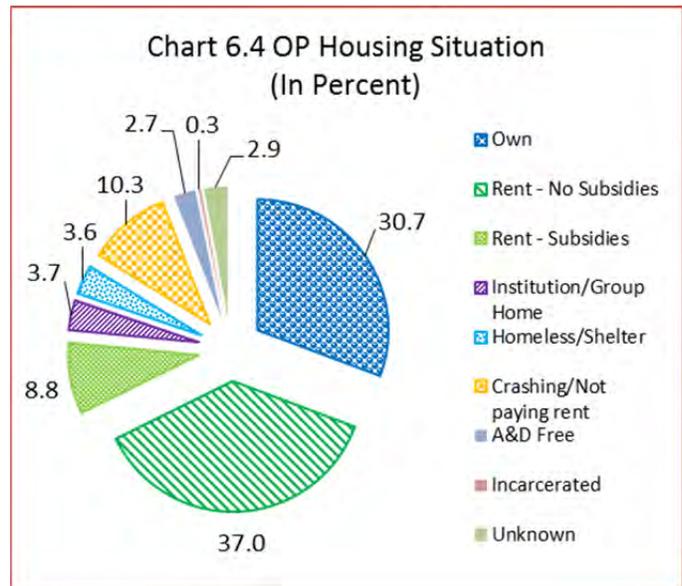
Approximately 37.0% of the OP clients reported living in a rental without

subsidies and 30.7% reported living in a home that was owned. These distributions were very

similar to those seen in the OP population in previous years. (Chart 6.4)

Females were significantly<sup>37</sup> more likely to report living in a home owned (33.4%) than males (28.2%) and subsequently males significantly more likely to be living a non-subsidized rental (39.2%). (Table 6.4)

	All	Males	Females
Married	29.8	30.3	29.2
Single Never Married	29.5	35.4	23.1
Separated	25.2	20.3	30.6
Living as Married	6.1	6.7	5.6
Widowed	5.1	5.1	5.0
Divorced	4.0	2.1	6.1
Not Reported	0.3	0.1	0.3



<sup>35</sup> p < .05

<sup>36</sup> p < .01

<sup>37</sup> p < .05

As previously reported, males continued to be significantly<sup>38</sup> more likely to be working full-time (50.0%) than females (33.4%) while females were significantly<sup>39</sup> more likely to be unemployed and looking for work. There were only minor fluctuations in the employment categories when compared with previous reports. (Table 6.5)

	All	Males	Females
Rent - No Subsidies	37.0	39.2	34.5
Own	30.7	28.2	33.4
Crashing/Not paying rent	10.3	11.0	9.5
Rent - Subsidies	8.8	6.7	11.1
Institution/Group Home	3.7	5.1	2.2
Homeless/Shelter	3.6	3.3	3.9
SUD Free	2.7	3.1	2.2
Incarcerated	0.3	0.3	0.3

The average household income for OP clients who reported an income was \$37,960 up somewhat from \$36,580. Females again reported an average income below that of males but the difference was not statistically significant. Overall, the median income was \$32,796; \$33,600 for males and \$30,000 for females – all somewhat higher than last year. There were only slight changes for those median incomes reported last year. (Table 6.6)

Status	All	Males	Females
Full-Time	42.1	50.0	33.4
Part-Time	10.5	9.5	11.7
Irregular	4.7	5.9	3.3
Unemployed Looking	8.3	6.2	10.6
Unemployed - Not Looking	9.3	8.7	10.0
Retired	10.7	9.2	12.3
Disabled	11.6	9.2	14.2
Other/Not Reported	2.8	1.3	4.5

	n	mean	sd
All	693	37,960	37,003
Males	362	39,273	36,950
Females	331	36,523	37,008

<sup>38</sup> p < .01

<sup>39</sup> p < .05

Wages were most frequently (56.6%) cited as the source of the household income followed by retirement/pension (14.0%), disability (9.3%) and other sources (6.1%). Approximately 8.5% were reported as having no income. Males were significantly more likely<sup>40</sup> to report wages while females were significantly more likely to report disability<sup>41</sup> and public assistance<sup>42</sup> as their source of income than males. (Table 6.7)

	All	Males	Females
Wages	56.6	63.8	48.7
Retirement/Pension	14.0	12.3	15.9
Disability	9.3	7.2	11.7
Other	6.1	5.4	7.0
Public Assistance	4.4	2.6	6.4
Dividends/Interest	0.3	0.0	0.6
None	8.5	8.2	8.9

Approximately 87.3% of clients entering OP were reported as being covered by some form of private or public insurance and approximately 42.2% being covered by some form of public coverage. Females were significantly more like to be covered by MEDICAID,<sup>43</sup> and MEDICARE,<sup>44</sup> while males were significantly more likely to have VA insurance,<sup>45</sup> or no insurance at all.<sup>46</sup> It must be noted that all treatment is paid for by the state regardless of insurance coverage. (Table 6.8)

	All	Males	Females
Private	37.5	40.5	34.5
MEDICAID/OHP	30.7	27.2	34.3
MEDICARE	10.7	7.2	14.5
VA	4.8	7.2	2.2
Other Insurance	2.8	3.3	2.2
Other Public	0.8	0.5	1.1
None	11.6	13.1	10.0
Unknown	1.1	1.0	1.2

<sup>40</sup> p < .001

<sup>41</sup> p < .05

<sup>42</sup> p < .001

<sup>43</sup> p < .05

<sup>44</sup> P < .001

<sup>45</sup> p < .01

<sup>46</sup> p < .05

## 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	747	3.6	4.3
Work Days	748	3.5	4.4

average number of work days to the first available appointment was 3.5 work days, up slightly from 3.3 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 3.6 days, up slightly from 3.5 days previously reported. The average lag from first call to admission in the outpatient programs was 6.5 calendar days accounting for client delays and essentially the same as last year. There were no significant gender differences in the lag time to first available appointment or to first seen again this year. (Table 6.9)

The average length of stay (LOS) in the OP programs was 176.3 days, up somewhat from 156.2 days previously reported. Although females were more likely to remain enrolled longer (191.4 days) than males (163.3 days) the difference was not significant. Of those cases being closed during the period, 35 were coded as assessment only and 60 cases were reported as only receiving an assessment but were coded as not returning following the enrollment. This latter group was split evenly between males and females. (Table 6.10a)

	n	Mean	sd
All	681	176.3	216.3
Males	365	163.3	202.4
Females	316	191.4	230.5

	n	Mean	sd
All	186	336.0	227.2
Males	99	307.5	199.3
Females	87	368.4	251.4

Individuals who were reported as successfully completing treatment remained

somewhat longer (336 days) than the 296.4 days previously reported. Females successfully completing treatment remained somewhat longer in treatment (368.4 days) than males (307.5 days). (Table 6.10b)

The unadjusted program completion rate for the OP programs was 27.3%, down very slightly from 28.7% with essentially no difference between males and females. Using the state adjustment formula that only includes successful completers, those who stopped coming against

<b>Status</b>	<b>All</b>	<b>Males</b>	<b>Females</b>
Adjusted Successful Completion Rate*	34.6	33.4	36.0
Stopped Attending ASA*	51.0	54.0	47.5
Successful Completion*	27.3	27.1	27.5
Evaluation Only	6.8	6.3	0.3
Refused Service	3.7	3.0	4.4
Moved from Catchment Area	2.8	1.6	4.1
Further Treatment Not Appropriate	2.5	2.7	2.2
Conflicting Hours	1.6	1.4	7.3
Physical/Mental Illness	1.2	1.1	0.6
Program Closure - Non Cap	1.0	1.4	1.3
Non-Compliance With Rules*	0.6	0.0	1.3
Incarcerated	0.3	0.3	0.6
Deceased	0.3	0.0	0.6
No Transportation	0.1	0.3	1.9
Other	0.9	0.8	0.4
*Used for Adjustment			

staff advice, and those who were discharged for not following program rules, the overall rate was 34.6%, down from 37.9% previously reported. Although females were slightly more likely to complete using the adjusted rate (36.0%) the difference between genders was not significant. (Table 6.11)

The average number of OP treatment encounters for those discharged during the report period was 20.3 up from 17.2 encounters. The average number of treatment encounters for those successfully completing treatment was 38.3, up from 33.7.

The average case cost for all gamblers was \$1,706.3 up significantly<sup>47</sup> from \$1,357.6 previously reported. Successful completer case cost was \$3,138.7, up significantly<sup>48</sup> from \$2,635.0. It is interesting to note that enrollment numbers and the successful completion rate were both down while case cost for both completers and non-completers rose over 24% each.<sup>49</sup> It has been found to be typical that when enrollments are down providers tend to keep compliant clients longer and not necessarily improve successful completion rates. (Table 6.12)

	<b>n</b>	<b>mean</b>	<b>sd</b>
<b>Encounters</b>			
All Gamblers	640	20.3	28.7
Successful Completers	187	38.3	35.4
<b>Dollars</b>			
All Gamblers	640	1,706.3	2,256.9
Successful Completers	187	3,138.7	2,848.0

## **Outpatient Gambler Activities and Consequences**

The average age of the first gambling experience for the outpatient clients was 24.9 years, essentially the same as previously reported. Males continued to report their first gambling experience at a significantly<sup>50</sup> younger age (22.9 years) than females (27.0 years). (Table 6.13)

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	735	24.9	13.0
Males	384	22.9	12.3
Females	351	27.0	13.3

Similarly, males reported a significantly<sup>51</sup> earlier age (34.7 years) of the onset of problems with gambling than females (39.7 years) and the overall average age was 37.1 years,

<sup>47</sup> p < .01

<sup>48</sup> p < .01

<sup>49</sup> This increase is due to a combination of longer lengths of stay as well as an increase in the reimbursement rates for services provided.

<sup>50</sup> p < .05

<sup>51</sup> p < .01

essentially the same as previously reported. (Table 6.14)

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

gambling was approximately 14.6 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

consistency across two decades of data. The average number of items endorsed by those enrolling in the outpatient programs was 7.7 items, essentially the same as previously reported with no significant difference between genders. (Table 6.15)

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	719	37.1	13.5
Males	372	34.7	13.6
Females	347	39.7	12.9

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	738	7.7	2.1
Males	386	7.6	2.2
Females	352	7.9	2.0

	<b>All</b>	<b>Males</b>	<b>Females</b>
Unsuccessful attempts to stop	90.9	90.4	91.5
Preoccupation	90.7	88.9	92.6
Escaping	89.0	85.2	93.2
Lying	86.9	86.3	87.5
Increasing size of bets	86.3	85.5	87.2
Returning to get even	85.6	85.2	86.1
Restlessness	81.2	78.5	84.1
Jeopardized relationship/job	65.7	70.5	60.5
Relies on others for money	63.4	60.4	66.8
Committed illegal acts	33.9	32.1	35.8

An item analysis revealed females were significantly more likely to endorse restlessness,<sup>52</sup> escaping,<sup>53</sup> and doing things not necessarily legal<sup>54</sup> than males while males were significantly<sup>55</sup> more likely to have jeopardized a significant relationship or job. (Table 6.16)

<sup>52</sup> p < .05

<sup>53</sup> p < .001

<sup>54</sup> p < .01

<sup>55</sup> p < .01

Approximately 27.8% of those enrolling in the outpatient programs reported to their counselors of having thoughts of suicide in the past six months. About 2.3% reported making suicidal threats, 2.4% reported having a plan, and 2.4% indicated they had attempted to commit suicide. Although there were differences in the distributions between males and females the differences were not statistically significant. Interestingly, from the written confidential enrollment survey, approximately 44% endorsed having thoughts of suicide (always 2.0%, often 7.2%, 13.7% sometimes, and 21.0% rarely) while 4.1% reported attempting suicide (always, often, or sometimes).<sup>56</sup> (Table 6.17)

	All	Males	Females
Thoughts	27.8	30.3	25.1
Threat	2.3	1.5	3.1
Plan	2.4	2.3	2.5
Action	2.4	2.3	2.5

Approximately 48.6% reported experiencing significant relationship problems, 18.0% reported problems at work, 11.3% legal problems, and 8.6% reported having filed, or planned to file, for bankruptcy in the past six months. There were no significant differences between the genders. (Table 6.18)

	All	Males	Females
Relationships	48.6	51.0	46.0
Job	18.0	20.2	15.5
Legal	11.3	12.6	10.0
Bankruptcy	8.6	9.2	8.0

Approximately 5.7% reported on their survey experiencing physical violence in the six months prior to enrollment; 24.6% reported verbal, emotional, or psychological abuse; and, 21.7% reported feeling controlled or trapped in 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	5.7	4.0	7.9
Non-Physical	24.6	21.4	27.7
Controlled/Trapped	21.7	19.7	23.1

<sup>56</sup> The enrollment survey structure is discussed below.

Approximately 68.4% of the clients reported having a gambling related debt at enrollment. The average amount owed was \$25,402.9, up slightly from \$24,019.2. Males were somewhat more likely to report a larger debt than females. The average debt to income ratio was also up slightly from approximately 1:0.78 to 1:0.98. (Table 6.20)

	All	mean	sd
All	512	25,402.9	62,331.1
Males	266	30,021.0	77,070.1
Females	246	20,409.4	40,193.2

Approximately 32.0%, essentially the same as last year, reported having any prior SUD treatment episodes of care. The average number of prior SUD treatments was 2.4. 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	240	2.4	2.1
Males	140	2.3	2.3
Females	100	2.6	2.6

Approximately 35.9%, down from 36.6%, of the clients were reported as having prior mental health (MH) episodes of care. For these individuals, the average number of MH episodes was 2.7. As

	n	mean	sd
All	269	2.7	2.9
Males	111	2.4	3.2
Females	158	3	1.9

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

Approximately 15.2%, up from 14.0%, of the outpatient clients were concurrently enrolled in SUD treatment. Of these, 8.9% were in the same agency, 6.0% were enrolled in another publicly funded agency, and 0.3% were receiving services at a private agency. Concurrent enrollment in a mental health program was reported for 17.4%, down from 20.2%, of the gamblers. For this care, 7.3% were enrolled in the same agency, 4.1% in another publically funded agency, and 5.9% in a private agency. Overall, 5.2% were reported as

being concurrently enrolled in MH and SUD treatment. This was comprised of 0.8 of the males and 7.0% of the females.

Females were significantly<sup>57</sup> more likely to be enrolled in all three disciplines. (Table 6.23)

Of those enrolling in the outpatient programs, 42.2% were reported as having prior gambling treatment enrollments, up slightly from 39.0% previously reported. The average number of prior enrollments was reported as 2.0. (Table 6.24)

At the time of enrollment, approximately 6.8%, up from 6.1%, reported they were currently active in self-help, while 14.2%, down from 16.8% previously reported indicated 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.

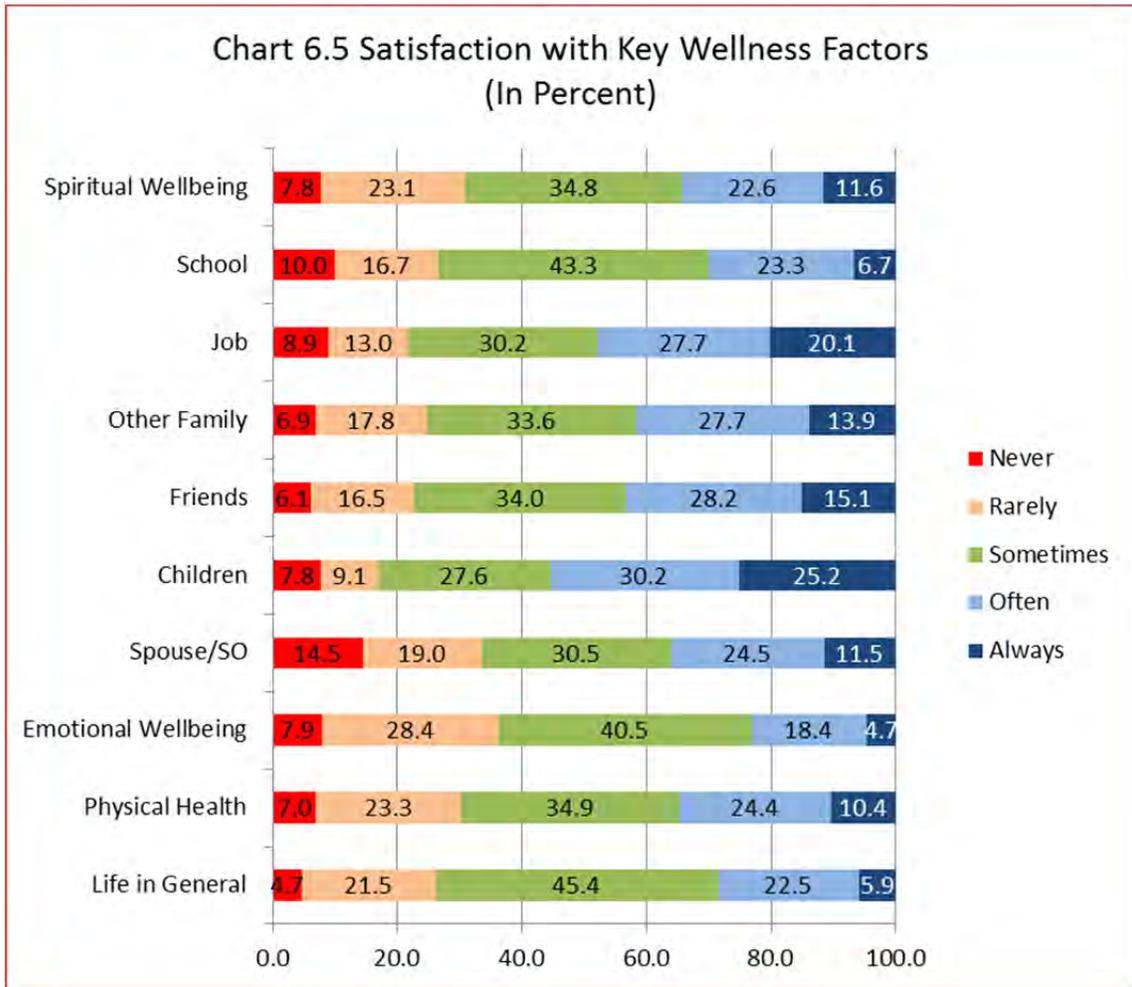
<b>Table 6.23 OP Concurrently Enrolled (In Percent)</b>			
<i>Location</i>	<i>All</i>	<i>Males</i>	<i>Females</i>
<b>SUD Treatment</b>			
Same Agency	8.9	8.7	9.2
Other Public Agency	6.0	7.4	4.5
Other Private Agency	0.3	0.5	0.0
<i>Total</i>	<i>15.2</i>	<i>16.7</i>	<i>13.6</i>
<b>MH Treatment</b>			
Same Agency	7.3	5.4	9.5
Other Public Agency	4.1	3.6	4.7
Other Private Agency	5.9	11.3	6.7
<i>Total</i>	<i>17.4</i>	<i>20.3</i>	<i>20.9</i>

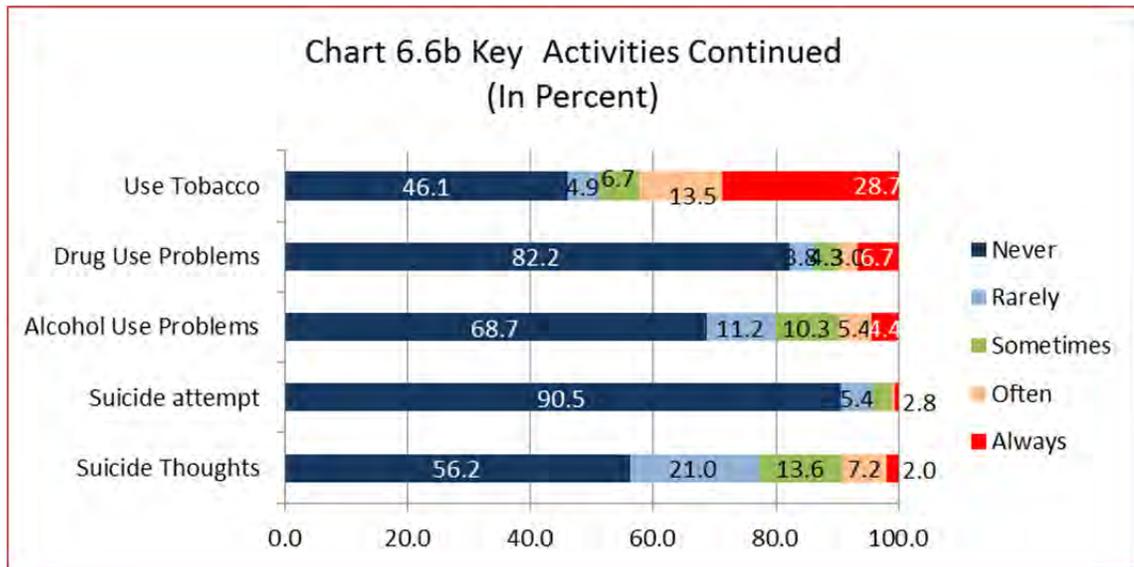
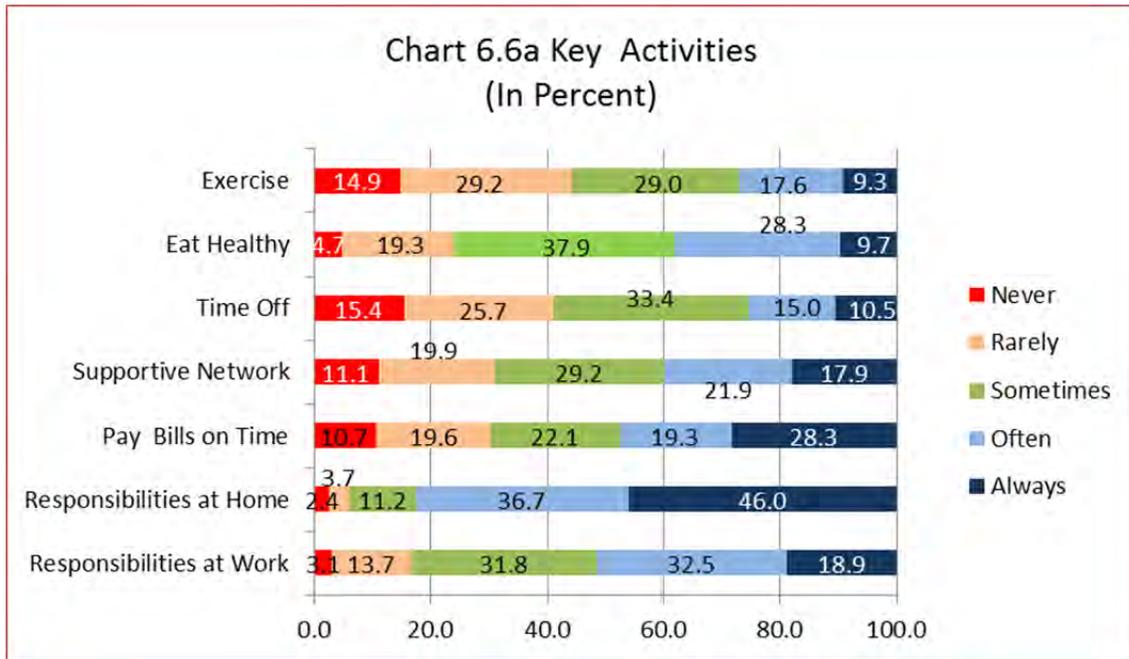
<b>Table 6.24 OP Prior Gambling Treatment Episodes</b>			
	<b>n</b>	<b>mean</b>	<b>sd</b>
All	314	2.0	1.4
Males	140	1.9	1.9
Females	174	2.2	1

<b>Table 6.25 OP Self Help for Gambling (In Percent)</b>		
	<b>Previous</b>	<b>Current</b>
All	14.2	6.8
Males	10.8	6.4
Females	17.8	7.2

<sup>57</sup> P < .05

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





## Outpatient Gambler Outcomes

Self-reported abstinence has remained relatively stable across past years with some minor shifts. This year, at 12-month follow-up, 39.7% of the participants reported abstinence since enrolling in the program compared with 53.6% previously reported. Although this is a relatively large proportional change from last year it was not statistically significant. Another

38.1% reported gambling much less than before enrollment compared to only 29.0% previously reported. Only 1.6% reported gambling much more compared with 4.3% previously reported. Again, only program completers are tracked at 12 months post discharge.

At six months the abstinence rate for program completers was 51.1%, up from 45.8% with 37.8% reported gambling much less. For those who did not successfully complete treatment their reported abstinence was 21.0%, down from 28.9%, with 25.8% reporting much less down also from 36.7% previously reported. None of these differences were statistically significant. (Table 6.26)

	<b>None</b>	<b>Much Less</b>	<b>Less</b>	<b>Same</b>	<b>More</b>	<b>Much More</b>
12-Month Completers	39.7	38.1	12.7	4.8	3.2	1.6
6-Month Completer	51.1	37.8	6.7	4.4	0.0	0.0
6-Month Non-Completers	21.0	25.8	30.6	14.5	8.1	0.0

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

is most likely related to the relatively strong level of satisfaction at the time of enrollment which would not allow the opportunity for significant improvement along the scale. (Table 6.27)

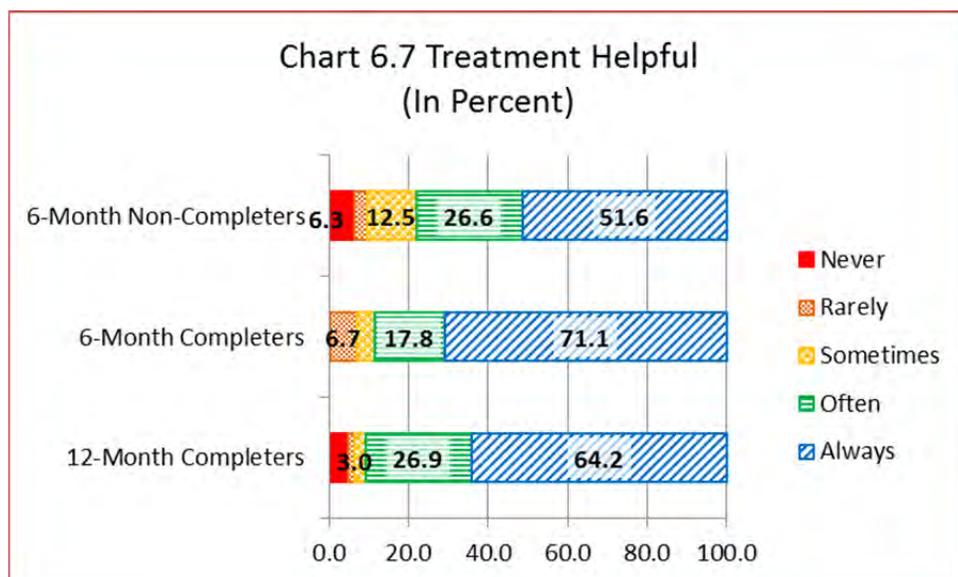
<b>Table 6.27 OP ANOVA Pre/Post Survey</b>			
	<b>Six-Month Completers</b>	<b>Six-Month Non- Completers</b>	<b>Twelve Month Completers</b>
<b>Satisfaction With</b>			
Life in General	↑ p < .01	↔ ns	↑ p < .01
Physical Health	↔ ns	↔ ns	↑ p < .01
Emotional Wellbeing	↑ p < .01	↔ ns	↑ p < .01
Relationship with Spouse/SO	↑ p < .05	↔ ns	↔ ns
Relationship with Children	↔ ns	↔ ns	↔ ns
Relationship with Friends	↔ ns	↔ ns	↔ ns
Relationship with other Family	↔ ns	↔ ns	↔ ns
Job	↔ ns	↔ ns	↔ ns
School	↔ ns	↔ ns	↔ ns
Spiritual Wellbeing	↑ p < .05	↔ ns	↔ ns
<b>Activities</b>			
Accomplish Responsibility at Home	↔ ns	↔ ns	↔ ns
Accomplish Responsibility at Work	↔ ns	↔ ns	↔ ns
Pay Bills	↔ ns	↑ p < .01	↔ ns
Thoughts of Suicide	↔ ns	↑ p < .01	↔ 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 < .01
Eat Health Foods	↔ ns	↔ ns	↔ ns
Exercise	↔ ns	↔ ns	↔ ns
Attend GA/Community Support	↔ ns	↔ ns	↔ ns
<b>DSM Criteria</b>			
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 < .01	↑ p < .05
Borrowed from others	↑ p < .01	↑ p < .01	↑ p < .01
Key: ↑ Improvement; ↓ Regression; ↔ No Change			

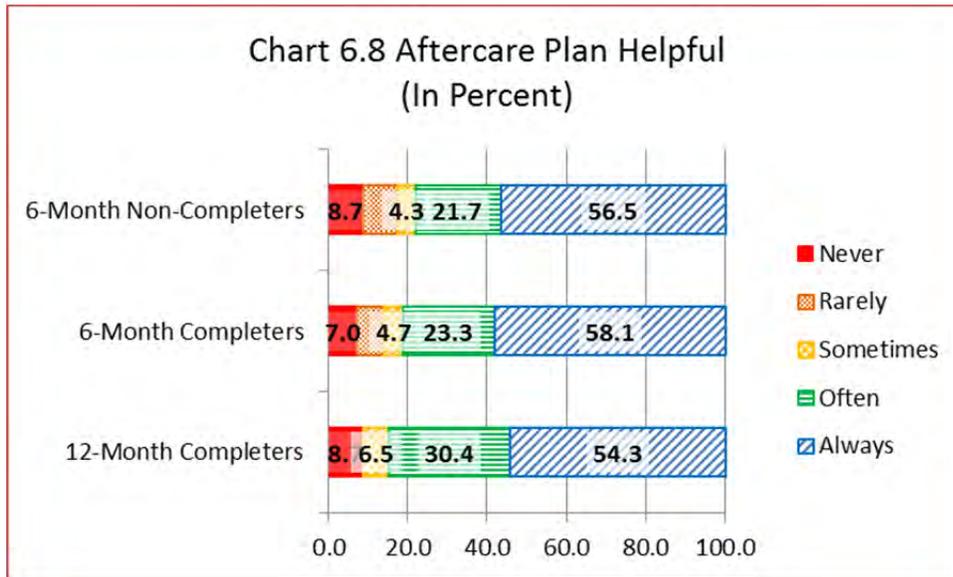
Care should also be taken in interpreting the ANOVA findings as the findings are not from a controlled study and intervening variables, such as higher levels of satisfaction in the key wellness and recovery domains at enrollment for example as noted above, preclude the opportunity to numerically demonstrate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

Individuals who completed treatment were again this year positive regarding the helpfulness of their treatment experience. Nearly 91.1%, up from 86.4%, of those in the 12-month sample were positive (64.2% always; 26.9% often) and 88.9%, down from 92.1%, of the six month successful completer sample reported positive satisfaction. Approximately 78.2%, up slightly from 76.1%, of the non-completers endorsed this item as often or always.

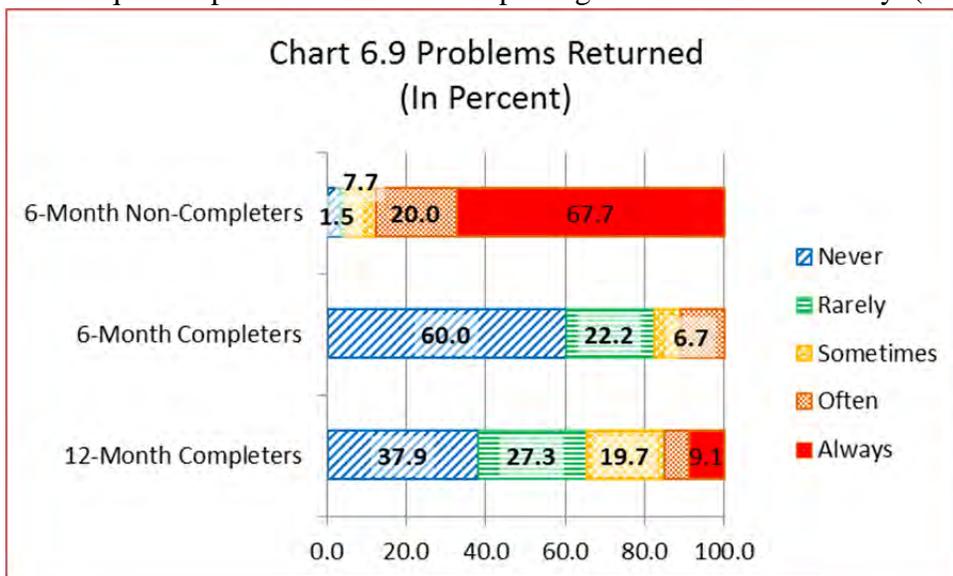
(Chart 6.7)



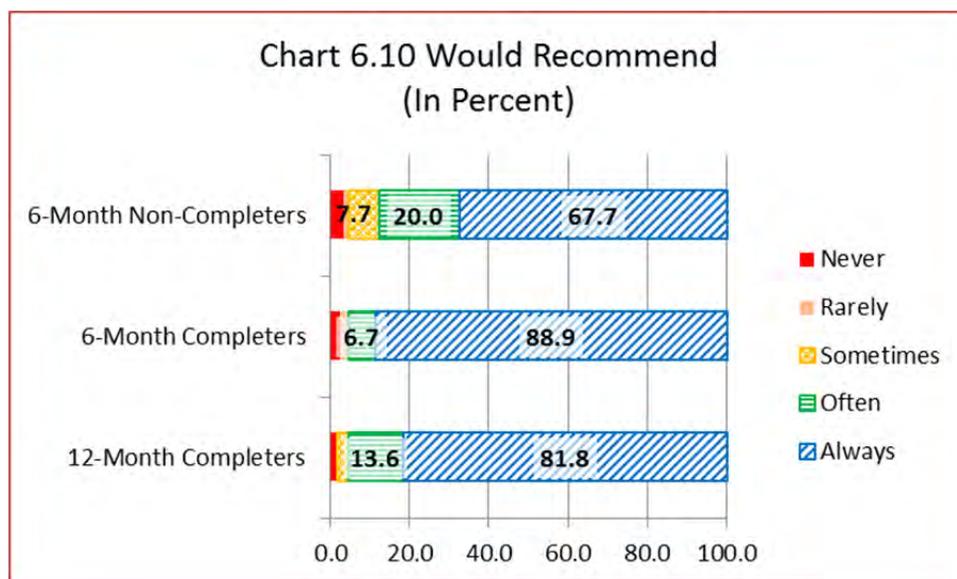
Approximately 84.7% of the twelve-month sample and 81.4% of the six-month reported positive satisfaction with the helpfulness of their aftercare/continuing care plan compared with 78.2% of the non-completers . (Chart 6.8)



As previously reported, one of the more telling charts of this section is the high return rate of the problems that brought them to treatment for the non-completers with 87.7% reporting always or often. The six month completers' sample strongly endorsed not having the problems return with 60.0% indicating never and 22.2% rarely. Those in the 12-month sample were not quite as positive with 37.9% reporting never and 27.3% rarely. (Chart 6.9)



As has been consistently reported in previous reports, after several decades consulting with a large number of behavioral health service providers, the evaluation team has established a rule of thumb regarding clients' willingness to recommend the program to others. Those agencies with a combined score below 85% (always and often) have been found to have ample opportunity for quality improvement and have tended to document poorer long term success with their clients. The willingness to endorse the program to others by the 12-month sample was quite strong at 95.4%, up from 92.4%. Similarly, the six-month sample demonstrated a 95.6% positive endorsement, up from 93.4%. As expected, those who did not successfully complete the programs reported a lower endorsement rate of 87.7%, up from 81.6%, which is still considered good for those who left the program prior to completion. (Chart 6.10)



## 7. RESIDENTIAL CARE

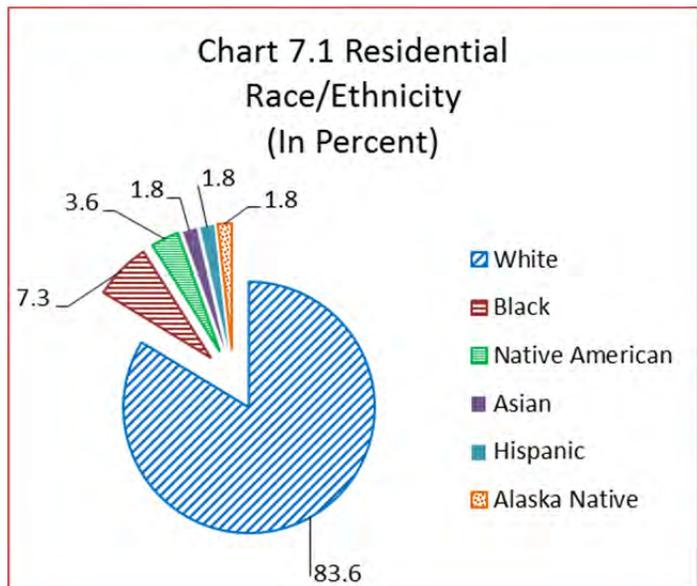
The active residential program, located in Marion County (Salem), is operated by Bridgeway Recovery Services and has a varied-length treatment program for male and female adults. Traditionally, the residential program is available to accept referrals from any of the state-funded outpatient programs and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

In order for individuals to be eligible for residential or respite care they normally need to have a referral from a state-approved gambling treatment program and are expected to be referred back to that outpatient program following treatment. During the period, 55 individuals, down from 61 reported last year, were enrolled. Approximately 16.4%, up from 13.1%, of the clients had received prior treatment at the program since 2009.

	n	mean	sd
All	55	46.8	13.6
Males	27	47.9	12.4
Females	28	45.7	14.6

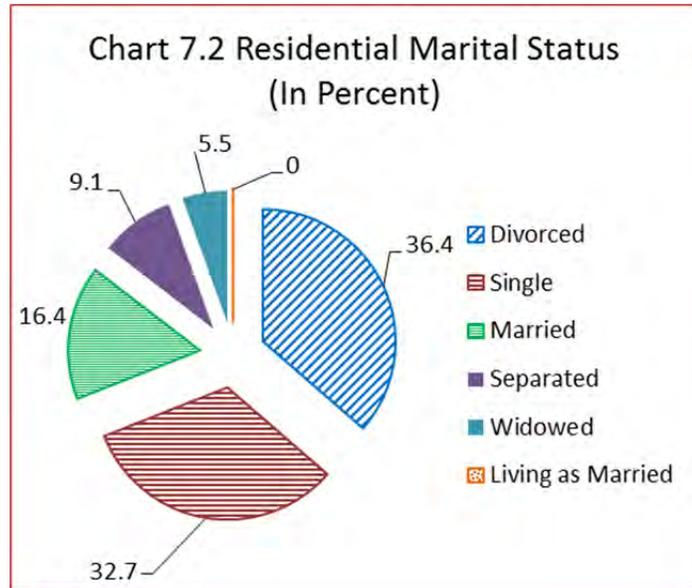
The average age of clients in the residential program was 46.8 years, down slightly from 48.5 years. This was statistically similar to the age of those enrolling in the outpatient programs. There was also no significant difference between males and females in regards to age. This year, approximately 50.9%, down from 60.5% of the clients were female. (Table 7.1)

Approximately 83.6%, down slightly from 85.2%, of the clients were reported as White, 7.3% Black/African American, 3.6% Native American and



1.8% each Asian, Hispanic, and Alaska Native. Differences in distribution across year and gender were not significant. (Chart 7.1)

The distribution of divorced clients increased this year from 26.2% to 36.4%. Approximately 32.7% of those enrolling were reported as being single, 16.4% married, 9.1% separated and 5.5% widowed. Again this year, there was shifting of the distributions of marital status from last year but, due to the small sample size, none were statistically significant. (Chart 7.2)



	n	mean	sd
All	54	17,392	22,225
Males	26	12,960	25,947
Females	28	21,507	17,097

The average annual household income was reported as \$17,392, down from \$24,420 previously reported. Females were slightly more likely to report a higher average income at \$21,507 than males at \$12,960 although none of these differences

reached statistical significance. The median income was \$21,600, up from \$18,000. (Table 7.2)

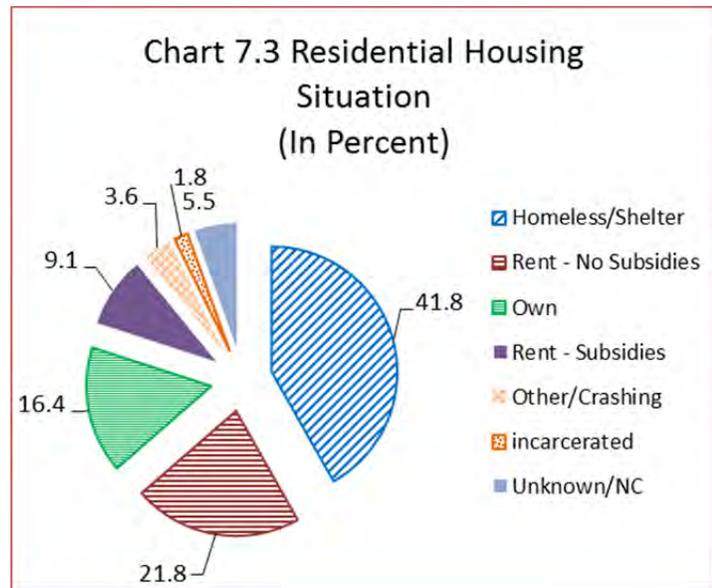
The average gambling related debt, for those who reported a gambling debt, was approximately \$31,647 somewhat lower than the

	n	mean	sd
All	45	31,647	45,487
Males	24	39,996	54,009
Females	21	22,105	30,485

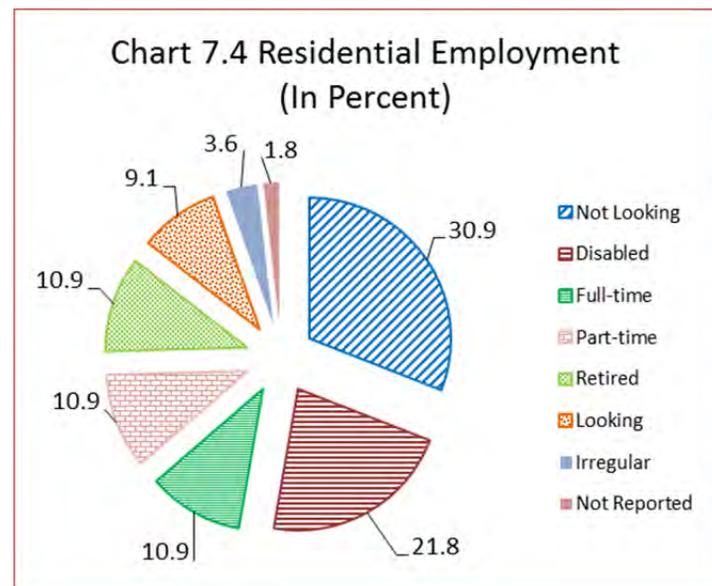
\$33,195 reported last year (after adjusting for outliers last year). Males' average debt of \$39,996 was higher than that of the females but was not statistically significant. (Table 7.3)

The average number of years of education was 13.4, up slightly from last year's 12.9 years with females having slightly more years with 13.6 compared with 13.1 years for males.

This year, clients were significantly<sup>58</sup> more likely to report being homeless (41.8%) than previously reported (29.5%). When adding other/crashing (3.6%) the actual homeless rate was 45.2%. Approximately 21.8% were reported as renting, 16.4% owning, and 9.1% renting with subsidies. (Chart 7.3)



There was shifting in the distribution of employment categories again this year but none were statistically significant. Full-time employment was 10.9%, up from 9.8% and part-time employment was also 10.9%, up from 6.6%. The only category with



a noticeable difference was looking for employment with a 9.1% endorsement, down from

<sup>58</sup> P < .05

19.7% last year. It is interesting that the employment distributions were not more different than last year with the larger distribution of homeless clients enrolling. (Chart 7.4)

The primary gambling activity of residential clients was video line games (69.1%), video poker (16.4%), and slot machines (7.3%). Females were slightly more likely to report video line games and males to report video poker.

	<b>All</b>	<b>Males</b>	<b>Females</b>
Video Line Games	69.1	63.0	75.0
Video Poker	16.4	22.2	10.7
Slot Machines	7.3	11.1	3.6
Cards	5.5	3.7	7.1
Dice	1.8	0.0	3.6

None of the differences between years or genders were statistically significant. Approximately 74.5% reported primarily gambling at a lottery retailer (bar/pub) and 14.5% at a casino/IGC. (Table 7.4)

The average age of first gambling experience was 22.2 years. Males reported averaging 15.5 years old and females 28.6 years. The average age of onset of problem gambling was reported as 34.7 years with males younger (30.5 years) than females (38.8 years). These findings were similar to those previously reported.

The average number of DSM IV criteria endorsed by the residential clients was 8.6. There was no statistical difference between the males and females, and the only

	<b>All</b>	<b>Males</b>	<b>Females</b>
Unsuccessful attempts to stop	100.0	100.0	100.0
Escaping	100.0	100.0	100.0
Preoccupation	98.2	98.2	96.3
Restlessness	98.2	98.2	96.3
Increasing size of bets	96.4	96.4	92.6
Lying	90.9	90.9	88.9
Returning to get even	85.5	85.5	85.2
Jeopardized relationship/job	78.2	78.2	77.8
Relies on others for money	78.2	78.2	77.8
Committed illegal acts	34.5	34.5	44.4

criterion that was less likely to be endorsed was that of committing acts that were not strictly legal. (Table 7.5)

Approximately 40.0% of the residential clients reported having thoughts of suicide, none reported threatening suicide, 3.6% reported having a plan, and 7.3% reported making an attempt at suicide in the past six months. Females were more likely to report making an attempt but the difference was not statistically significant due to the small sample size. These findings are similar to last year. (Table 7.6)

	All	Males	Females
Thoughts	40.0	40.7	39.3
Threat	0.0	0.0	0.0
Plan	3.6	3.7	3.6
Action	7.3	3.7	10.7

Approximately 41.8% reported having employment problems; 16.4% filing for, or planning to file, bankruptcy; 69.1% reported relationship problems related to their gambling; and, 23.6% reported legal problems. (Table 7.7)

	All	Males	Females
Job	41.8	51.9	32.1
Bankruptcy	16.4	14.8	17.9
Relationship	69.1	77.8	60.7
Legal	23.6	37	10.7

Lag time from initial call to first availability of a bed was 13.2 days, down from 15.5 days previously reported. 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 14.5 days. There was essentially no difference between males and females. (Table 7.8)

	n	mean	sd
All	55	13.2	13.2
Males	27	13.9	13.2
Females	28	12.5	13.2

The average length of stay (LOS) at residential treatment was 44.7 days, up significantly from 37.1 days previously reported. For those successfully completing

	n	mean	sd
All	56	44.7	25.9
Males	27	50.0	22.0
Females	29	39.7	28.2

treatment, the average number of days enrolled was 59.2 days up from 50.8 days. Males were somewhat more likely to remain in treatment longer than females. (Table 7.9)

The unadjusted successful completion rate was 51.8% down from 57.9% previously reported. The adjusted completion rate was 59.2%, down from 62.3%.

	All	Males	Females
Successful	51.8	55.6	48.3
Against Staff Advice	35.7	29.6	41.4
Further Tx Not Appropriate	1.8	3.7	0.0
Physical/Mental Illness	3.6	3.7	3.4
Unknown	7.1	7.4	6.9

Approximately 35.7% were reported as refusing treatment and leaving against staff advice. (Table 7.10)

The average number of days' service for all gamblers was 11.0 and for those that successfully completed the program 14.5 days. The average cost was \$9,888.00 overall and \$12,870.60 for those successfully completing treatment. (Table 7.11)

	n	mean	sd
<b>Days</b>			
All Gamblers	55	11.0	6.4
Successful Completers	29	14.5	5.2
<b>Dollars</b>			
All Gamblers	55	9,888.0	5,527.9
Successful Completers	29	12,870.6	4,225.1

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 was only one enrollment reported for this service.

## **8. MINIMAL INTERVENTION PROGRAM (GEAR)**

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

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

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

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

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

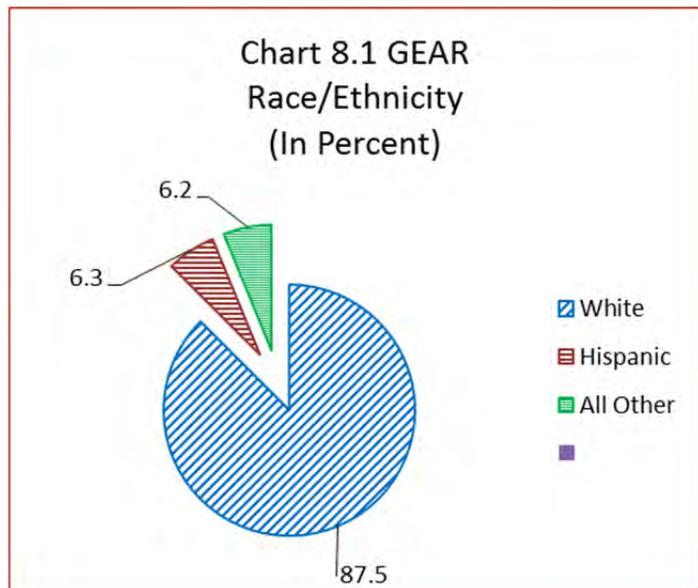
The total number of gamblers reported this year was 48, down from 53 reported last year. This year five family clients were enrolled, up from two last year. Due to the very small number of family member clients, their data is excluded from this report.

The average age of clients was 51.3 years, up slightly from 49.3 years. Females were somewhat older than males and were somewhat more likely than males to enroll in the GEAR program than as in the outpatient programs.

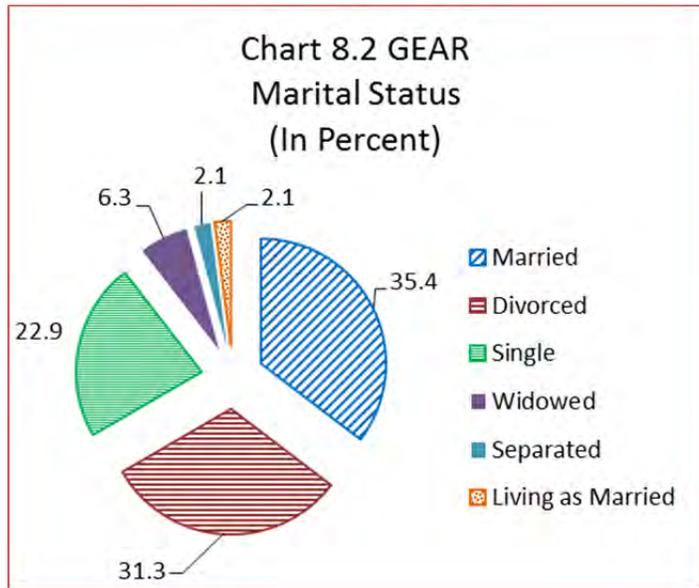
(Table 8.1)

	n	mean	sd
All	46	51.3	14.3
Males	19	50.2	13.8
Females	27	52.0	14.6

Approximately 87.5%, up from 75.5%, were reported as White (95.2% of the males compared to 81.5% of the females). Approximately 6.3%, down from 15.1%, were reported as Hispanic and the rest were comprised of Asian and Native American. (Chart 8.1)



Approximately 35.4%, down from 49.1%, of those enrolling in GEAR were reported as being married. Slightly over 31%, up from 17.0%, were reported as divorced and 22.9%, up from 15.1% were reported as single. These distributions are different from those previously reported but the differences were not



significant due to the small sample size and normal fluctuations due also to small sample size. (Chart 8.2)

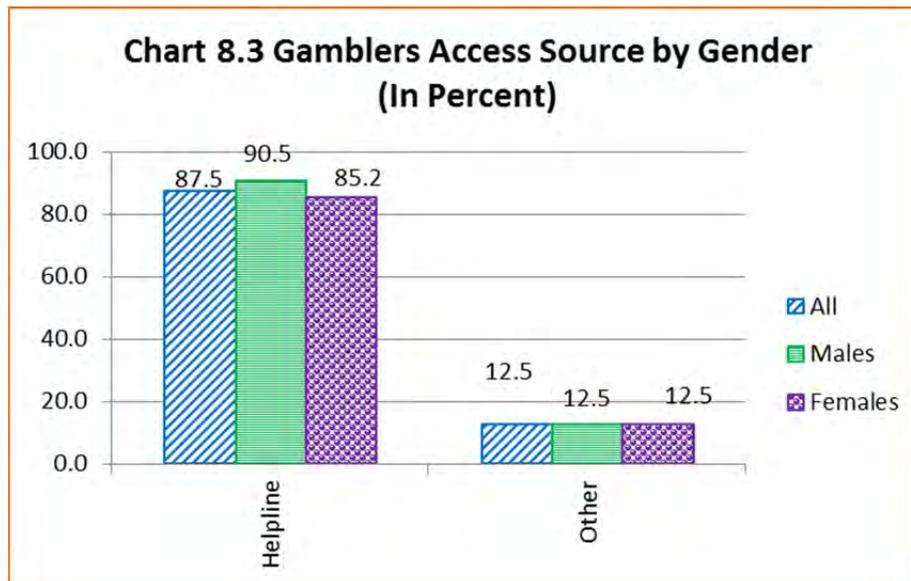
The average annual household income for the GEAR clients was \$47,670.50, down from \$59,471.30. The median income was \$36,000, down from \$48,000. The average income was somewhat higher than the outpatient clients' and there was no statistically significant difference between the genders. (Table 8.2)

	n	mean	sd
All	44	47,670.5	36,901.6
Males	20	52,359.0	38,637.2
Females	24	43,763.5	34,912.6

The average numbers of years of education completed was 13.5, the same as previously reported with no difference between males and females. (Table 8.3)

	n	Mean	sd
All	48	13.5	2.8
Males	21	13.2	2.2
Females	27	13.8	3.1

A majority of the clients (87.5%) reported accessing the GEAR program through the Helpline<sup>59</sup> and 12.5% reported learning of the program from another source, down slightly from last year. (Chart 8.3)



As previously reported, the primary gambling activity for both males and females were machines (85.4%) with some expected differences between the genders. (Table 8.4)

Approximately 68.8%, down from 77.4%, reported video lottery retailers as the

	All	Males	Females
Video Poker	37.5	52.4	25.9
Slot Machines	35.4	14.3	51.9
Video Line Games	12.5	9.5	14.8
Cards	8.3	14.3	3.7
Sports	2.1	4.8	0.0
Bingo	2.1	0.0	0.0
Sweepstakes	2.1	4.8	3.7

primary location followed by casino/IGC 25.0%, up from 17.0%. All other venues were only endorsed by one individual. Females were somewhat more likely to report casino/IGC (29.6%) than males (19.0%).

<sup>59</sup> It should be noted that the same agency operates the Helpline and GEAR.

The reported lag time from initial call to first available was reported as 12.5 days, varying little from 11.5 calendar days previously reported. There was essentially no statistical difference between males and females. The lag from initial call to first clinical contact was reported as 15.6 days, up slightly from 14.3 day. (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 27.1 years, up from 26.0 years previously reported. Females reported an older age (30.3 years) of their first gambling experience than males (22.9 years) and the difference was significant.<sup>60</sup> (Table 8.5)

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	47	27.1	13.5
Males	20	22.9	9.9
Females	27	30.3	14.8

The average age of onset was 37.4 years, down slightly from 38.1 years previously reported. Females (41.2 years) reported a significantly<sup>61</sup> older age than males (32.7 years). (Tables 8.6)

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	45	37.4	14.1
Males	20	32.7	11.1
Females	25	41.2	15.1

The average number of DSM IV criteria endorsed was 8.4, up from 8.2 reported last year. This average was significantly<sup>62</sup> greater than the average for the outpatient population which was 7.7, and not significantly different from the residential clients with an average of 8.6 items endorsed.

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<sup>60</sup> p < .01

<sup>61</sup> p < .01

<sup>62</sup> p < .05

Two females 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	6.3
Threat	0.0
Plan	0.0
Action	0.0

One male and two females were reported as having employment related problems due to their gambling; two males and one female reported planning, or recently filing, for bankruptcy. Three females and one male reported relationship problems and one female reported legal problems associated with their gambling.

The average length of time reported being enrolled in GEAR was 249.1 days, down from 294.0 days previously reported with no significant differences in length of stay for males and females. (Table 8.8)

	n	Mean	sd
All	48	249.1	200.1
Males	15	231.4	174.7
Females	33	257.2	210.1

The average length of enrollment for those who were reported as successfully completing the program was 405.8 days with females remaining longer but not significantly so due to the small sample size. (Table 8.9)

	n	Mean	sd
All	18	405.8	128.1
Males	7	374.3	90.6
Females	11	425.8	143.5

The unadjusted successful completion rate was 37.5%, down noticeably from 56.9%.

## **9. CORRECTIONAL INSTITUTION PROGRAMS**

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

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

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

During the report period 95 incarcerated individuals were enrolled in the three programs with 37 at CRCI, 34 at CCCF, and 24 at OSCI. Those enrolled at CCCF are all

females. Due to the nature of these programs a much abbreviated dataset was utilized for the documentation and evaluation.<sup>63</sup>

The average age of the CRCI participants was 38.7 years, up from 33.8 years; and, that for the CCCF participants the average age was 39.7, up from 33.7 years. Both these groups were significantly<sup>64</sup> older than the ages reported last year.

	n	mean	sd
CRCI Males	37	38.7	8.2
CCCF Females	34	39.7	8.8
OSCI Males	24	33.1	11.8

The average age of OSCI participants was 33.1 years - significantly younger than their counterparts in the other corrections programs. All three groups were significantly younger than those in the traditional outpatient programs. (Table 9.1)

As with the traditional programs, White/Caucasian was the largest racial/ethnic group in the corrections programs. Nonetheless, minorities were more likely to be present in the corrections programs than in the traditional outpatient programs. (Table 9.2)

	CRCI	CCCF	OSCI
White	67.6	85.3	66.7
Hispanic	8.1	2.9	20.8
Black	13.5	2.9	4.2
Native American	8.1	5.9	4.2
Asian	2.7	2.9	4.2

The average number of years of education for all programs was 11.8 years, significantly<sup>65</sup> less than that of those in the traditional outpatient programs. (Table 9.3)

	n	mean	sd
CRCI Males	37	11.6	1.5
CCCF Females	34	11.8	2.1
OSCI Males	24	11.8	0.5

<sup>63</sup> Due to special request for corrections personnel some questions were not asked of these individuals during the intake process.

<sup>64</sup> p < .01

<sup>65</sup> p < .01

Overall, 60.0% of the participants were reported as single (never married) and 21.1% were reported as divorced. Only 8.4% were reported as being married at the time of enrollment in the programs. As can be seen in the accompanying table, there are differences in the distributions among the

	CRCI	CCCF	OSCI
Single Never Married	56.8	50.0	79.2
Married	10.8	5.9	8.3
Widowed	0.0	2.9	0.0
Divorced	16.2	32.4	12.5
Separated	2.7	2.9	0.0
Living as Married	13.5	5.9	0.0

programs, but due to small sub-sample sizes determination of statistical significance was not possible. (Table 9.4)

Overall, the average age of first gambling was 18.3 years with males reporting an average age of 16.8 years and females 21.1 years. The corrections participants were significantly<sup>66</sup> more

	n	mean	sd
CRCI	37	16.9	3.5
CCCF	34	21.1	8.1
OSCI	24	16.7	3.6

likely to report a younger age than those in the traditional outpatient programs. Males reported a significantly<sup>67</sup> younger age than females. There was essentially no difference between the males in the two programs. (Table 9.5)

Overall, the average age of onset of problems related to gambling was 25.8 years. Males were somewhat more likely to report a younger age (24.7 years) than females (27.6 years). This group was

	n	mean	sd
CRCI	36	25.9	8.5
CCCF	34	27.6	8.9
OSCI	24	23.0	8.7

<sup>66</sup> p < .01

<sup>67</sup> p < .01

significantly<sup>68</sup> more likely to report a younger age of onset than those in the traditional outpatient programs. (Table 9.6)

The average number of DSM criteria endorsed by this group was 6.5, significantly<sup>69</sup> less than the average reported by those in the traditional outpatient programs. Males were significantly more likely to report a smaller average number of endorsed criteria than females in the corrections programs. (Table 9.7)

	<b>n</b>	<b>mean</b>	<b>sd</b>
CRCI	37	6.5	2.4
CCCF	34	7.4	2.5
OSCI	24	4.9	2.6

Only 15 of the 95 corrections participants were reported as having a debt related to gambling. The overall average debt was \$7,140.0 with males reporting a lower average debt of \$4,083.3 than females at \$9,177.8. The difference was not statistically significant. (Table 9.8)

	<b>n</b>	<b>mean</b>	<b>sd</b>
CRCI	4	4,250.0	3,363.4
CCCF	9	9,177.8	8,043.5
OSCI	2	3,750.0	3,250.0

During the report period 86 cases were closed with 63 (73.3%) reported as successful completions. The average number of encounters overall was 9.4 with an average of 10.8 encounters for those reported as successfully completing

	<b>n</b>	<b>mean</b>	<b>sd</b>
<b>Encounters</b>			
All Gamblers	86	9.4	4.3
Successful Completers	63	10.8	3.6
<b>Dollars</b>			
All Gamblers	86	418.8	184.7
Successful Completers	63	473.0	155.0

<sup>68</sup> p < .01

<sup>69</sup> p < .01

their course of treatment. The average case cost overall was \$418.80 and for the successful completers it was \$473.00. (Table 9.9)

## 10. PEER SUPPORT SERVICES

Peer Delivered Service is defined as any services in an array of agency or community-based services and support that are 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.<sup>70</sup>

Prior to the issuance of the billing codes for peer services, Voices of Problem Gambling Recovery (VPGR)<sup>71</sup> working closely with the Mental Health and Addiction Certification Board of Oregon (MHACBO) took the initiative to develop and implement a training curricula that would meet the certification standards of MHACBO and be consistent with standards associated with peer support in mental health and other addictions.<sup>72</sup> The terminology utilized by MHACBO is Certified Gambling Recovery Mentor (CGRM).<sup>73</sup>

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<sup>70</sup> Extracted from Oregon PGS Procedure Codes and Rates 2015-16

<sup>71</sup> A consumer-based 501 (c) 3 funded by PGS and based in Portland, Oregon

<sup>72</sup> Previously known as ACCBO, MHACBO is affiliated with the International Certification & Reciprocity Consortium

<sup>73</sup> The re[http://accbo.com/general\\_images/pdf\\_files/PRCCertification.pdf](http://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 ten agencies reported any peer mentor encounters and only four reported any encounters for the current report period. Several other agencies have accessed these services from VPGR and that activity is reported below.

Only seven outpatient clients received direct peer services this year, down from twenty-six receiving services last year. Only 17

Total Clients Served	7
Total Encounters Reported	17
Total Cost of Services	\$761.4

encounters were reported, down from 195 encounters were reported last year. The total cost of these agency-based services was \$761.4, down from \$6,753 previously reported. (Table 10.1)

The average age of clients was 57.4 years, up from 49.7 years previously reported.

Approximately two-thirds were reported as successfully completing their outpatient course of treatment. (Table 10.2)

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	7	57.4	16.5
Males	4	62.3	8.9
Females	3	50.8	21.3

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,<sup>74</sup> 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 111 individuals have been reported as enrolled. During the report period a total of 35 clients were enrolled with 51.4% reported

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	35	53.5	12.8
Males	17	49.9	13.5
Females	18	56.9	11.1

as female. The average age was reported as 53.5 years with females being older than males. (Table 10.3)

During the report period, clients were reported as coming from four state-funded agencies and the community. Approximately 91.5% were from the state-funded agencies and 8.6% from the community (not associated with any state-funded program). (Table 10.4)

Lewis & Clark	20.0
Cascadia Multnomah	14.3
Volunteers of America	54.3
Bridgeway Residential	2.9
Community	8.6

During the report period, 28 cases were closed with a 28.6% successful closing rate. Over the life of the project the evaluation team was able to match 71 mentor clients with their outpatient treatment program data. Of these, 54 had been discharged from the outpatient program with an unadjusted successful completion rate of 53.7%.

Encounter data was submitted for 70

Total Clients Served	70
Total Direct Service Hours	2,682.3

<sup>74</sup> This was state PGS funding that was not used for the established treatment programs in the County.

VPGR clients with approximately 2,682.3 direct service hours. The program is grant funded (not a fee for service model) so it is difficult to determine actual case costs. (Table 10.5)

Overall the average number of contact hours was 0.7 hours per week per client. (These figures were not adjusted for length of enrollment.) During the year, two participants received, on average, 3.5 hours per week of direct services for the year.

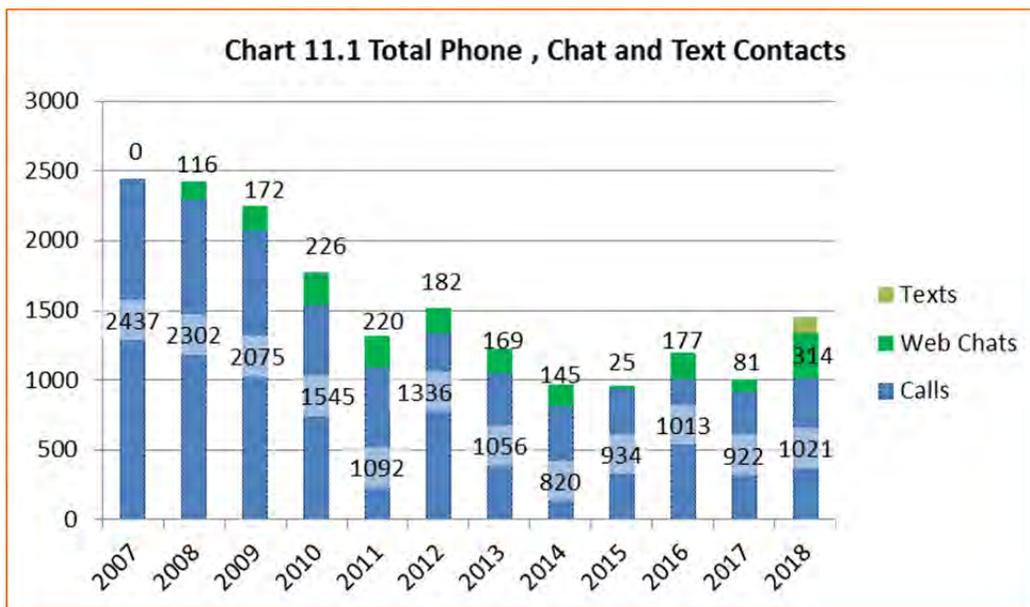
There were three mentors actively providing services during the year. Their level of effort averaged approximately 0.5 FTE each. Of the total hours reported, 2,512 were one-on-one activities with individual participants, 153 hours were services provided with groups of participants, and 17.25 hours were reported as administrative or case management activities. Supervision hours were the time spent with their supervisor and outreach was primarily devoted to case finding. (Table 10.6)

Individual Services	2,512.00
Group Services	153.00
Case Management	17.25
Supervision	81.75
Outreach	287.75
<b>Total</b>	<b>3,051.75</b>

## 11. HELPLINE

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

Over the last eight years contact with the Helpline has remain depressed with some fluctuations compared to earlier years. This year 1,021 calls for assistance were reported to the evaluation team. The total number of chat sessions was reported as 314 and the number of text messages was 124. Although the number of web chats appears to have increased dramatically during the report year this change should be viewed with some caution as previous years' reporting appears to have experienced some problems with missing data. This is the first year the number of text messages has been reported. (Chart 11.1)



Tracking Spanish language calls was initiated for the FY 15-16 report period where 68 (6.7%) of all the calls were reported as Spanish speaking callers. Last year 109 (11.8%) Spanish language calls were reported and this year 100 (9.8%) such calls were reported.

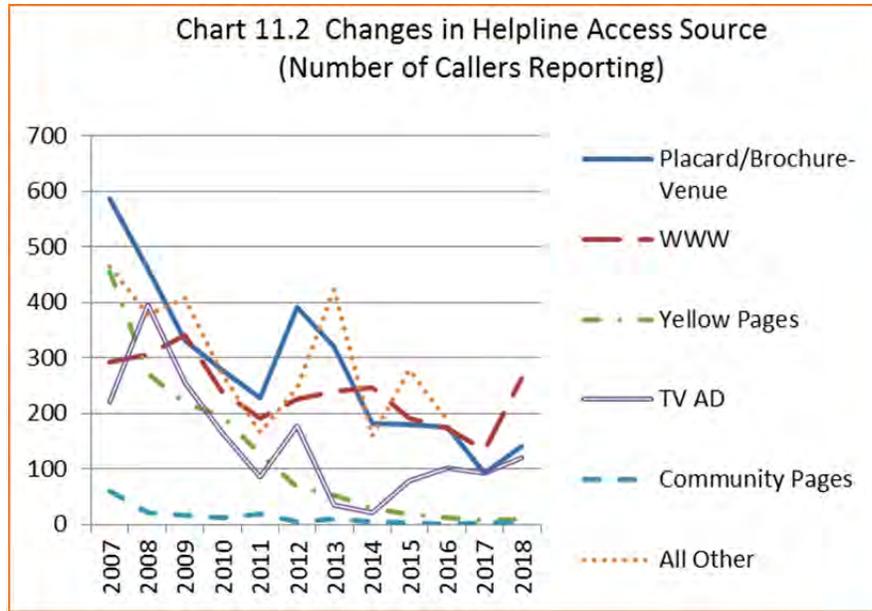
After callers have engaged with the helpline staff and any impending crisis has been sufficiently resolved, the callers are asked a short series of questions to track both the nature of the call and how the caller acquired the Helpline phone number.

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. Also, early on the use of Yellow and White Page ads were a popular resource for access to the toll free number. For several years the Oregon Lottery provided extensive treatment orientated advertising and that became a frequently cited source for accessing the Helpline. More recently, that all has shifted with an increasing number of callers reporting accessing the toll-free number by use of the internet.

During the current reporting period, the more frequently cited access source for the phone number was the internet (37.2%), followed distantly by placards on the VLTs (19.8%) and TV advertisements (17.0%). (Table 11.1)

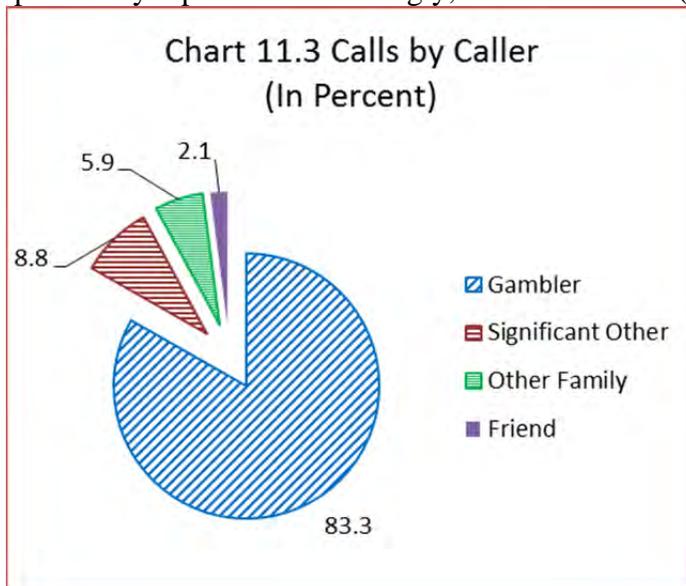
<b>11.1 Access Source for Phone Number (In Percent)</b>	
Web/Internet	37.2
VLT Placard	19.8
TV Ad	17.0
Other	13.7
Brochure/Poster Local	5.4
Radio	2.4
Billboard	1.4
Yellow Pages	1.3
Brochure/Poster Community	1.0
Community Pages	0.3
Print Ad	0.3
TV Program	0.1
Presentation	0.1
White Pages	0.0
Print Story	0.0

As can be seen in the accompanying table, sources for the phone number have fluctuated extensively due to a plethora of intervening variables. (Chart 11.2)<sup>75</sup>



Approximately 52.8% of the calls reported were made during normal work hours, slightly down from 56.4% previously reported. Interestingly, after-hours calls (weekdays)

Normal Work Hours	52.8
After Hours	17.5
Weekend	29.7



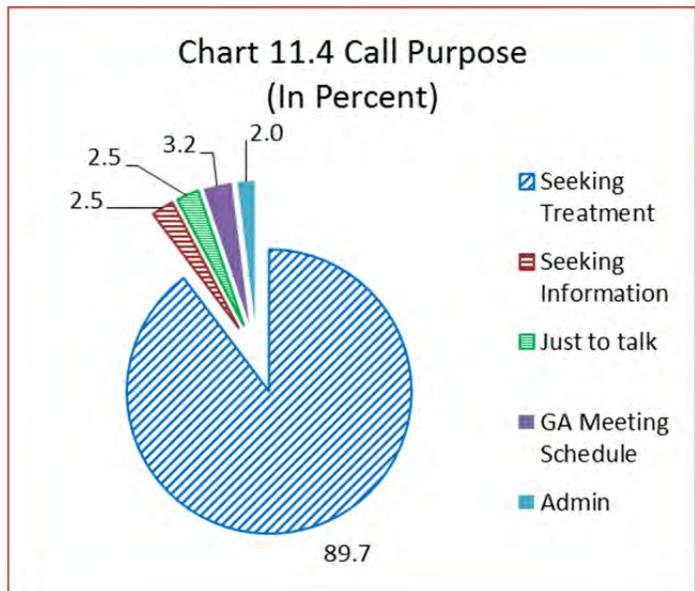
dropped from 28.7% to 17.5% and weekend calls increased from 15.0% to 29.7%. (Table 11.2)

Approximately 83.3% (up from 81.2%) of the calls for assistance or information were reported as coming from the individual who was

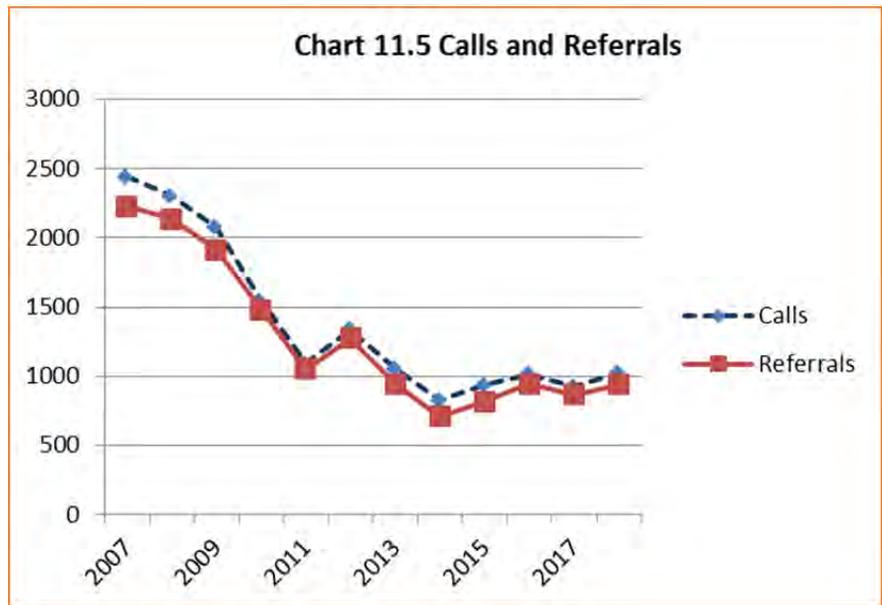
<sup>75</sup> There was extensive missing data for FY 16-17 therefore that time period should be viewed with caution.

experiencing the gambling problems. Approximately 8.8% (up from 7.2%) came from a spouse or significant other and another 5.9% (down from 9.4%) from other family members. Approximately 2.1% 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 (89.7%, down from 94.5%), as expected, were reported to be by individuals seeking treatment followed distantly by those seeking information (2.5%), the opportunity to speak with a counselor for support (2.5%), and those looking for recovery support and GA meeting schedules (3.2%). (Chart 11.4)



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



when treating agency personnel are available. During the report period 221 (up from 182)

direct referrals were reported. Overall, 92.1% of all calls resulted in a referral to a local treating agency. (Chart 11.5)

Twelve individuals were reported as experiencing suicidal ideation, seven additional individuals having a plan with the means to carry out the plan and one more with plan and no means to carry out the plan. Two individuals were reported as having a recent history of attempts. (Table 11.3)

Ideation	12
Plan/Means	7
Plan/No Means	1
Recent Attempts	2

There was an extremely large amount of missing data submitted to the evaluation team regarding the number and context of the chats this year.

## 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 112, up from 97. Females were much more likely<sup>76</sup> to be enrolled (73.0%) than males and they were significantly<sup>77</sup> more likely to be younger than males (48.6 years compared with 57.5 years). There were two individuals enrolled in family treatment who were younger than 18

	<b>n</b>	<b>mean</b>	<b>sd</b>
All	109	50.9	17.1
Males	29	57.5	17.2
Females	80	48.6	16.4

	<b>All</b>	<b>Males</b>	<b>Females</b>
Spouse/SO	65.3	59.3	67.1
Parent	13.3	14.8	12.9
Child	13.3	18.5	11.4
Sibling	4.1	3.7	4.3
Other Family	1.0	0.0	1.4
Co-Worker/Friend	1.0	3.7	0.0
Employee/Employer	0.0	0.0	0.0
Other	2.0	0.0	2.9

<sup>76</sup> p < .05

<sup>77</sup> p < .05

years old. (Table 12.1)

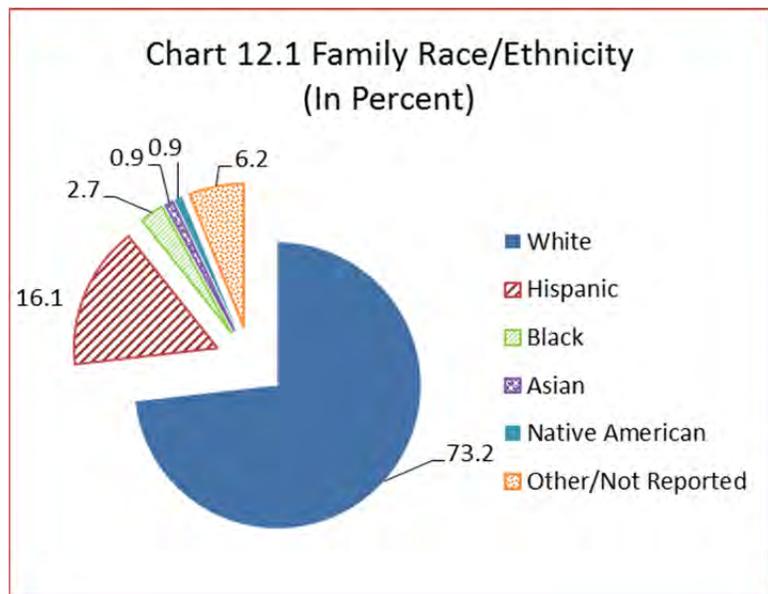
The majority (65.3%, down from 69.4%) of family clients were the spouse or significant other (SO) of a gambler with the SO somewhat more likely to be female as consistently reported in previous reports. Following distantly, and equally, were children and parents (13.3%). (Table 12.2)

Approximately 59.0% of the family members were reported as having a family member enrolled in gambler treatment. As consistently reported previously, male gamblers were

Gambler Male - Family Male	8.7
Gambler Male - Family Female	58.0
Gambler Female - Family Male	20.3
Gambler Female - Family Female	11.6

significantly<sup>78</sup> more likely to have a female family member attending treatment than females. This year, gamblers successfully completing treatment during the year were not significantly more likely to have a family member enrolled in treatment. (Table 12.3)

Family client race/ethnicity somewhat mirrored that of the overall gambler population as would be expected. The majority were reported as White (73.2, down from 77.4%), followed by Hispanic (16.1%, up from

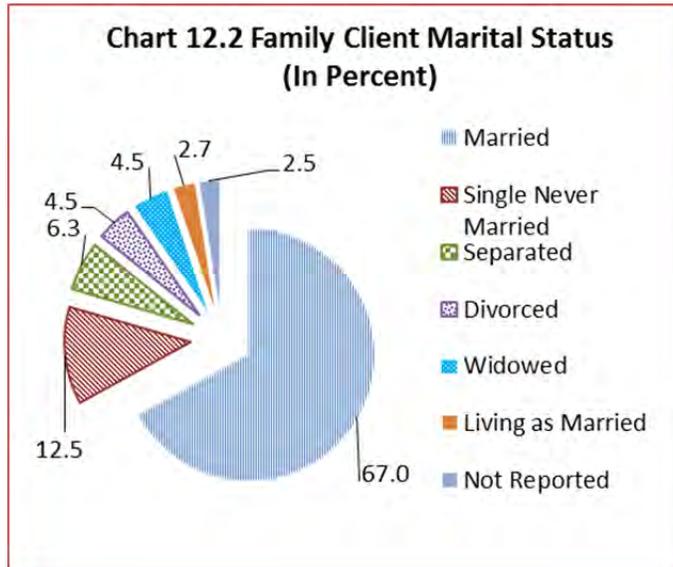


9.2%), Black/African American (2.7%), and Native American (0.9%). The increase in Hispanic family clients was attributed to the increased emphasis on Spanish speaking

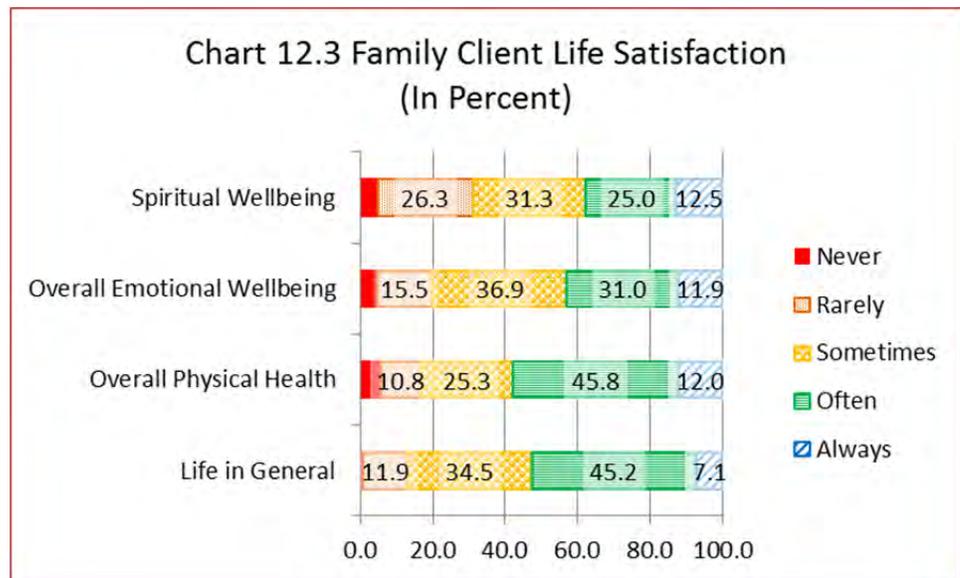
<sup>78</sup> p < .01

programs implemented in Multnomah, Clackamas, and Washington counties by Lewis & Clark College as well as the implementation of a special contract with the College to strengthen family care statewide. (Chart 12.1)

Approximately 67.0% ( up from 64.2% ) of the family clients were married, 12.5% were reported as single - never married, 6.3% separated, 4.5% widowed, and 4.5% divorced. There were no statistically significant differences. (Chart 12.2)



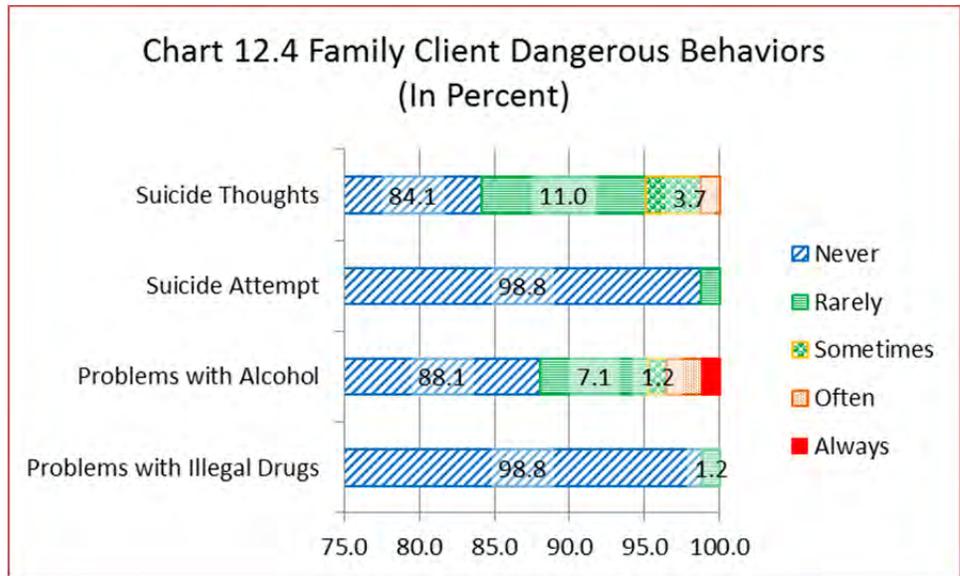
At enrollment, family clients were only moderately satisfied with their life in general and overall physical



health. Satisfaction with spiritual and emotional wellbeing was low similar to last year. (Chart 12.3)

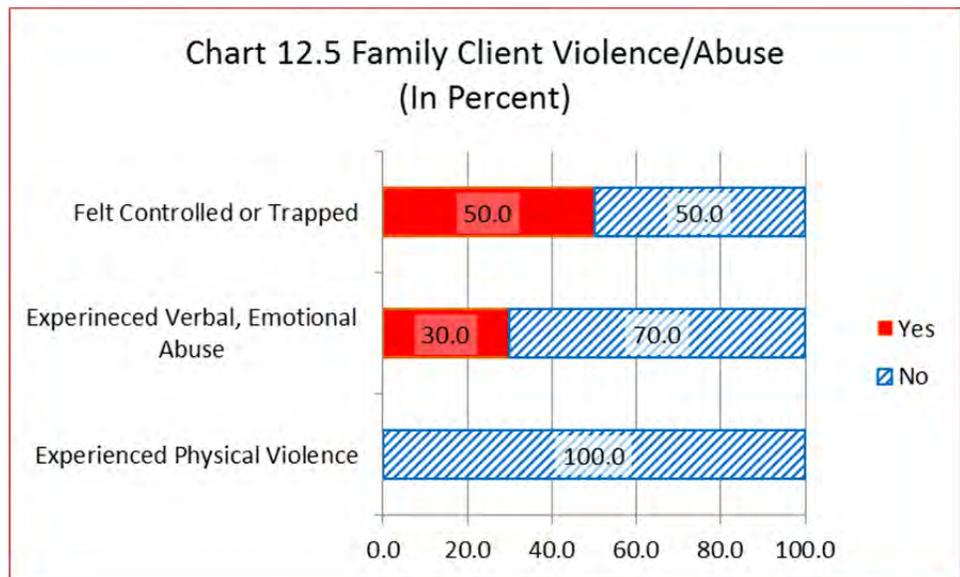
Approximately 15.9% (down from 21.8%) of the family members reported having any thought of suicide in the past six months with 1.2% reporting often. Approximately 1.2%

reported attempting suicide rarely. Having any problems with alcohol were endorsed by 11.9% of the family clients and



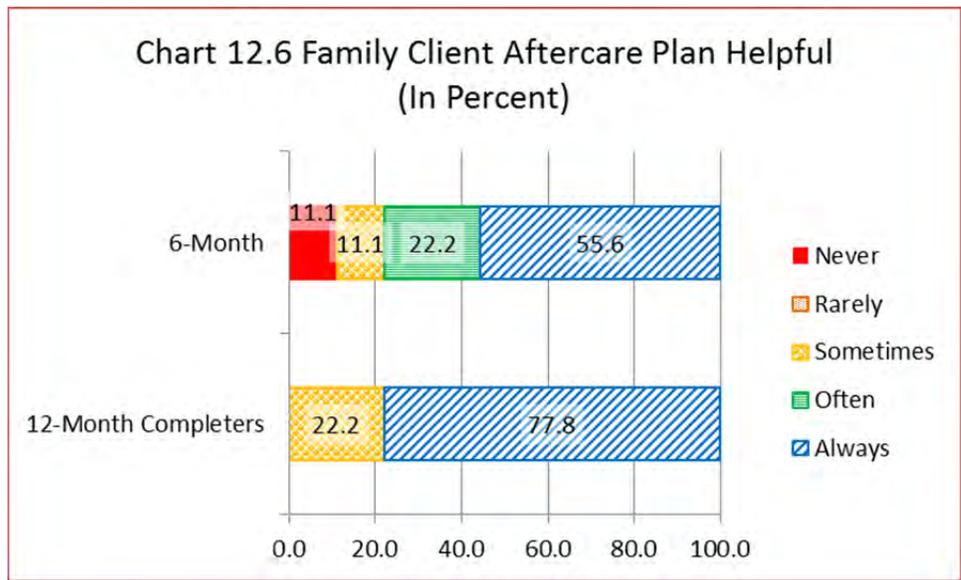
4.2% reported having any problems with drugs. (Chart 12.4)

None of the family clients reported experiencing any physical violence in the previous six months while 30% reported



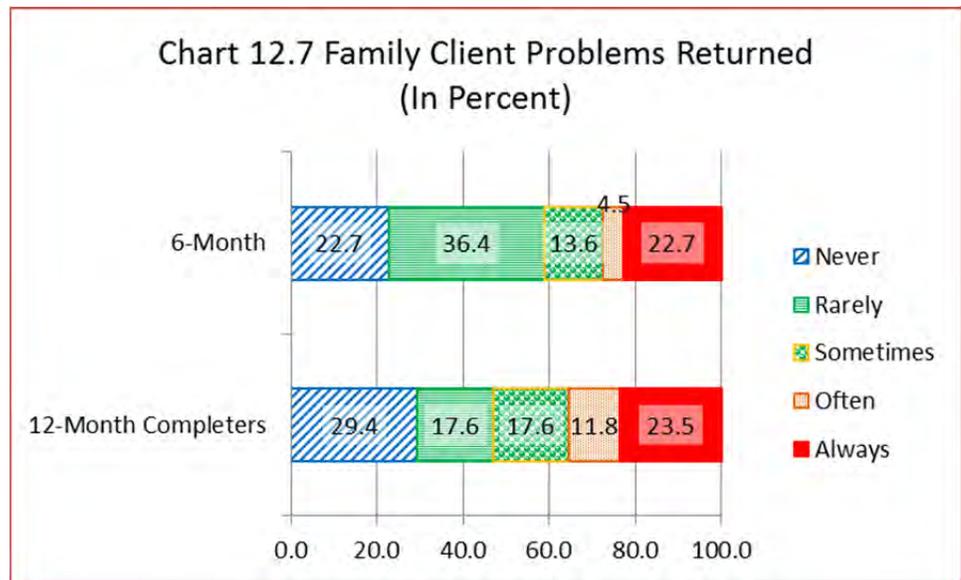
experiencing verbal or emotional abuse and 50% reported feeling controlled or trapped in their relationship. These findings are similar to those previously reported. (Chart 12.5)

Family clients reported moderate helpfulness of their aftercare plans at both the six and twelve-month follow-up.



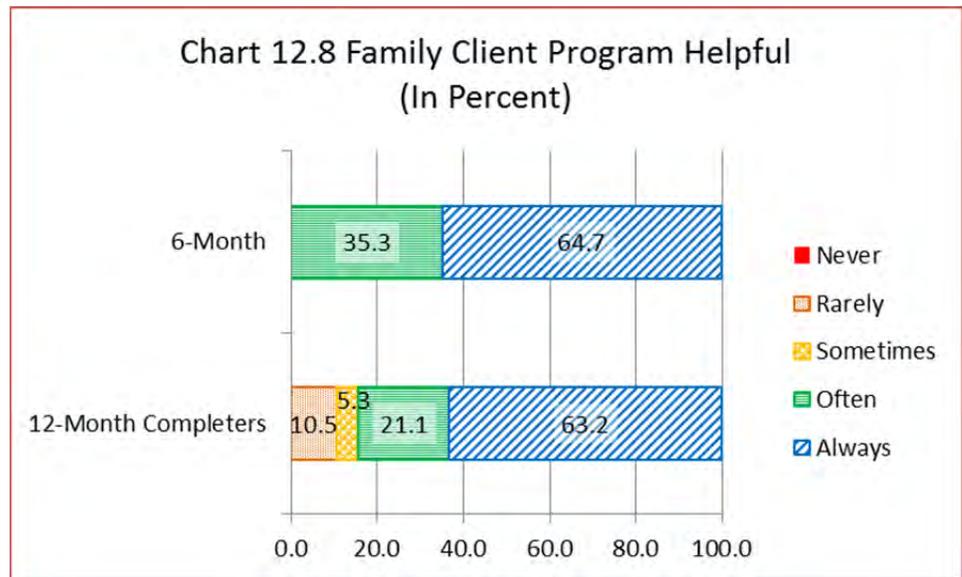
It should be noted that family treatment encompasses an extremely broad range of care – from simple short-duration education to in depth, long term therapy – based on the needs of the individual. With this in mind, satisfaction with continuing care, or aftercare plans, also has a broad range of meaning for the family clients. (Chart 12.6)

About 29.4% of the twelve-month sample and 22.7% of the six-month sample reported no return of the problems that



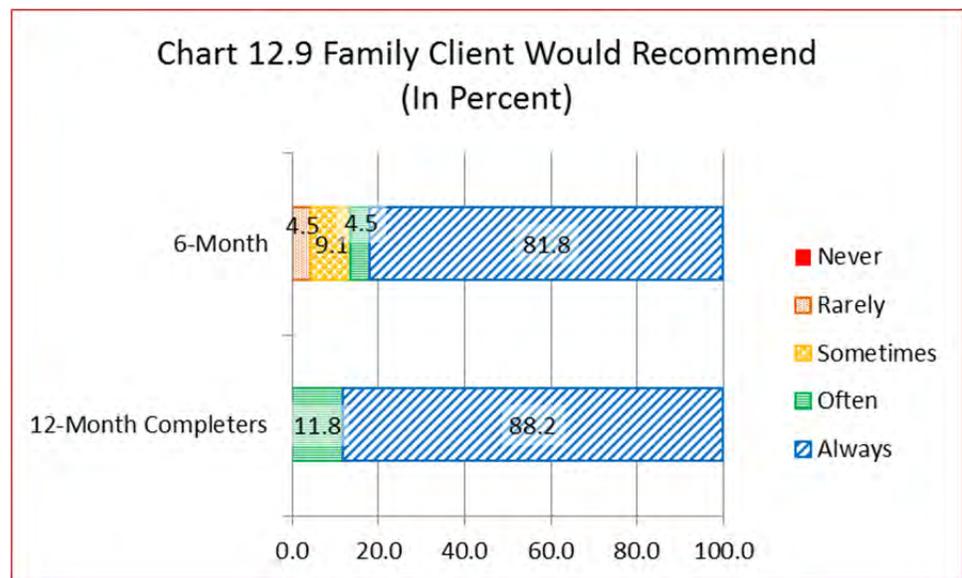
brought them to the program. On the other end of the scale, 23.5% of the twelve-month sample reported the problems returned “always,” while 22.7% of the six-month sample so reported. (Chart 12.7)

About 84.3% in the twelve-month follow-up reported the program was helpful “always” or “often” while 100.0% of those



in the six-month sample so reported. It’s interesting to note that both samples were satisfied with the helpfulness of the family services even when the problems had returned. (Chart 12.8)

A strong endorsement of the willingness of the six-month follow-up sample was reported with 86.3% indicating “always” or



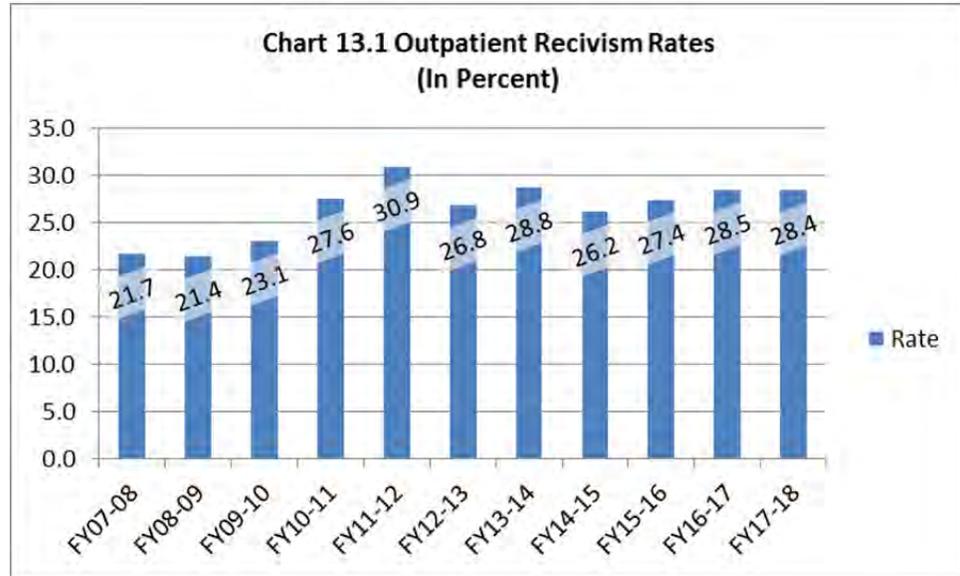
“often.” The twelve-month sample was more positive with 100% so reporting. It should be noted that willingness to recommend usually tends to diminish the longer away from the

experience and that the six and twelve-month samples are comprised of different participants and that the two samples are comprised on different participants. (Chart 12.9)

### 13. COMMENTS AND SUMMARY

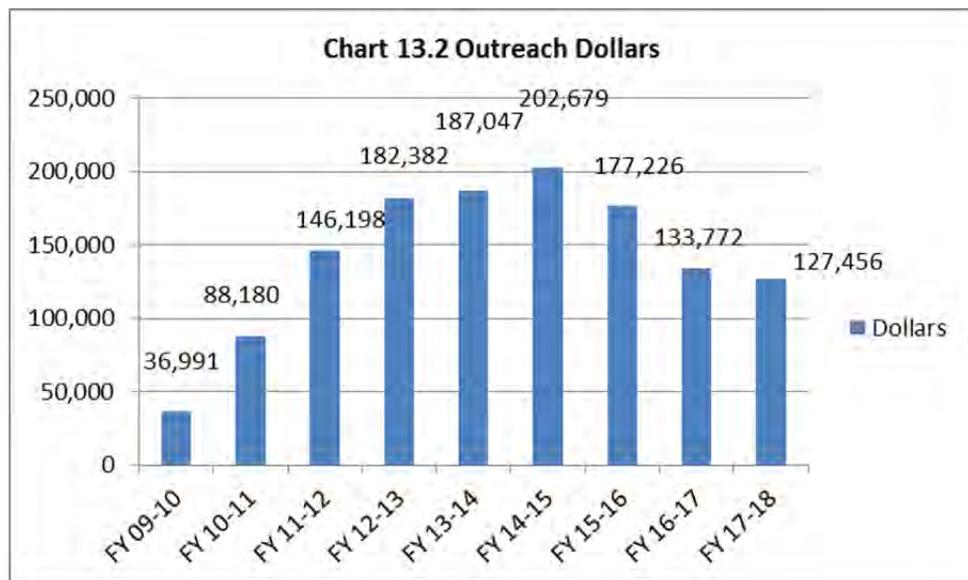
Gambler enrollments in all programs reached the lowest level since FY 98-99 with a 2.7% decrease from last year. Recidivism rates have remained somewhat stable over the past six years averaging 27.7% of outpatient enrollments. As noted last year, adult prevalence studies

conducted in Oregon since that time have generally seen a fairly stable rate of problem gambling in the



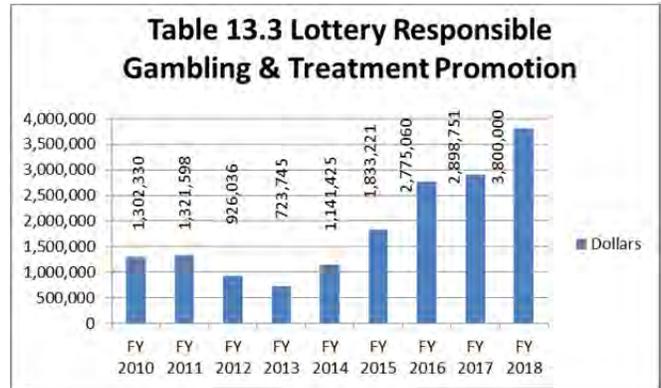
adult population. These studies have also suggested a decline in the rate of gambling by adults in Oregon. The National Council on Problem Gambling also reports that this decline in enrollments is being seen on a national basis. (Chart 13.1)

In an effort to 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 has continued to decline over the past three years to approximately \$127,500. As noted last year, a cursory comparison of these investments with the enrollments for FY 09-10 through FY 17-18 suggest a potential inverse relationship but with all the intervening variables there was more likely no effect. (Chart 13.2)

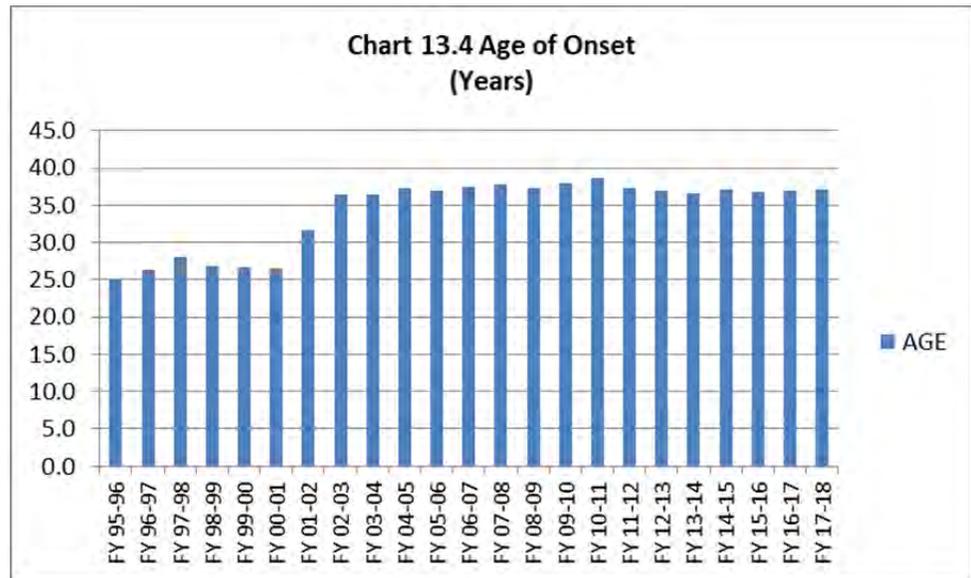
As noted above, the Oregon Lottery has an extensive history of promoting responsible gambling as well as access to treatment. Over the last five fiscal years the amount of that investment has risen from approximately \$0.7 million



to approximately \$3.2 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

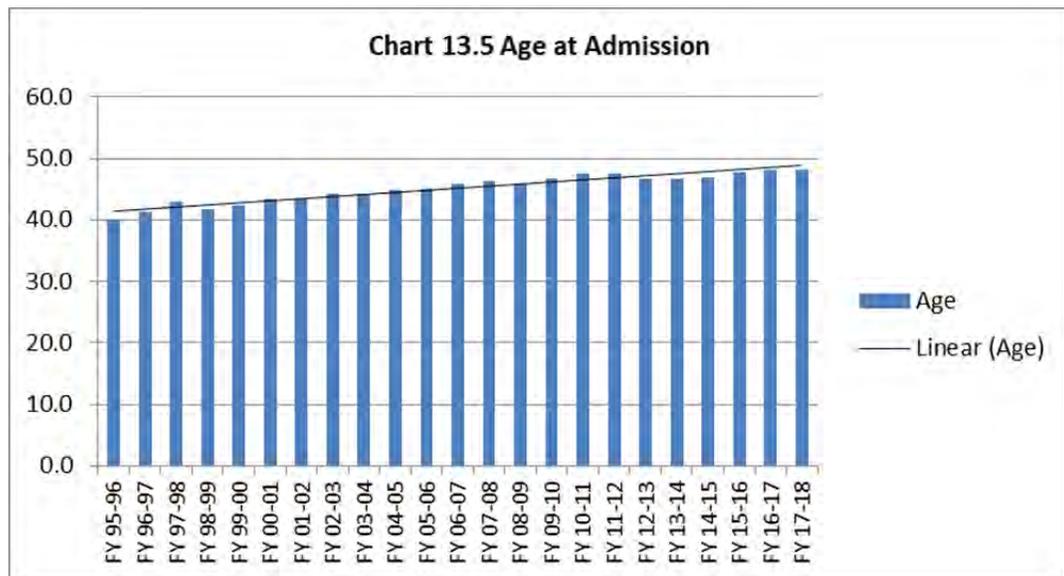
13.3)

In the first decade of treatment availability, the age of onset of



problem gambling rose significantly<sup>79</sup> from an average of 24.9 years to 37.2 years with the first the major jump in years coming for FY 00-01 to FY 02-03. However, that trend has not continued since. (Chart 13.4)

Further analysis of the available historic data continued to demonstrate, that since inception of the treatment programs, the average age at the time of enrollment in the outpatient programs has continued to increase. The average age of those entering treatment in the early years was significantly<sup>80</sup> younger that the average age of those entering treatment over the past several years. This is consistent with the increasing age of onset of problem



gambling. (Chart 13.5)

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

<sup>79</sup> p < .01

<sup>80</sup> p < .001

those efforts in the schools and community have been in place long enough that many younger adults in Oregon have been exposed to preventative measures for problem gambling.

Although beyond the scope of this report, there are potentially untapped populations that could benefit from disordered gambling specific treatment. As discussed in Chapter 9, therapeutic treatment interventions were continued in two prisons and added to a third. A recent study in Oregon<sup>81</sup> strongly supported the potential need for additional intervention into disordered gambling within the corrections system.

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

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<sup>81</sup> Not released for publication at the time of this report.

## APPENDIX A: SOCIAL ECOLOGICAL MODEL

### Applying a Socio-Ecological Model to Prevention

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



and strategies that influence those factors at the various levels.

#### **Individual Level:**

Includes strategies that focus on the individual.

#### **Relationship Level:**

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

#### **Community Level:**

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

#### **Societal Level:**

Includes strategies that focus on changing social and

cultural norms such as broad-based policy changes.

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

## APPENDIX B: STRATEGIC PREVENTION FRAMEWORK

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

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

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



The steps of the SPF include:

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

The SPF also includes two guiding principles:

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

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

## **APPENDIX C: 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.

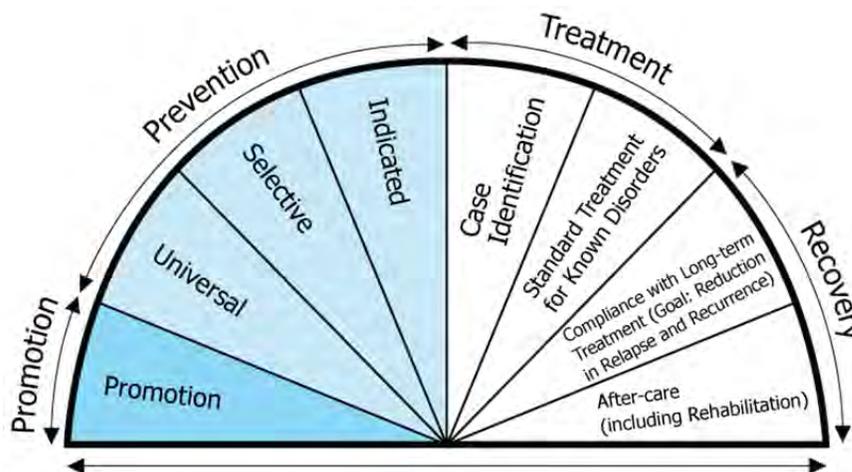
*Reference: Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies. (2002). Best and Promising Practices for Substance Abuse Prevention (3rd ed.). Also available online: <http://www.unr.edu/westcapt/bestpractices/bpcsap.htm>*

## APPENDIX D: THE BEHAVIORAL HEALTH CONTINUUM OF CARE MODEL

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

- 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>).

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## **APPENDIX F: BRIEF HISTORY OF LEGAL GAMBLING AND PROGRAM DEVELOPMENT**

- 1933 Legislature legalizes pari-mutuel wagering on horses and dogs (same year repeals prohibition)
- 1973 Social gambling legalized in counties and cities
- 1976 Constitutional amendment legalizes charitable gambling (bingo, raffles)
- 1984 Constitutional amendment creates The Oregon Lottery (Scratch-its™ Megabucks™)
- 1987 Legislature legalizes off-track pari-mutuel gambling
- 1989 Multi-state lotteries incorporated into Lottery
- 1989 Lottery introduces Sports Action™ (Stopped in: NFL 1990; NBA 2007)
- 1991 Lottery introduces Keno™
- 1991 Contentious legislative session approves video poker but only with 3% of net to treatment (ORS 461.549 1992 – amount to 1%)
- 1992 Video Poker machines introduced
- 1992 Treatment programs established (ORS 409-435); Problem Gambling Treatment Fund created (ORS 409.430); Funding DAS to Counties (no apparent restrictions)
- 1993 First of nine IGCs established (Federal Indian Gaming Regulatory Act 1988)
- 1994 State Supreme Court rules PG treatment funding illegal under constitution. Legislature takes action and funded at 1%
- 1995 PG Treatment consolidated statewide Association of Community Mental Health Providers (AOCMHP)
- 1995 Helpline established
- 1995 Oregon Lottery tasked with delivering a “Play Responsibly” campaign that included problem gambling awareness through TV, radio, and print advertising.
- 1996 Governor’s Taskforce (Executive Order 96-03)
- 1996 2<sup>nd</sup> 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 Service encounter tracking commences with reconciliation to budgets
- 2001 First of two respite treatment programs opened
- 2001 Win for Life introduced
- 2001 Adult Gambling Replication Study (Volberg)
- 2001 Older Adult Gambling Prevalence Study (Moore)
- 2001 PGS expands from two to fifteen 15 regional prevention programs
- 2002 Etiology of Pathological Study (Moore)
- 2003 PGS prevention activities moved away from generalized treatment programs to performance based contract
- 2003 PGS funding slated for elimination (HB5077 and the rejection of a surtax)

- 2003 Number of Lottery VLTs increases from five to six
- 2003 First annual Problem Gambling Awareness Week (OPGAW) consolidated activities including first art search for PG posters
- 2003 Development of first OPGAW Community Resource Guides
- 2004 Emergency Board restores expenditure authority but budget reduced
- 2005 State funded treatment agencies required to report treatment service encounter data
- 2005 All Oregon counties receive problem gambling prevention funds
- 2006 Adult Gambling Prevalence Replication Study (Moore)
- 2006 Adult Residential Gambling Treatment Program opened in Marion County.
- 2007 Line games introduces on VLTs
- 2007 RFP issued for the establishment of what would become the Voices of Problem Gambling Recovery
- 2007 Teen gambling video “It’s a Risky Deal” created and distributed
- 2008 First PG Services calendar distributed utilizing artwork from middle school student art search
- 2009 Helpline incorporates live web chat
- 2009 Development of Problem Gambling Prevention Coordinators website
- 2010 Adolescent Gambling Study (Volberg)
- 2010 Implementation of Online Problem Gambling “101” training
- 2011 Prevention Infusion Projects funded
- 2013 DOJ opinion Lottery funding treatment ads not legal
- 2013 HB 4028A Allows Lottery to resume treatment ad funding
- 2013 HB 2355 Stabilizes PGS funding to not go below 7/1/11 baseline
- 2013 HB 2613 Legalized gambling based on historic horse races
- 2014 PGS Office fully staffed
- 2015 Peer support services introduced with the first certification for gamblers
- 2014 Implementation of the Spanish language helpline number – 844-TU VALES
- 2014 Creation of Oregon Problem Gambling Resource web page
- 2014 Oregon Lottery Commission adopts Responsible Gambling Code of Practice
- 2015 Responsible Gambling Code of Practice adopted into statute
- 2015 Peer support services introduced with the first certification for mentors
- 2015 OHA develops 2016 to 2020 System Improvement Plan for Problem Gambling Services
- 2015 Beginning of Positive Cultural Framework Campaign and funding
- 2015 Adult Gambling Behavior Study funded
- 2015 Adolescent Gambling Behavior Study funded
- 2016 Prevention Special Projects funded
- 2016 Implementation of clinical supervisor and clinician online trainings by Lewis & Clark College
- 2017 Motivational messaging incorporated in Helpline services
- 2017 Community Readiness Projects funded