OREGON HEALTH AUTHORITY

OREGON'S PUBLICLY FUNDED GAMBLING TREATMENT SERVICES EVALUATION REPORT

Fiscal Year 2023-24

OREGON HEALTH AUTHORITY
PROBLEM GAMBLING SERVICES

ACKNOWLEDGMENTS

Special thanks go to the staff at Oregon Health Authority, Problem Gambling Services (PGS), particularly Greta Coe, for the time spent meeting with the evaluators and compiling program materials for the evaluation team's review.

This evaluation would not be possible without the PGS contracted gambling treatment providers, who input client data. Together our efforts create a more informed and evidence-driven system of care.

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INTRODUCTION

For decades, Oregon has committed to addressing the risks associated with gambling, supporting research, prevention, education, and treatment initiatives, implementing responsible gambling guidelines, and maintaining strong partnerships for collaborative efforts. State legislation requires no less than one percent of Oregon Lottery revenues to fund problem gambling services, supporting these efforts. In state fiscal year 2023/24, approximately nine million dollars in Oregon Lottery revenues were transferred to the Oregon Health Authority (OHA) for administering their Problem Gambling Services (PGS), including problem gambling prevention, treatment, and related services throughout the state.

The present report focuses on state fiscal year 2023/24 (July 1, 2023 to June 30, 2024) gambling treatment and recovery components of the OHA Problem Gambling Services system, which accounts for a large percentage of the entire program budget. These funds allow for gambling treatment and recovery services to be made available to any Oregon resident, without any out-of-pocket costs, who has problems related to gambling, either as an individual or a concerned other who has been affected by someone else's gambling (e.g., family, friends, significant others, colleagues).

Information and help is made available to the public

- Oregon Problem Gambling Resources: www.opgr.org
- Problem Gambling Helpline: My Limit (1-877-695-4648)

DESCRIPTION OF SERVICES & PROVIDERS

Problem gambling occurs on a spectrum, which individuals can move back and forth along throughout their lifetime and recovery journey. Depending on the severity of the problem and the needs of an individual, there are a number of options for engaging in help-seeking and treatment services.

Non-gambling	Gambling without problems	Mild gambling problems	Moderate gambling problems	Severe gambling problems

Spectrum of problem gambling severity

OHA supports efforts to identify individuals experiencing harmful gambling and to help them engage in positive change. Awareness campaigns and helpline resources encourage those who are passively looking for help to move into active help-seeking. Individuals and agencies contracted by OHA to provide problem gambling treatment offer an array of treatment services and support for recovery, which are covered in this section.

Not seeking help	Passively or actively looking for help	Diverse treatment services	Recovery support

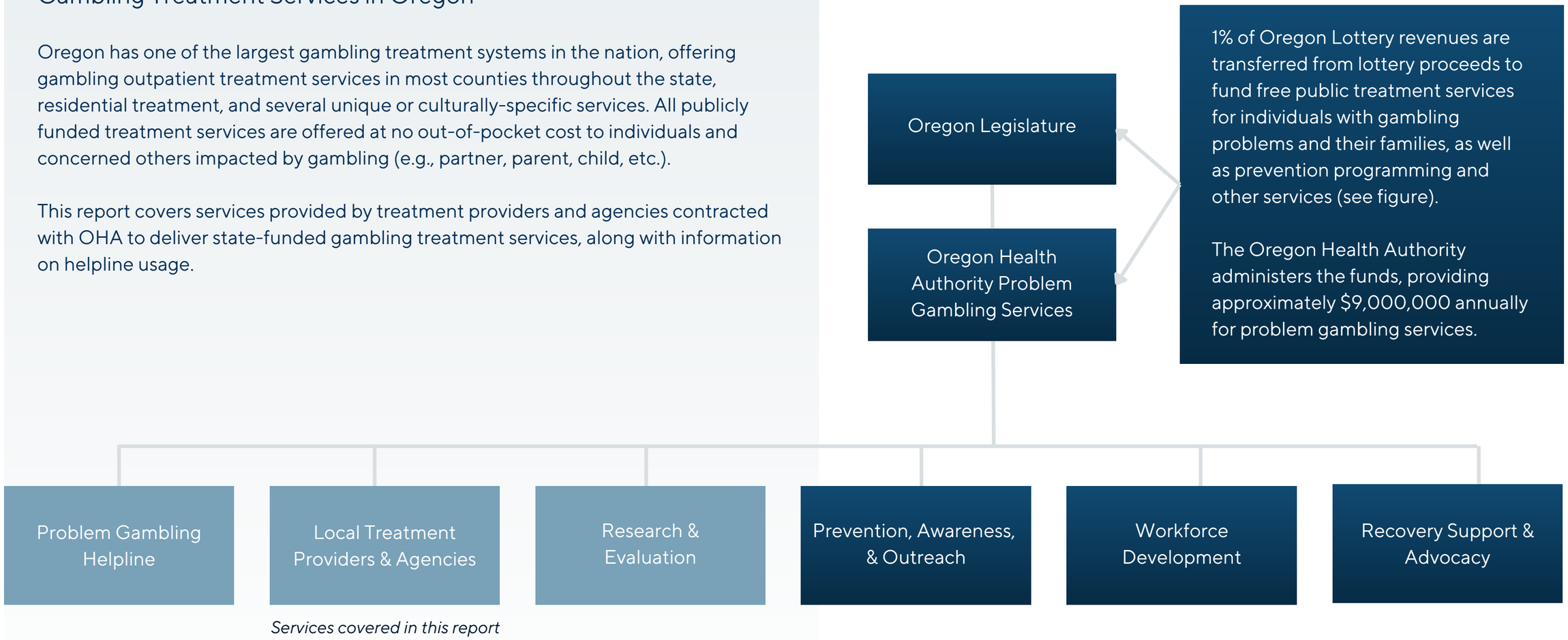
Spectrum of engagement in problem gambling services

PUBLICLY FUNDED GAMBLING TREATMENT SERVICES

Gambling Treatment Services in Oregon

Oregon has one of the largest gambling treatment systems in the nation, offering gambling outpatient treatment services in most counties throughout the state, residential treatment, and several unique or culturally-specific services. All publicly funded treatment services are offered at no out-of-pocket cost to individuals and concerned others impacted by gambling (e.g., partner, parent, child, etc.).

This report covers services provided by treatment providers and agencies contracted with OHA to deliver state-funded gambling treatment services, along with information on helpline usage.



Services covered in this report

TYPES OF TREATMENT SERVICES

Funded by Oregon Health Authority, Problem Gambling Services (PGS), treatment services range to fit a level of care approach. In this model, individuals are offered the most effective and least restrictive treatment approach before being "stepped up" to a higher level of care if needed, and "stepped down" to a lower level of care when appropriate. GEAR, a minimal intervention program is the lowest level of care, followed by outpatient treatment (which includes culturally-specific programs), residential treatment, and respite - the highest level of care offered in Oregon. Peer support can be an additional source of support for individuals during their recovery process, at any level of care.

Home-Based Minimal Intervention (GEAR)

A treatment option often utilized by individuals who travel frequently, require anonymity, or are looking for self-help support is a state-wide home-based minimal intervention program, GEAR.

This program consists of a self-help workbook that is designed to be completed at home with telephone or video-conferencing support from a professional counselor.

Outpatient Gambling Treatment

In FY2023-24, there were 102 problem gambling counselors from 44 different agencies contracted with PGS to provide problem gambling treatment services.

Outpatient treatment may include individual and family therapy, group therapies, and peer support, and community recovery group participation is encouraged (e.g., Gambler's Anonymous).

Culturally-Specific Service Programs

Oregon's gambling treatment system works diligently to ensure that culturally relevant and linguistically appropriate treatment services for Hispanic or Latino, Black or African-American, Native American, and Asian-American individuals and families are available.

Residential Gambling Treatment

There is one residential treatment facility located in Marion County, designed exclusively for problem gambling treatment.

The co-ed treatment facility provides peer support, counseling, and nutritious meals. The location is in an unlocked home-like environment with support for visitations.

On average, clients stay for about 5 weeks.

Respite

Respite services are delivered to individuals who have special needs related to their treatment, such as high suicide risk or co-occurring psychiatric conditions. Services are provided at a secure residential treatment facility to provide stabilization before a referral to problem gambling residential or outpatient services.

Peer Support

Nine programs provided peer support services in FY2023-24.[1]

Peer mentors (or peer support specialists) utilize their lived experience with problem gambling to support others in recovery.

1. Voices of Problem Gambling Recovery, Inc. (VPGR) HOPE program is one of the nine programs. Some of their data is included in this report although it is not entered into the PG Net data management system.

PEER SUPPORT SERVICES

Peer services is an additional layer of support delivered across treatment types and delivered by peer mentors (or peer support specialists) who utilize their lived experience with problem gambling to support others in recovery. In FY2023-24, these services were delivered by nine facilities.

A total of 176 clients received peer services support, representing a 20% increase from the previous year.

Of the 176 clients that received peer services support, 140 clients were treated by the Voices of Problem Gambling Recovery's HOPE Peer Mentor Program.

A variety of service delivery modalities were used, including in-person, group, phone, text, and video conferencing.

EVALUATION OVERVIEW

The OHA problem gambling treatment system includes a robust evaluation program. Historically, this treatment evaluation system included two primary components: (1) A data management system that collected intake, discharge, and encounter data inputted directly from gambling treatment providers, and (2) a follow-up treatment evaluation that collected longer-term client outcome data collected by an independent researcher. These data management and evaluation services were provided by a single contractor who retired at the end of FY2020-21. At the beginning of FY2021-22, OHA brought data management in-house by creating the Problem Gambling Network (PG Net) Data Collection System. PG Net was created as a web-based system where contracted gambling treatment providers log in and enter intake, discharge, and encounter data. Beginning in FY2023-24, gambling treatment follow-up evaluation resumed under a new contract with a third-party evaluator.

The current report reflects data captured from two primary sources for FY2023-24:

- The PG Net system for clients who were seen by OHA contracted gambling treatment providers.
- Data collected from the problem gambling treatment follow-up evaluation.

Other secondary data sources for FY2023-24 include:

- Information gathered from Oregon's Problem Gambling Helpline.
- Limited data collected from the HOPE Peer Mentor Program.

Detailed information about PG Net, including a PG Net Users Guide with all the data fields, can be found on the OHA Problem Gambling Services website: https://www.oregon.gov/PGNet.

PROBLEM GAMBLING NETWORK (PG NET) DATA COLLECTION SYSTEM

OHA gambling treatment providers are required to enter intake, discharge, and encounter data into PG Net for all gambling treatment enrolled clients.

The data system allows OHA to evaluate all programs consistently, resulting in the ability to utilize treatment data to inform policy, practice, and continual improvement efforts. Most data fields within PG Net are required, however, several are optional and sometimes left incomplete.

With partially empty data fields, analyses are limited. For example, missing data on gender identity can result in an underestimate of clients who identify outside of the male/female binary. In the end, underrepresented groups are left unrepresented. To address this, OHA PGS initiated a program to improve data quality and data collection methods moving forward, which will be reflected in future reports.

The system provides insights into:

- Demographics of clients utilizing services throughout the state.
- Effectiveness of the services provided.
- How treatments offered by client demographics relate to treatment success.
- How treatment and utilization factors apply to treatment success.
- Local programs' compliance to contractually required performance standards and metrics.

PROBLEM GAMBLING TREATMENT FOLLOW-UP EVALUATION

The current follow-up evaluation protocol was initiated in July 2023. Clients are eligible to participate in the evaluation upon enrolling in treatment services, including outpatient treatment for problem gambling or gaming, residential treatment for problem gambling, or outpatient services as a concerned other. Participating clients in outpatient treatment complete telephone surveys after 30, 90, 180, and 365 days from the date they enrolled in services. Clients also have the opportunity to provide feedback when they exit treatment and are followed for up to a year after exiting, completing telephone surveys 180 and 365 days later.

Participating clients enrolled in residential treatment complete a telephone survey about their experience once, though they may continue to participate when established with an outpatient provider.

The evaluation allows the treatment system to be evaluated by an external research team, providing important feedback about client experiences and behavior change.

The evaluation gathers information on:

- Treatment motivation and recovery goals.
- Gambling behaviors and urges.
- Supportive factors, such as wellness variables, recovery community engagement, and social support.
- Treatment experience, including both qualitative and quantitative ratings.

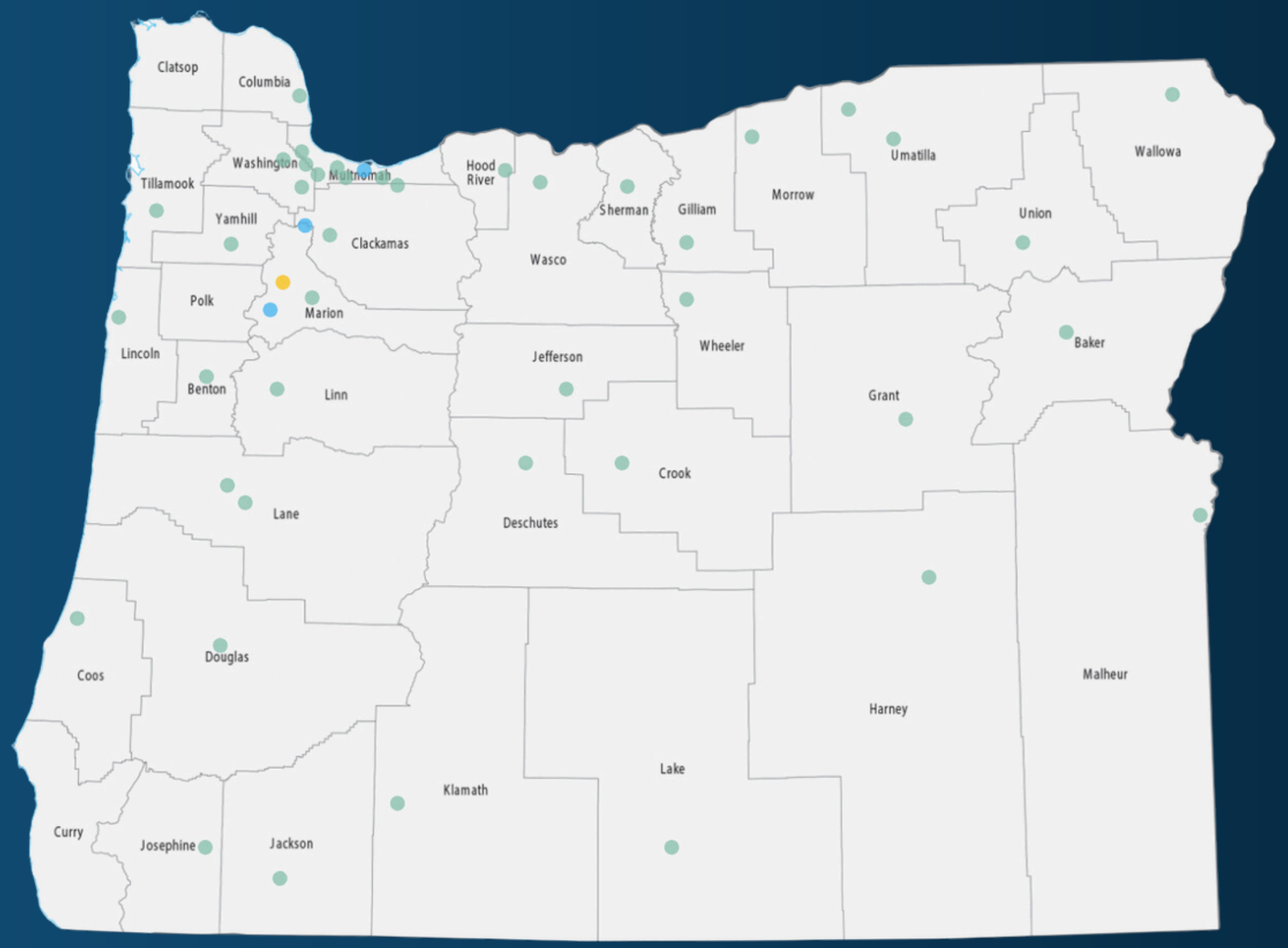
METHOD

The scope of this analysis includes all clients who had an encounter during the FY2023-24 period and whose activities were reported in the PG Net data management system or collected through phone-based surveys. This includes clients admitted to the program in a previous fiscal year who had at least one encounter in FY2023-24, as well as those who were either admitted or discharged within FY2023-24. Notably, these results do not include clients receiving treatment through private insurance or Medicaid, unless otherwise stated.

The analyses are primarily descriptive, providing (1) an in-depth profile of clients in the PGS treatment population, (2) an account of encounter activities by treatment providers, (3) an examination of program performance based on client discharge data, and (4) client feedback and behavioral changes based on survey data.

Charts are used extensively to make complex data more accessible and understandable. Tables are also used when a more detailed, precise data representation is required.

Statistical tests are used when it is important to establish an insight with statistical rigor. A 0.05 level of significance is used. The Python and R programming languages are used to perform the analyses.



GEOGRAPHIC LOCATION OF PROBLEM GAMBLING TREATMENT SERVICES IN OREGON

Key

- Outpatient treatment locations
- Residential treatment locations
- Correctional locations

Telehealth Services Expand Access to Treatment

Oregonians have the opportunity to enroll in gambling treatment services virtually, expanding access to individuals without programs nearby.

TREATMENT SERVICE ANALYSES

OHA PGS funded treatment services are analyzed and presented in this report in five categories:

Overall Treatment Services

(a) Service delivery, (b) Clients and encounters, (c) Treatment programs, (d) County of residence, (e) Referral source, (f) Wait time, (g) Encounter location, and (h) Telehealth use

Client Demographics

(a) Gender, (b), Primary ethnicity, (c) Age, (d) Marital status, (e) Age of dependents, (f) Annual income, (g) Military status, and (h) Educational attainment

Gambling Behavior

(a) Primary gambling activities and (b) Primary gambling venues

Treatment & Problem Characteristics

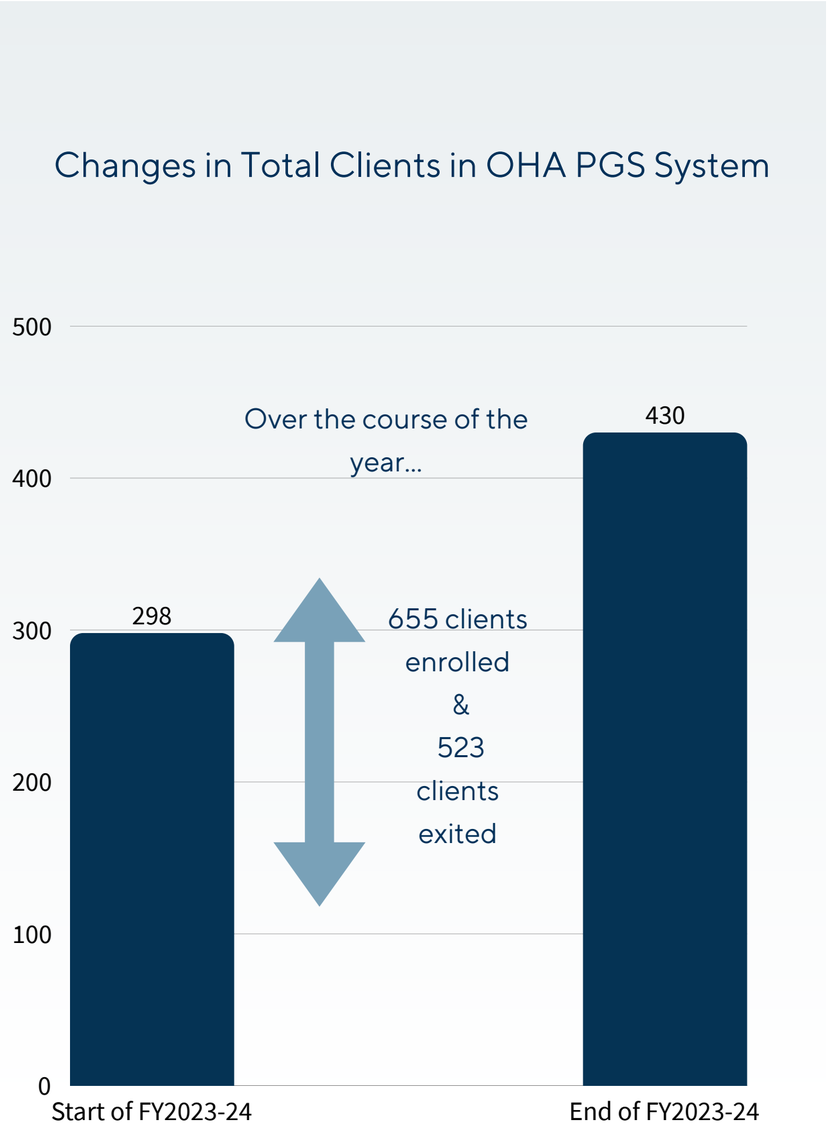
(a) Prior treatment episodes, (b) Client-reported problem behaviors related to gambling, (c) Counselor diagnostic impressions, and (d) Gambling disorder severity

Treatment Discharge Details

(a) Reasons for discharge, (b) Factors associated with successful program completion, (c) Cost and encounter characteristics associated with successful program completion, and (d) Referrals following program discharge

OVERALL TREATMENT SERVICES

OVERALL TREATMENT SERVICES DELIVERED



Client Services Delivery

Through its network of 44 problem gambling treatment programs, the PGS program conducted 10,788 treatment encounters, serving 849 clients during FY 2023-24. Compared to the previous year, the number of encounters increased by 0.7%, while the number of clients treated increased by 6.7%.

PGS began FY2023-24 with 298 clients. Over the course of the year, 655 clients were admitted, while 523 were discharged, resulting in a net gain of 132 clients by the end of the fiscal year.

Medicaid clients, not part of the PGS treatment network, received approximately 1,806 treatment encounters.

849 Oregon adults were provided gambling treatment services through PGS-funded programs in FY2023-24

Definitions

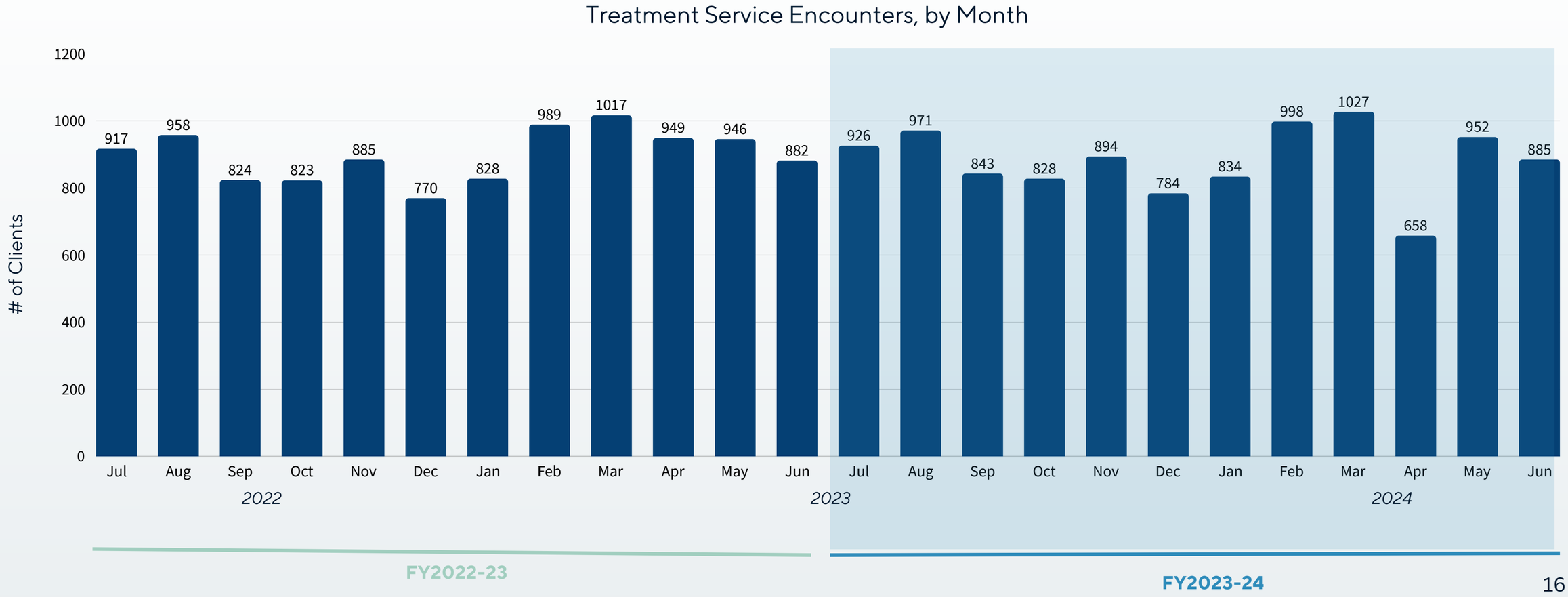
An ***encounter*** is a unit of direct client contact (e.g., a session between a client and a provider). The length of an encounter varies by treatment service type.

For example, an encounter in traditional outpatient counseling is often 53-60 minutes long, whereas an encounter in residential treatment may last a full day.

As defined in this report, a **Medicaid** client is an individual whose costs of encounters are covered under Medicaid (not covered under the OHA PGS System) and not tracked in PG Net

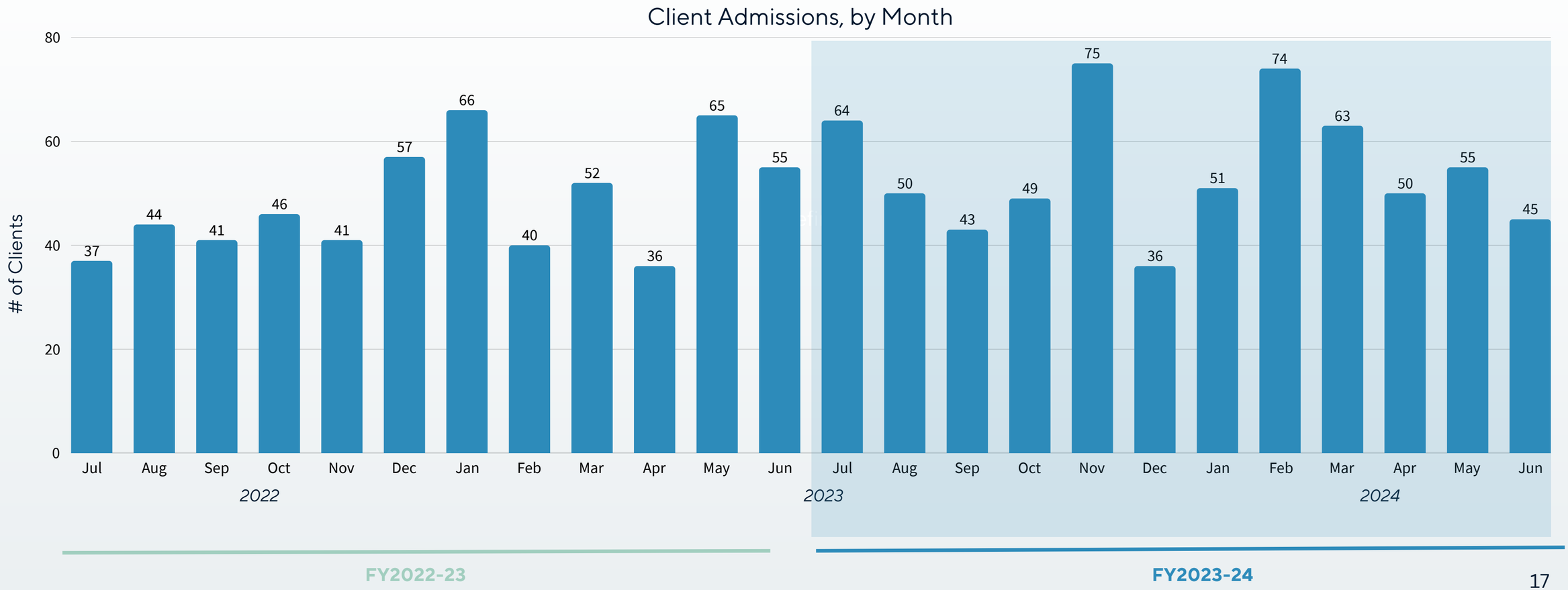
MONTHLY PGS DELIVERED SERVICES

On average, the PGS system conducted 908 encounters per month during FY2023-24 (compared to 899 during FY2022-23). March and February recorded the highest number of treatment encounters, with 1,017 and 989 encounters, respectively, while December and January had the lowest, with 770 and 828 encounters, respectively. The average monthly variation in treatment services delivered was 7%.



MONTHLY PGS CLIENT ADMISSIONS

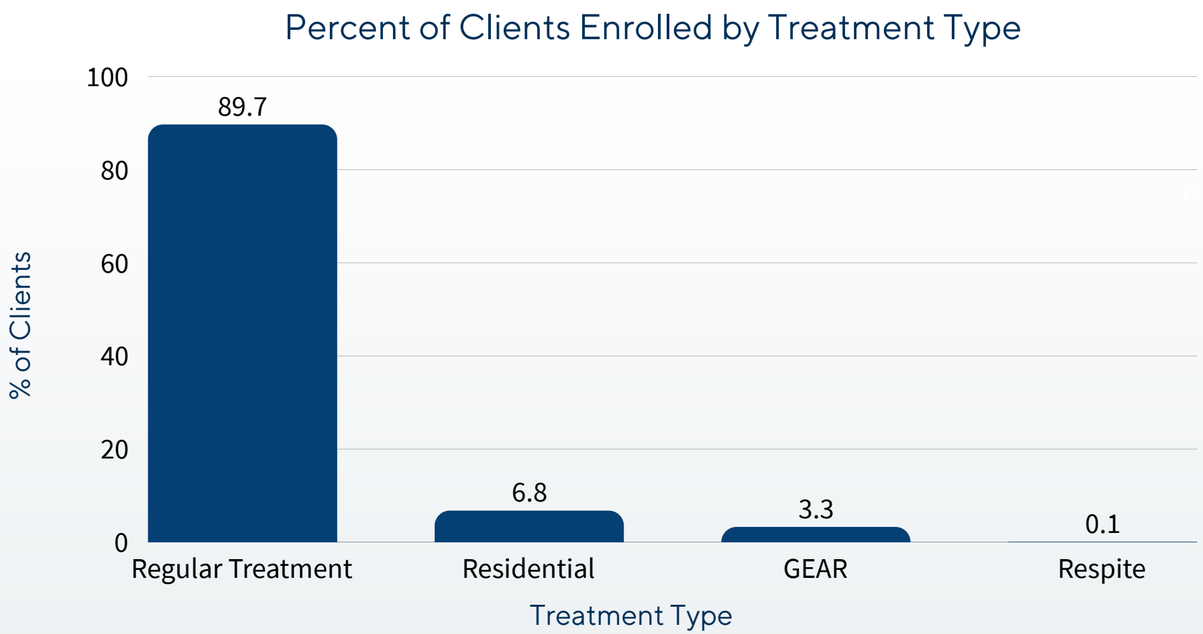
Approximately 55 clients were admitted into the OHA PGS system per month in FY2023-24 (compared to 48 in FY2022-23). November (75) and February (74) had the highest number of admissions, while December (36) and September (43) recorded the lowest. In contrast to the relatively stable volume of monthly encounters, the rate of admissions varied considerably across months, with an average difference of 17.5%.



CLIENT TYPES AND TREATMENT PROGRAMS

In FY2023-24, 91.6% of clients treated were individuals addressing their own gambling behavior, while the remaining 8.4% were concerned others. This is slightly lower than the 10% of clients that identified themselves as concerned others in the previous year.

The network of problem gambling service providers offered a wide range of treatment options tailored to the needs of individuals. Most clients (89.7%) were enrolled in Regular Treatment, while 6.8% received treatment in a residential setting, 3.3% participated in the GEAR program, and fewer than 1% received Respite services. (See sidebar for descriptions of the treatment programs.)



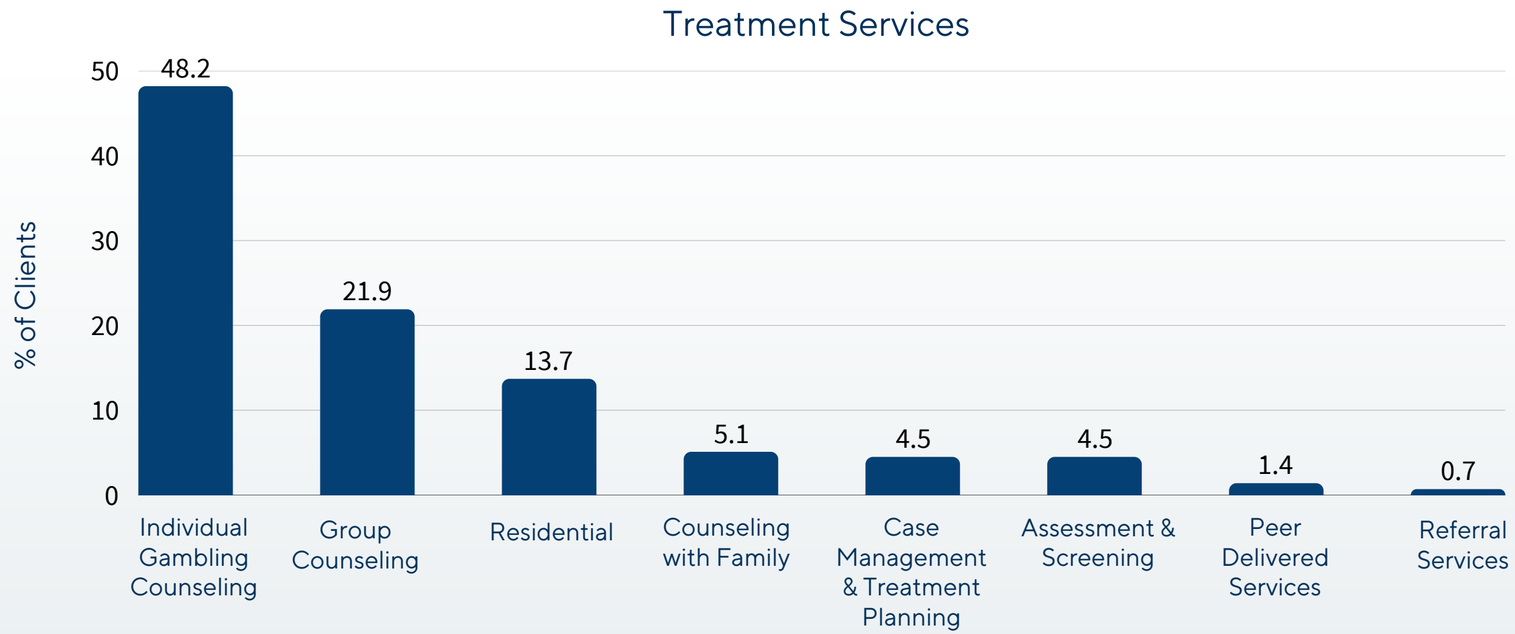
Treatment Types

- **Regular Treatment:** Typically, regular treatment may include individual and family counseling, group therapies, peer support, and outpatient counseling, delivered by a certified mental health or substance abuse professional , most commonly consisting of once weekly one-hour sessions with a recommended length of stay no less than three months.
- **GEAR:** A self-help program that offers minimal intervention. The program consists of a self-help workbook that is designed to be completed at home with remote support from a professional counselor.
- **Residential:** Treatment that involves individuals staying at a treatment facility that provides an immersive and comprehensive problem gambling treatment program.
- **Respite:** Respite services are delivered to individuals who have special needs related to their treatment, such as high suicide risk. Services are provided at a secure residential treatment facility to provide stabilization before a referral to problem gambling residential or outpatient services.

TREATMENT SERVICES DELIVERED

The most common treatment service delivered was Individual Gambling Counseling and Therapy (48.2%), followed by Group Counseling (21.9%). Group Counseling includes continuing care for individuals who have completed their primary problem gambling treatment and is designed to support clients in their recovery journey. During FY2023-24, 36 clients received continuing care treatment. Residential Treatment accounted for 13.7% of services delivered, while Family Psychotherapy represented 5.1%.

Peer-Delivered Services accounted for only 1.4% of treatment services. However, as previously mentioned, OHA PGS indirectly supports the HOPE Peer Mentoring Program, whose data is not currently collected in OHA's Problem Gambling Network (PG Net) data collection system but is being integrated into PG Net in FY 2024-25.



Continuing Care Services

Continuing Care Group Services:. Support services provided in a group setting to individuals who have completed primary treatment for a specific issue, such as problem gambling, addiction, or mental health challenges. These services are designed to help clients maintain the progress they made during primary treatment and continue their recovery journey. Services include skill reinforcement, long-term recovery focus, relapse prevention planning, and emotional support.

Medicaid

Clients whose costs are covered under Medicaid had similar participation rates for Individual Gambling Counseling and Therapy (50.1%) and Group Therapy (21.85). However, it had a substantially larger share of Peer Delivered Services of 13.7% versus the 1.4% in the PGS treatment network.

CLIENT LOCATION

County	% of clients in PGS treatment population	% of Oregon population[1]	% over- or under-represented[2]
MULTNOMAH	20.7	18.7	11.1
WASHINGTON	15.8	14.1	11.6
MARION	12.7	8.2	55.3
LANE	10.4	9.0	15.1
CLACKAMAS	8.8	10.0	-11.6
YAMHILL	3.9	2.6	51.5
JOSEPHINE	3.1	2.1	47.6
LINN	2.7	3.1	-12.8
JACKSON	2.6	5.2	-50.3
COLUMBIA	2.2	1.3	75.8
DESCHUTES	2.0	4.9	-59.3
UMATILLA	2.0	1.9	5.9
DOUGLAS	1.9	2.7	-29.0
CROOK	1.4	0.6	122.0
LINCOLN	1.4	1.2	17.7
Other	8.4	13.6	-38.6

1. https://www.oregon-demographics.com/counties_by_population.
2. % overserved and underserved are computed by (% of clients in county / % of Oregon population)*100 – 100 and then multiplied by 100 to convert to a percentage. Positive values mean that the county had a greater share of clients relative to its population size. Negative values have the opposite interpretation.

Client County of Residence

The largest counties in Oregon accounted for the largest share of clients in the PGS treatment population. Specifically, the top four counties—Multnomah, Washington, Marion, and Lane—made up 59.6% of the treatment population.

However, the representation of counties in the treatment population does not always align with their relative sizes in Oregon's overall population. For example, Marion County represents 12.7% of the treatment population but only 8.2% of the state's population, indicating that it had a disproportionately larger share of the treatment population than expected. Similarly, Yamhill County accounted for 3.9% of the treatment population but only 2.6% of the state population. In contrast, counties such as Deschutes, Jackson, and Douglas had treatment population shares that were smaller than their relative shares of the overall state population. Specifically, these counties are underrepresented by 59.3%, 50.3%, and 29.0%, respectively.

Over- & Under-Representation

It is useful to compare the percentage of clients in a geographical area (such as a county) and compare it to the percentage of the population that the county represents. Such an analysis allows us to gauge whether there are more or less clients relative to the population size. In some cases, the analysis might reveal that some areas might be underserved or that there are geographical clusters of individuals with gambling problems.

CLIENT REFERRAL SOURCE

Over half of the clients treated in the PGS system during FY2023-24 reported self-referring to the treatment program (54.4%). Referrals from other treatment providers (e.g., private practitioners and agencies) accounted for 11.4%, while the helpline referred 10.7% of clients. Referrals from outpatient treatment made up 7.2% and primarily consisted of transfers into residential treatment.

Compared to FY2022-23, referrals from the helpline increased by 45% (from 7.4% to 10.7%) while Other decreased by 35% (from 17.1% to 11.1%).

Programs in Correctional Facilities

PGS contracts two agencies to provide treatment services to incarcerated individuals. While 3.2% reported being referred to problem gambling treatment by the legal system (e.g., courts and correctional facilities), 11.4% of clients in the PGS system were treated in correctional facilities.

54% of clients referred themselves to gambling treatment

11% were referred by the gambling helpline: MYLIMIT (1-877-695-4648)

11% were referred by behavioral health providers

Referral Source in the PGS System	%
Self	54.4
Other providers	11.4
Other	11.1
Helpline	10.7
Outpatient	7.2
Legal System	3.2
Mentor	1.5
Intervention	0.5

Insights from the Follow-Up Project

Readiness to engage in treatment services is an individual process. Participants in the follow-up evaluation described the process leading up to reaching out for help as an internal process they needed to come to on their own. In fact, 60% of respondents said that external initiatives would not have encouraged them to seek help sooner. 36% of respondents, however, provided ideas to encourage earlier help-seeking.

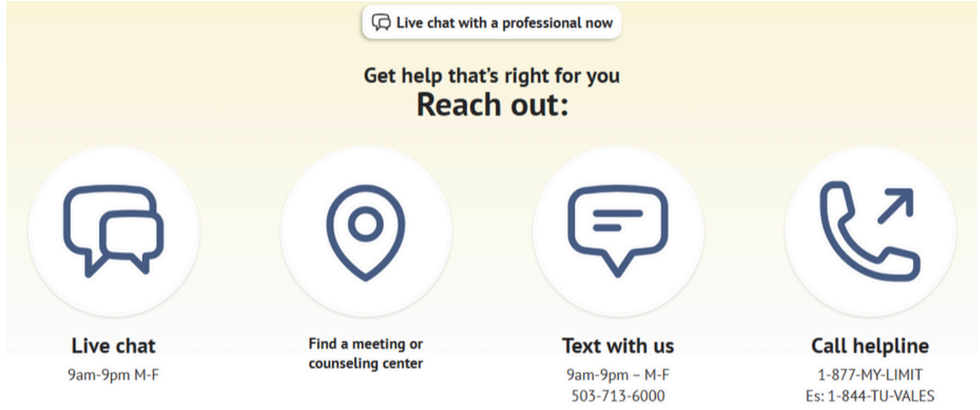
- Many stated that they were unaware of problem gambling services until someone else brought it up to them recently, and that increasing awareness campaigns and marketing could be helpful.
- Others suggested increasing communication with individuals who may be experiencing harm, such as having people inside gambling venues available to check in with and following up with those who have engaged in the treatment system previously.

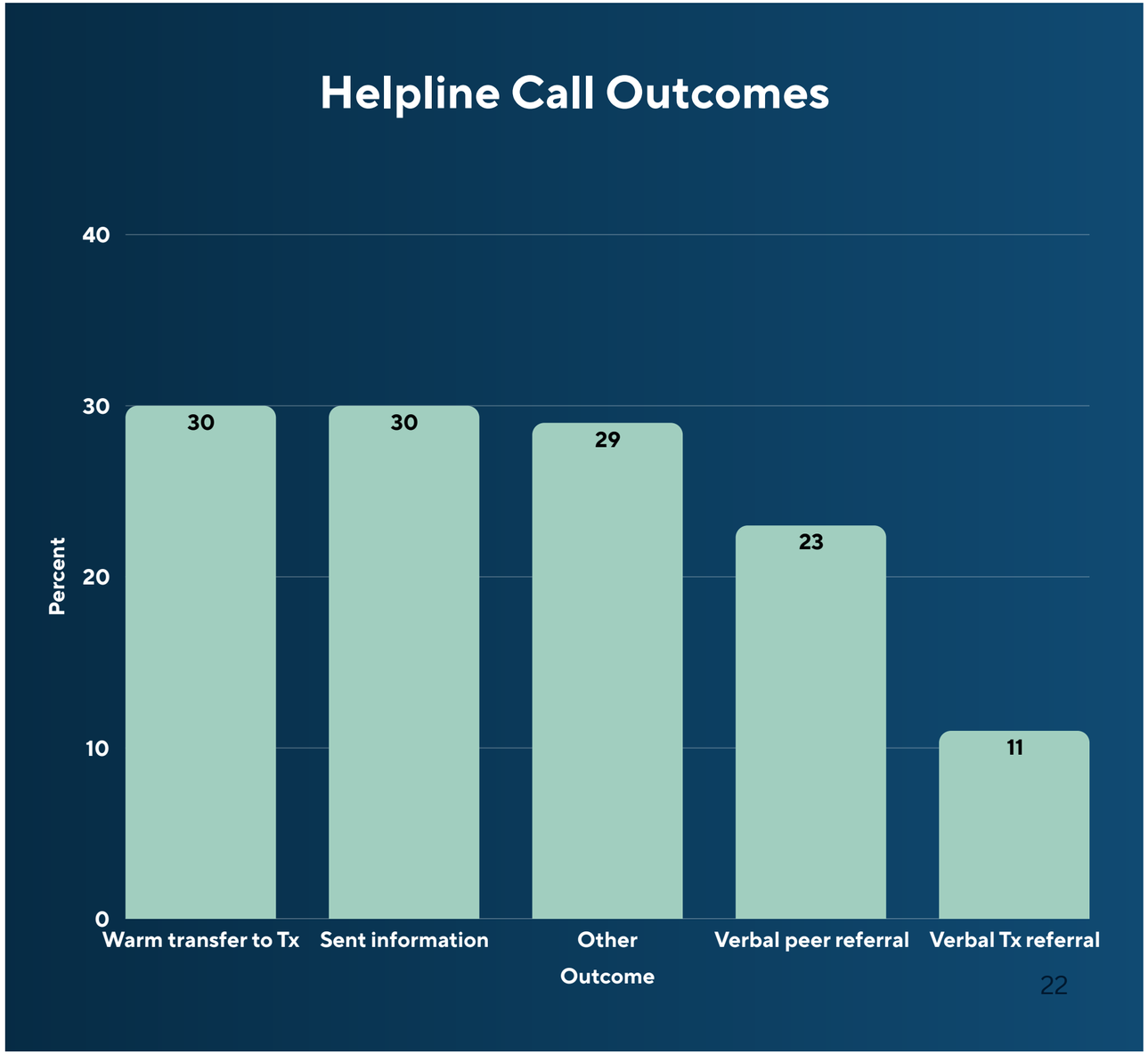
HELPLINE CLIENT REFERRALS

OREGON PROBLEM GAMBLING RESOURCE
OPGR

OHA contracts problem gambling helpline services by phone (1-877-MY-LIMIT, available 24/7), chat (opgr.org, 9 AM – 9 PM, Monday through Friday), and text (1-503-6000, 9 AM – 9 PM). In FY2023-24, the helpline received 560 phone calls. Of these, 30% resulted in warm transfers to counselor crisis services , 23% were verbal referrals to peers, and 11% were verbal referrals for treatment. Additionally, 30% of callers were sent information and/or received other types of problem gambling-related services. Note, multiple services can be offered to each caller.

Individuals were most likely to call on Mondays (18% versus an average of 14%) and slightly over half of the calls (53%) were received between 8 AM to 5 PM. Callers aged between 45-54 were the most likely to call (23%), slightly higher than those 35-44 (22%). (Note, these are also the most prevalent age groups in the OHA PGS treatment population.





WAIT TIME

Minimizing client wait time - the number of workdays between a client contacting a treatment provider and the first offered appointment - is important. The window of opportunity for individuals to feel motivated to seek gambling treatment can be narrow. Short wait times enable timely intervention, reducing the risk of gambling-related problems escalating.

For admissions that took place during FY2023-24, PGS system had an average wait time of 4.5 workdays (median of 2 workdays) and over a third of individuals seeking treatment were able to see a treatment provider without delay (same-day appointment).[1] In comparison, in FY2022-23, the average wait time was 4.2 workdays, a slight increase of 0.3 days.

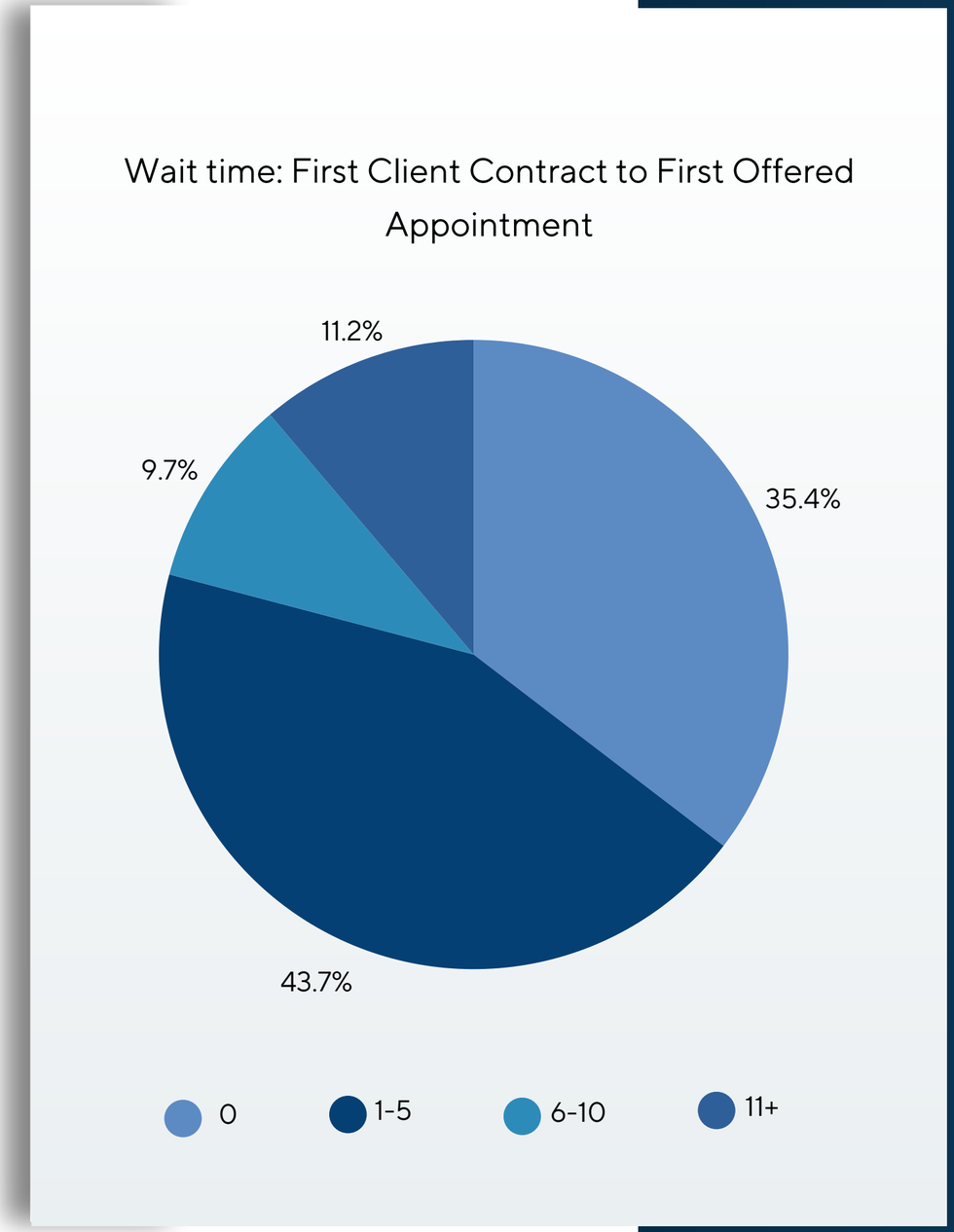
The longest average wait time was for Regular Treatment (4.6 workdays), followed closely by residential treatment (4.5 workdays). GEAR clients experienced the shortest wait time, averaging 1.3 workdays.

Variations in wait times across the provider network suggest differing levels of efficiency and/or capacity between agencies.

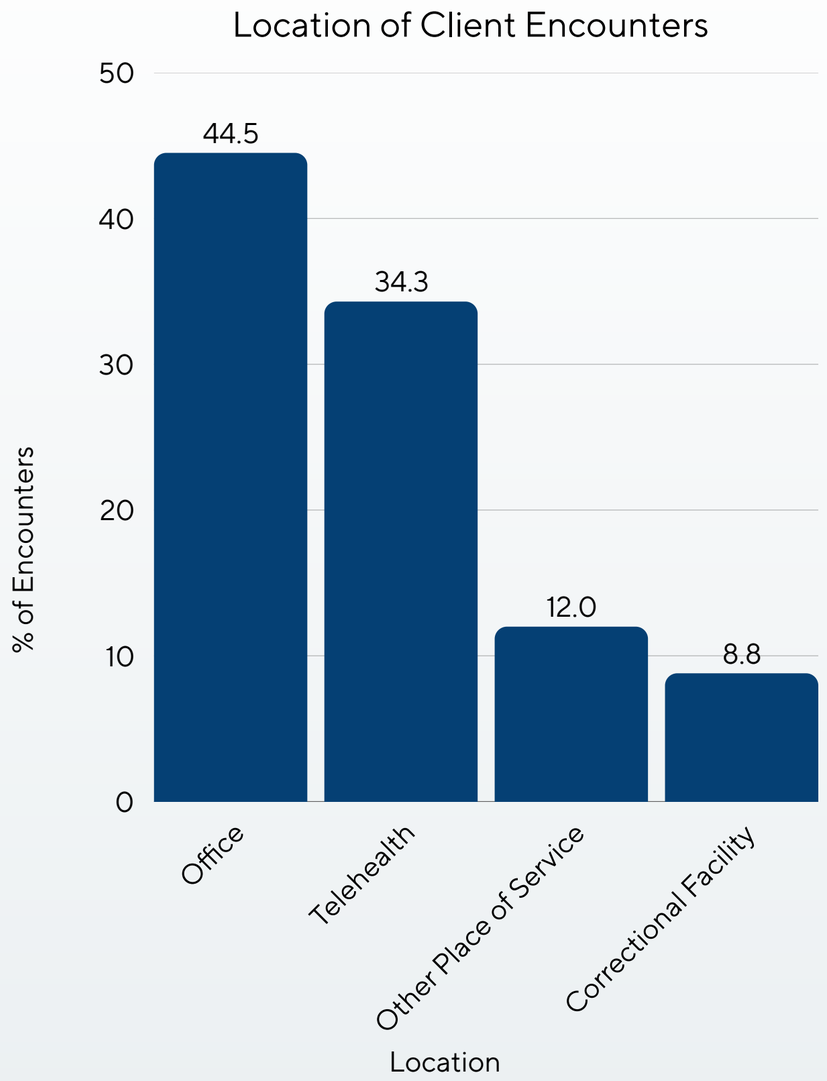
Short Wait Times Get People Into Treatment Quickly

Over one-third of Oregon adults seeking gambling treatment were able to see a provider the same day.

1. Several outliers were omitted due to suspect data.



ENCOUNTER LOCATION



Office encounters were the most common location for client treatments in FY2023-24 (44.5%). This category includes clients in residential facilities whose treatments are conducted by providers with on-site offices. Telehealth was the second most common method of conducting encounters (34.3%), representing a 28% decline from FY2022-23. This continues the trend away from remote services that peaked during the COVID-19 pandemic. (See "Trends in Telehealth Service Delivery.")

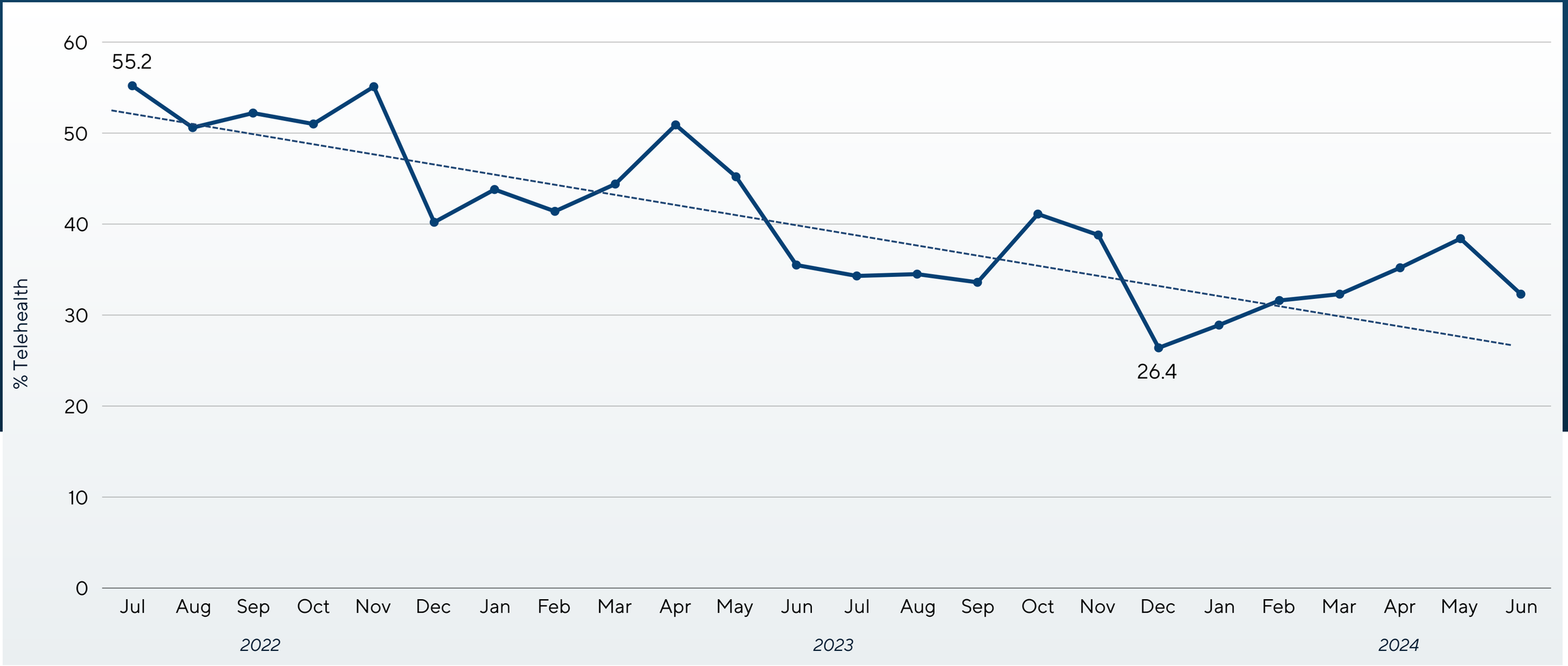
12.0% of encounters were conducted in other locations, such as clients' homes, residential substance abuse facilities, and community centers. Another 8.8% of encounters were conducted in correctional facilities. PGS contracts with two agencies that provide services to incarcerated individuals in the Oregon Department of Corrections.

GEAR, a home-based minimal intervention program, conducted all of its encounters through telehealth (by program design). For Regular Treatment, telehealth was the most common mode of service delivery (39.3%), followed by office-based encounters (37.2%) and other places of service (12.5%). Additionally, 10.2% of Regular Treatment encounters took place in correctional facilities.

Telehealth accounted for 34% of client encounters. Compared to FY2022-23, Telehealth encounters declined by 28%, reflecting a trend away from remote services that peaked during the COVID-19 pandemic.

Trends in Telehealth Service Delivery

The use of telehealth has declined over time with a peak of 55.2% in July 2023 and a low of 26.4% in December 2023. There are seasonal variations, with peak months in October-November and April-May, and lows in December-January.

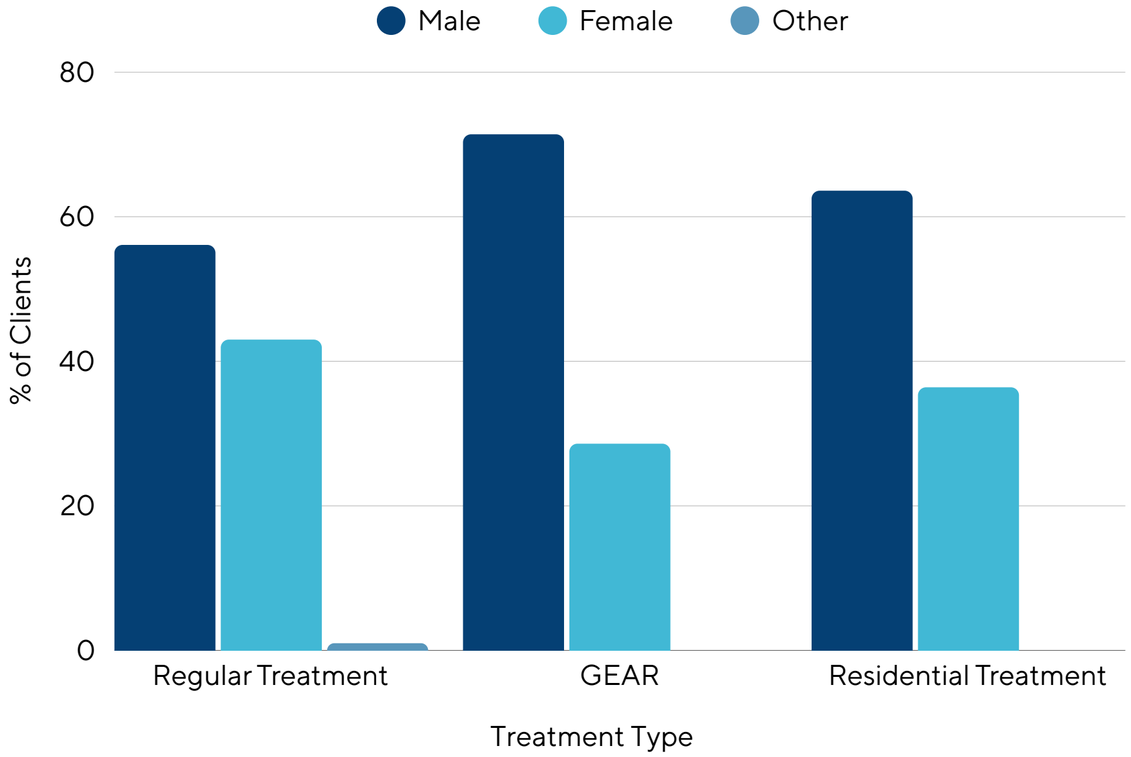


1. Chart includes a (least squares) trend line

CLIENT DEMOGRAPHICS

GENDER IDENTITY

56.9% of clients treated in FY2023-24 were male, compared to 42.5% female. 0.5% of clients identified as transgender or another unspecified gender. Based on 2023 census numbers, males represented 49.8% of Oregonians and females 50.2%.[1] Relative to the overall Oregon population, males are overrepresented in the treatment population by 14.2%, whereas females are underrepresented by 15.3%.



- 57% of clients identify as **male**.
- Almost 43% of clients identify as **female**.
- Less than one percent (0.5%)* of clients identify as transgender or another unspecified gender.

**This is likely an underrepresentation, due to missing data.*

By treatment type, compared to their overall representation in the treatment population, males are far more likely to be treated in the GEAR program and to reside in residential treatment centers.

Females are more likely to be concerned other clients, accounting for 69.0% of this group. They are also more likely to use telehealth services, making up 50.6% of telehealth users despite being only 42.5% of the treatment population. Males are more likely to receive treatment within correctional facilities, accounting for 73.1% of these clients, compared to their 56.9% representation in the overall treatment population. Also, of those clients who contacted the helpline, 55% were females compare to 44% males.

1. https://www.census.gov/quickfacts/fact/table/OR/PST045223.

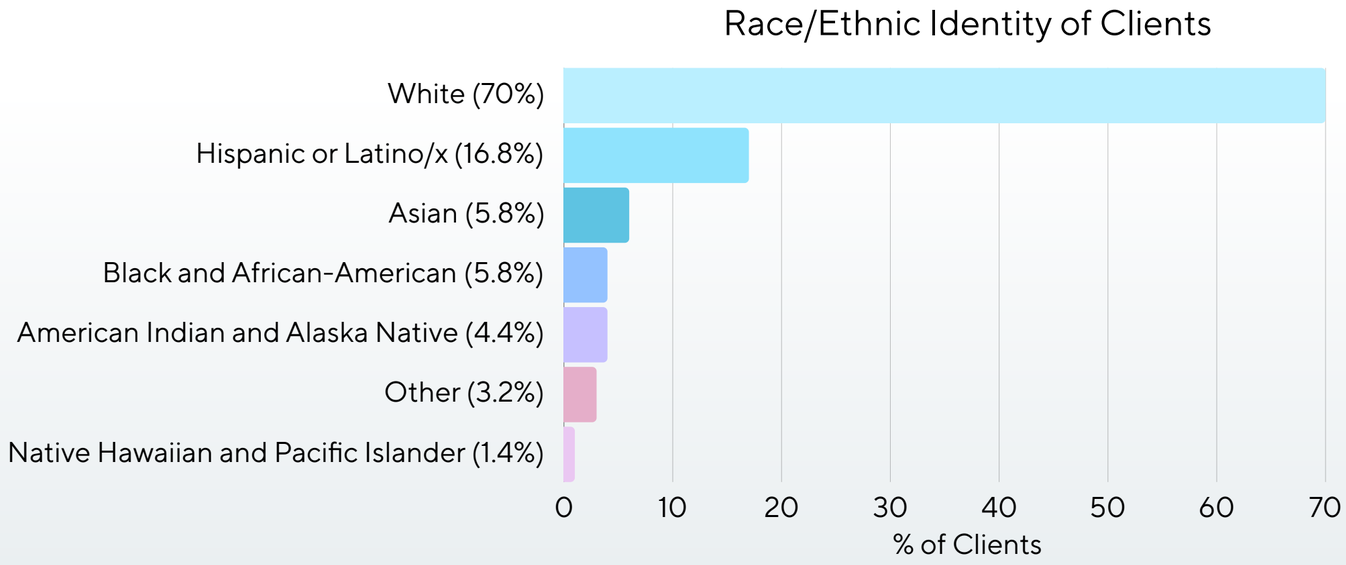
RACE/ETHNICITY

Clients are asked to report all race/ethnicities with which they identify based on the REALD framework. About 6% identified as having multiple race/ethnicities.

White was the largest represented ethnicity in the PGS treatment system, reflecting the demographics of Oregon's population. According to the US Census Bureau, approximately 86% of Oregonians were classified as “White Alone” as of July 2023. In contrast, 64% of clients in the PGS treatment system identified as “White Alone,” indicating a greater representation of racial and ethnic minority groups in the system.

Regarding telehealth usage, 54.3% of clients who identified as White used these services, despite comprising 69.7% of the treatment population. Asians accounted for 14.3% of GEAR clients while representing only 5.8% of the treatment population.

It is important to note that 31% of the race/ethnicity data were either missing or the client declined to answer the question. This introduces the potential for self-selection bias, resulting in a subsample that may not fully represent the treatment population.



REALD: Race, Ethnicity, Language & Disability

“REALD was passed into Oregon law and is a new type of demographic information that is collected by health care providers. Collecting this information helps to identify health inequities for populations within Oregon. Having this data allows the Oregon Health Authority (OHA) to better understand the different populations we work with and serve and will help us move toward the goal of ending health inequities by 2030”.

Primary ethnicity categories included seven options provided by REALD: American Indian and Alaska Native, Asian, Black and African American, Hispanic and Latino/a/x, Middle Eastern/North African, White, or Native Hawaiian and Pacific Islander, all of which have more specific cultural identity options (e.g., Asian Indian, Chinese, etc.). Additionally, there is an “Other” category.

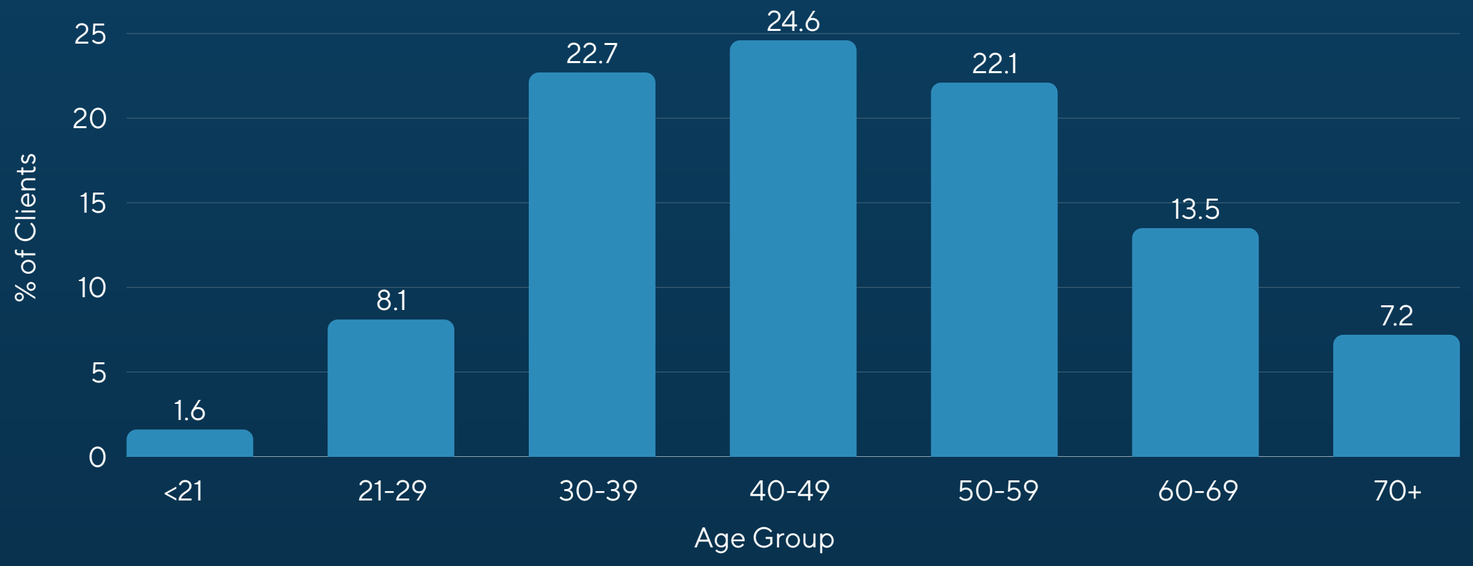
Source: https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/reald.aspx

CLIENT AGE & MILITARY STATUS

Client Age

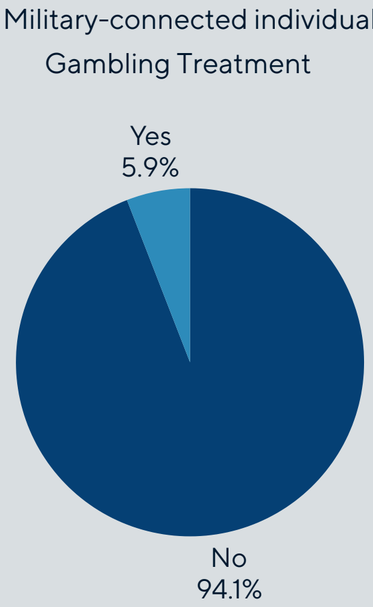
Overall, the average age of clients at the time of admission was 47, with females being older than males (52 versus 44). This age profile was very similar to the previous year, which had an average age of 48 (51 for males and 45 for females.) Only 1.6% of clients were under the age of 21, while the majority (69.5%) were between the ages of 30 and 59. By comparison, a recent 2023 census report indicated that just 39% of the general population falls within this age range, highlighting the older age profile of individuals who seek treatment for gambling.[1]

The GEAR program attracted older clients compared to other treatment methods, with an average age of 56 compared to 47 for clients in other programs. Clients in Regular Treatment had an average age equal to the overall average of 47. Additionally, on average, clients who used telehealth were older than those that did not (50 versus 46).



Client Military Service Status

5.3% of clients were connected to the military, compared to an estimated 7.4% of Oregonians who were veterans in 2022.[2] It is possible that many veterans seeking help for gambling problems are seen within the Veterans Administration Medical Centers and would not show up in the below depicted PGNet data.



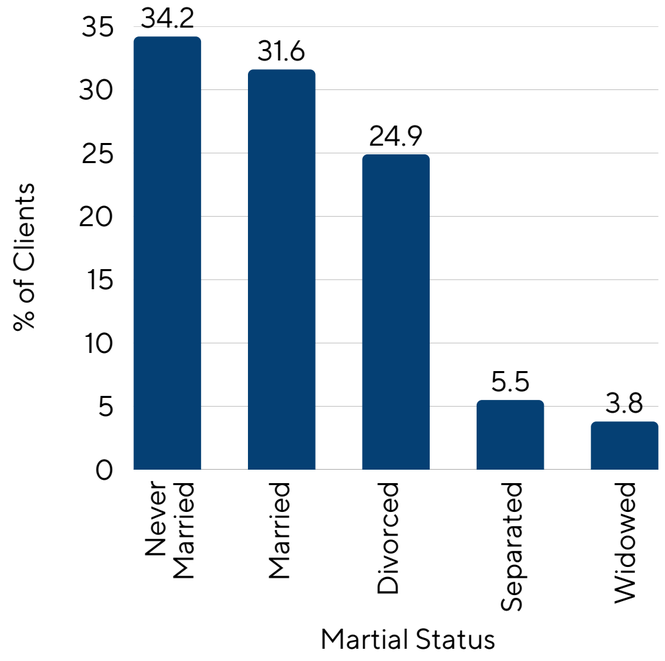
1. https://censusreporter.org/profiles/04000US41-oregon/.
2. https://usafacts.org/topics/veterans/state/oregon/#:~:text=The%20population%20share%20of%20a,nonveteran%20populations%20in%20Oregon%20compare?%E2%80%9D.

MARITAL STATUS, DEPENDENTS, & EDUCATION

Client Marital Status

At the time of admission, 34.2% of clients were never married and 31.61% were married, with the remaining clients being divorced, separated or widowed.

Males were more likely to be not married (39.5%) compared to females (23.8%).



Age of Client Dependents

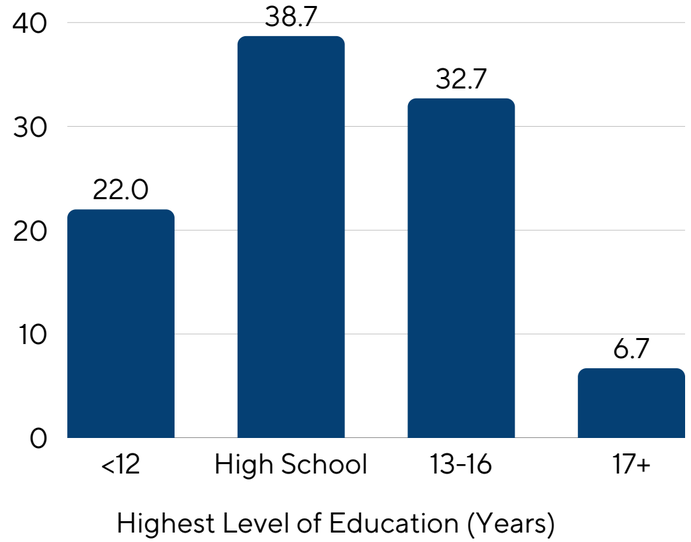
Most clients (78.3%) have one or more dependents relying on them financially.

- 27.8% have one or more infant or children dependents
- 66.2% have one or more adult dependents
- 12.1% have one or more older adult dependents

Educational Attainment

Fewer than half (39.3%) of clients had any postsecondary education (i.e., years beyond high school). Females had a higher postsecondary education level compared to males (42.1% versus 37.0%).

Among treatment types, GEAR has the highest postsecondary education (50%), while Regular Treatment (39.2%) and residential clients (37.2%) had comparable rates.



CLIENT INCOME

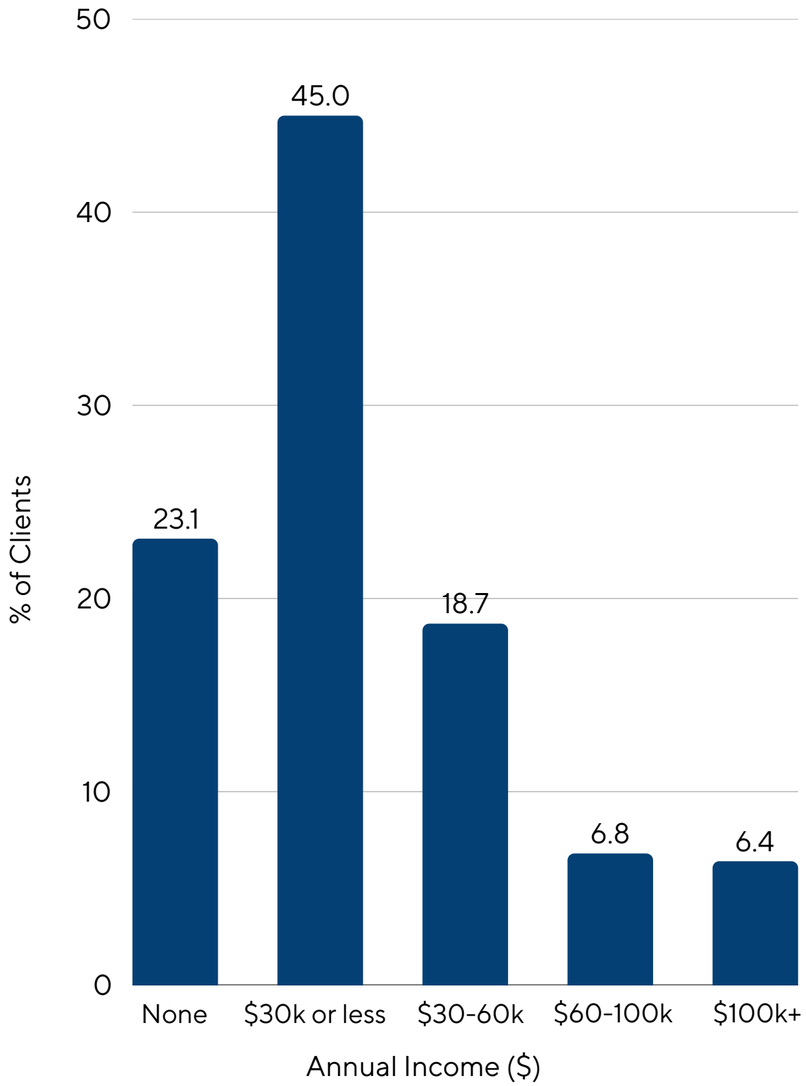
About one-half of clients (49.3%) reported being employed full-time or part-time. 9% of clients were retired and 15.3% unemployed (but seeking employment). The remaining clients were unemployed (and no longer seeking employment) or disabled.

The average annual client income was $27,486 ($9,600 median income). About 2/3rd of clients earned less than $30,000 per year, including 23% of clients who earned no income. Compared to the last fiscal year, average income declined from $35,481 to $27,486.

9.2% of clients were on fixed income (retirement/pension), 7.9% on disability, and 2.2% on public assistance.

Financial Challenges are Not Uncommon for Clients

About half of the clients in treatment were unemployed and 10% were uninsured. 40% reported no earned income while 63% earned less than $30k annually.



Publicly Funded Problem Gambling Services

These financial statistics highlight the critical role that OHA PGS plays in supporting individuals struggling with gambling issues. Many of these individuals lack the financial means to receive treatment in the absence of publicly funded programs.

By making problem gambling services available at no cost, OHA PGS ensures that support is available regardless of financial circumstances.

GAMBLING BEHAVIOR

PRIMARY GAMBLING ACTIVITIES

Clients report their primary gambling activities, with the option to select multiple choices. On average, clients reported 1.4 primary gambling activities, and 4.4% of clients report more than two activities. 0.8% of clients reported no gambling activities. There was no significant difference in the average number of gambling activities reported by males and females.

Electronic gaming was by far the most prevalent primary gambling activity (87.5%), making it 6.3 times more common than the second highest activity, Scratch tickets (13.9%). Cards followed as the next most popular gambling activities (12.6%).

Wagering on sports-related events have grown substantially in popularity over the past five years. 8.4% of clients reported either sporting events or sports betting as primary gambling activities. Males were more than 8 times more likely to report sporting events as their primary activities (13.2% versus 1.6%, respectively).

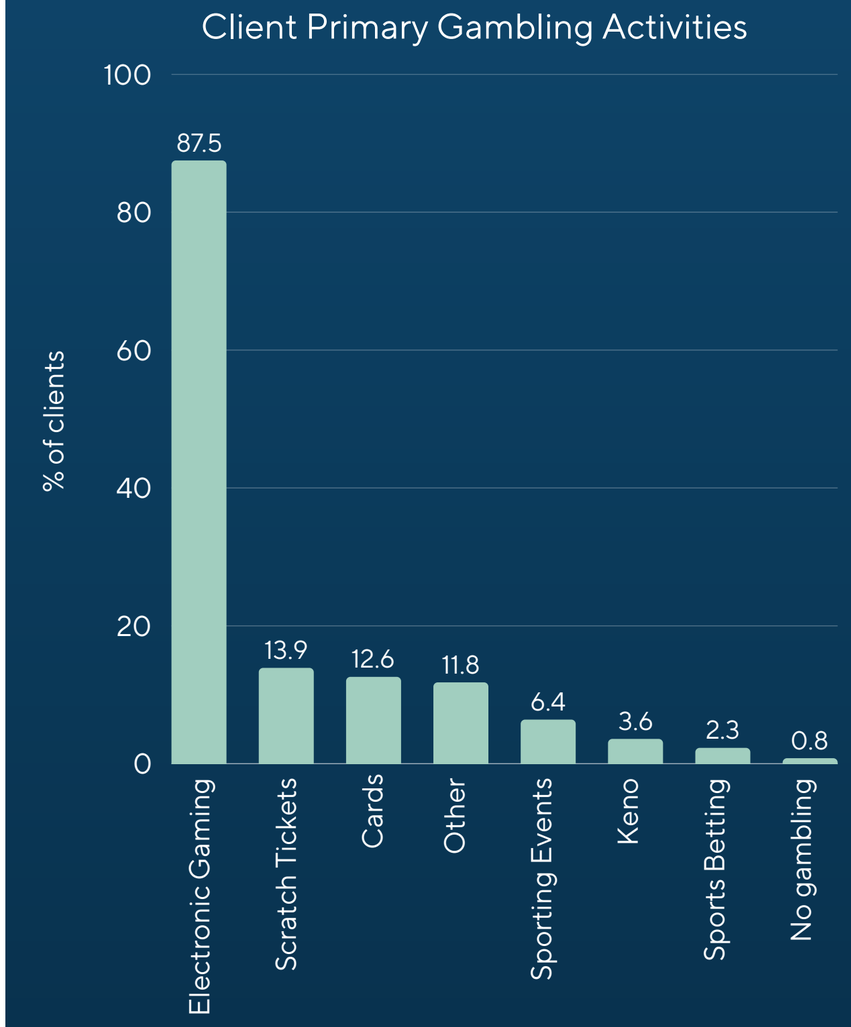
Insights from the Follow-Up

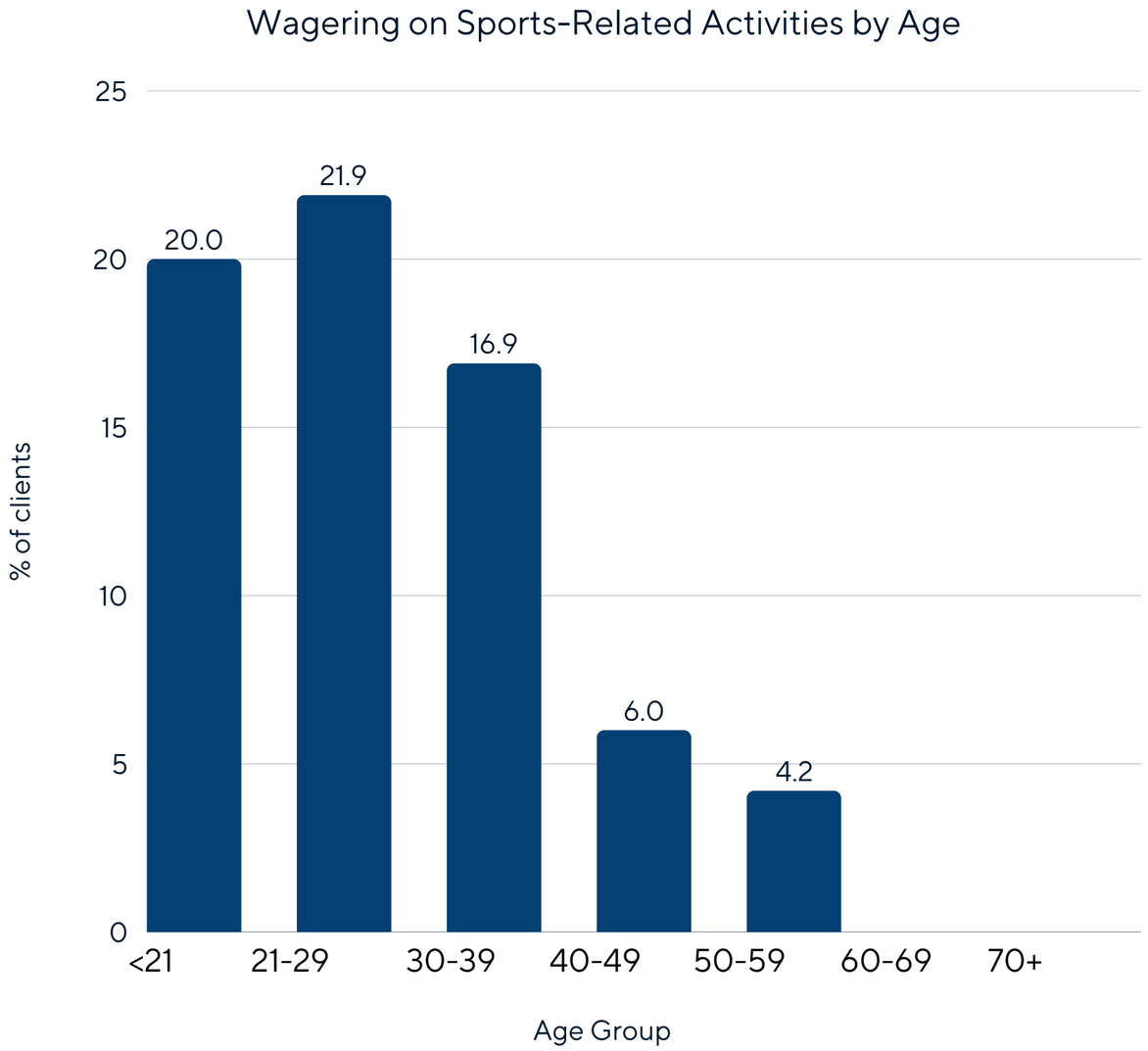
Electronic gambling machines (EGMs) were cited as a particular concern to public health among 11% of respondents, commenting on the ease of accessibility and highly addictive nature of EGMs.

Sports Betting is Most Common in Males

Males are more than 8 times more likely than females to report gambling on Sporting Events or Sports Betting as their primary gambling activities.

84% of callers to the gambling helpline reported Electronic Gaming as their most problematic form of gambling activities.

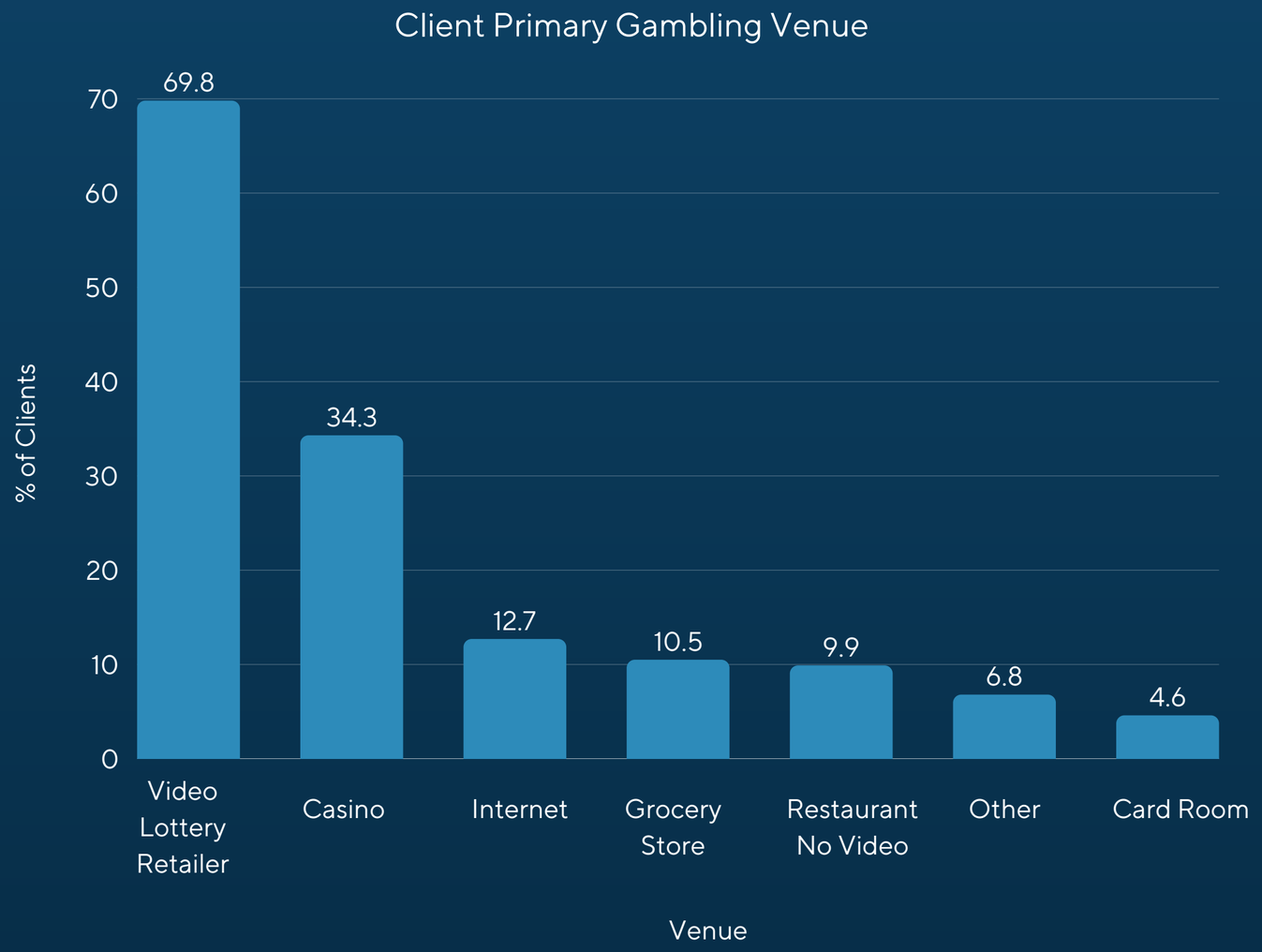




Younger Adults Sports Gamble the Most

The popularity of betting on sporting events is significantly associated with age. Clients aged 21 to 29 reported the highest participation rate at 21.9%, while no clients aged 60 or older reported wagering on sporting events as their primary activities.

PRIMARY GAMBLING VENUES



Similar to gambling activities, clients are asked to report their primary gambling venues, allowing for multiple selections. Video lottery retailers were by far the most popular gambling venue (69.8%), followed by casinos (34.3%).

Clients reported an average of 1.5 different types of primary gambling venues. Males had a slightly higher rate of 1.5 versus 1.4 for females.

The finding that video lottery retailers represented the most common primary gambling venue among persons seeking treatment for problem gambling is not surprising. Research suggests that electronic gaming machines (EGMs) (e.g., video lottery terminals) represent a form of gambling activity with heightened 'addictive potential' and increased availability of EGMs has been linked to the severity of gambling problems.[1-4] The Oregon Lottery licenses more than 11,500 video lottery terminals in nearly 4,000 locations throughout the state.

1. Dowling N, Smith D, Thomas T . Electronic gaming machines: are they the 'crack cocaine' of gambling? Addiction 2005; 100: 33–45.
2. Lund I . Gambling behaviour and the prevalence of gambling problems in adult EGM gamblers when EGMs are banned. A natural experiment. J Gambling Studies 2009; 25: 215–225.
3. Australia PC. Gambling Inquiry. 2009 Available athttp://www.pc.gov.au/projects/inquiry/gambling-2009.
4. Livingstone C, Adams PJ . Harm promotion: observations on the symbiosis between government and private industries in Australasia for the development of highly accessible gambling markets. Addiction 2011; 106: 3–8.

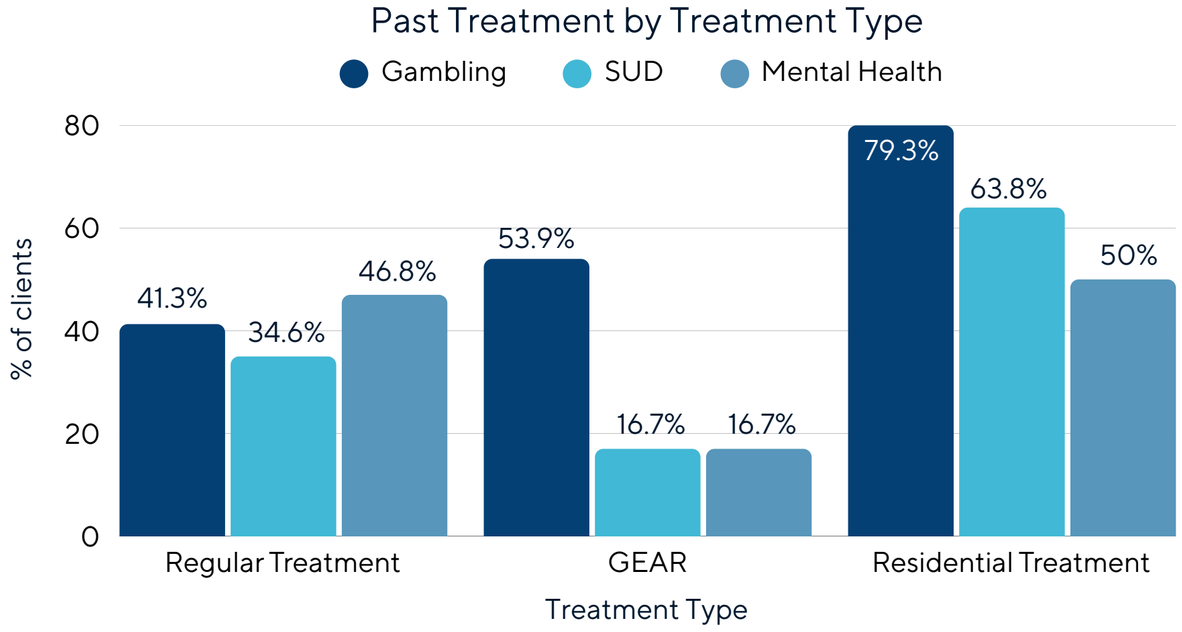
TREATMENT AND PROBLEM CHARACTERISTICS

TREATMENT CHARACTERISTICS

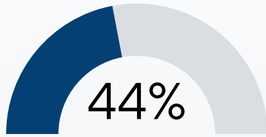
Prior Treatment Episodes

74.4% of clients had at least one episode of treatment for gambling, substance use, or mental health prior to their most recent admission to the PGS treatment system. These episodes represent professional counseling for at least one of these areas. Among these, mental health treatment was the most common (46.3%), followed closely by gambling (44.4%) and substance use (36.0%). Furthermore, 13.2% of clients reported having five or more treatment episodes across one or more of these three areas. These results were comparable to the previous year.

Gender-specific trends revealed that females were more likely than males to have received previous treatment for gambling and mental health, while males were more likely to have sought help for substance use. During FY2023-24, 131 clients reported having been treated for Substance Use Disorder (SUD) prior to or concurrently with their admission into gambling treatment, of whom 40.5% were females and 59.5% males. Clients treated in residential programs reported the highest number of previous treatment episodes across all three types..

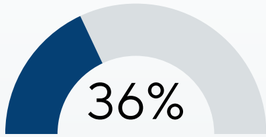


Gambling Treatment Clients are Likely to Have Sought Psychological Treatment Before.



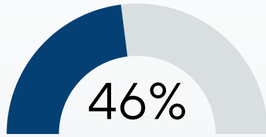
had previously received treatment for gambling

42.4% for males compared to 47.4% for females.



had previously received treatment for substance use

44.5% for males compared to 23.9% for females.

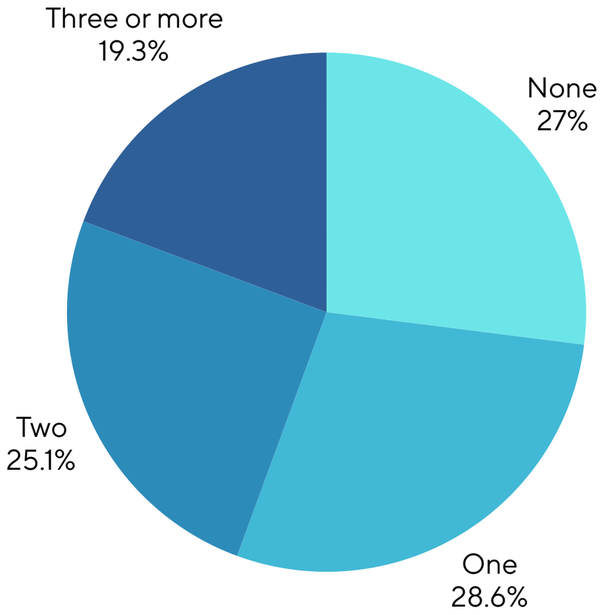


had previously received treatment for mental health

39.8% for males compared to 55% for females.

Gambling-Related Problem	% of Clients Endorsing
Relationship	76.0
Job or school	36.3
Suicidality[1]	25.7
Legal	19.8
Bankrupcy	9.9

Number of Gambling-Related Problems Reported by Clients



1. Suicide threat was positive if client reported suicidal thoughts, threats, actions, or plans.

Client-Reported Problems Related to Their Gambling

Upon intake, clients are asked whether they have specific problems related to their gambling. A total of 27.0% reported no problems, 28.6% reported one, 25.1% reported two, and 19.3% reported three or more problems. Relationship problems were the most prevalent, with about three out of four clients reporting them. Issues related to job or school (36.3%) and suicidal ideation (25.7%) were the next most commonly reported problems associated with gambling.

Overall, clients reported an average of 1.4 problems, a significant higher average compared to 1.0 for last year. Males had a higher average of 1.5 compared to 1.2 for females. The largest differences between males and females were in legal problems and job or school problems. Males reported legal problems at nearly twice the rate of females (24.8% versus 12.6%) and job or school problems at a 30% higher rate (40% versus 30.7%).

GEAR clients reported the lowest average number of problems at 0.7, followed by Regular Treatment clients (1.4), and clients in residential programs (2.0). Clients in residential programs also had the highest rates of reporting relationship problems (77.4%), job or school problems (74.1%), and legal problems (26.4%).

Male gambling treatment clients report more gambling-related problems than females.

Relationship problems are the most reported problem among clients. 76% report relationship problems

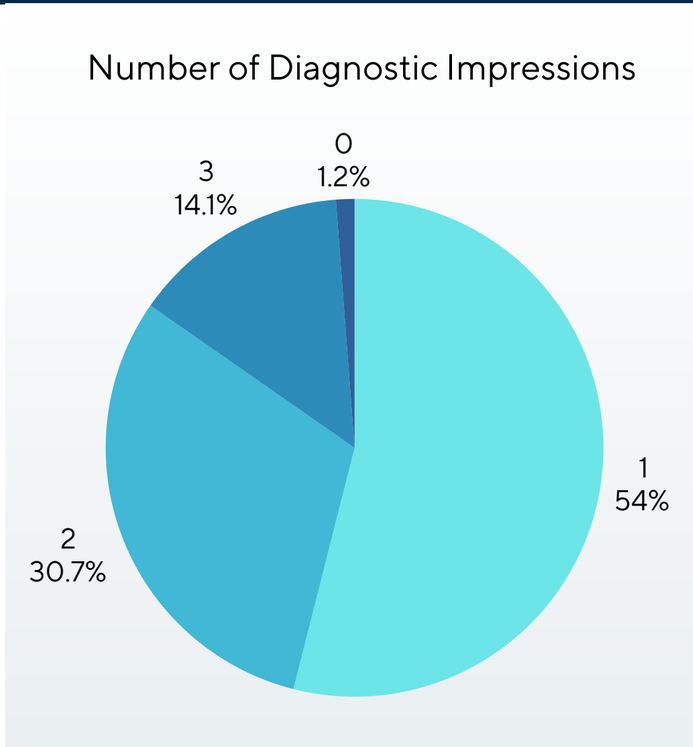
Suicidality affects 26% of gambling treatment clients.

Counselor Diagnostic Impressions

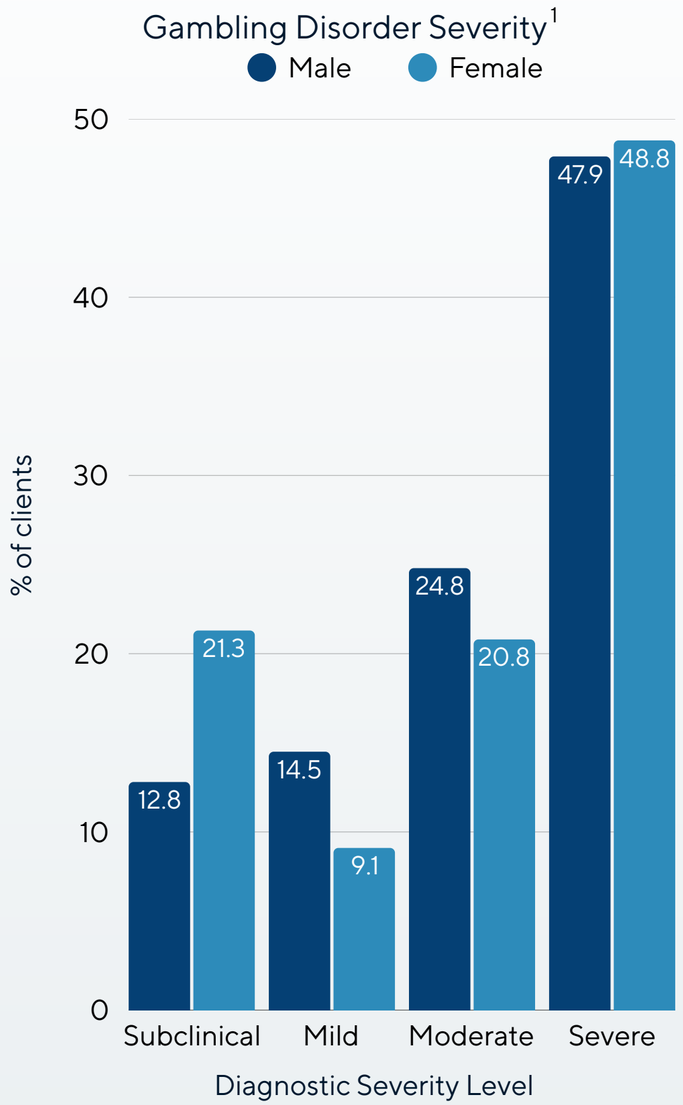
On average, clients received 1.6 diagnostic impressions. The most common diagnostic impression was Gambling Disorder, which was assigned to 90.2% of clients. As the system provides care for others affected by a loved ones gambling, those "Concerned Others" clients were diagnosed under "Relationship Problem" (11.3%). The most common secondary diagnoses were Substance Related (23.6%), followed by Mood Disorder (14.9%).

Most clients (54%) received only one diagnostic impression; however, 14% received three or more. Both males and females had an average of 1.6 diagnostic impressions. Clients in residential programs had the highest average number of diagnostic impressions (1.8), followed by those in Regular Treatment (1.6), and GEAR clients (1.0).

A **diagnostic impression** is a provisional diagnosis used when there is enough information to make a working diagnosis, but the clinician wishes to indicate a significant degree of diagnostic uncertainty.



Diagnostic Impression	%
Gambling Disorder	90.2
Substance Related	23.6
Mood Disorder	14.9
Relational Problem	11.3
Anxiety Disorder	8.3
Other	2.6
Impulse Control Disorders	2.5
Personality Disorder	2.1
Gaming Social	1.8
Schizophrenia and Other Psychotic Disorders	1.4
Adjustment Disorders	1.0
Childhood Disorders	1.0
Not Mentally Ill	1.0
Delirium, Dementia, and other Cognitive Disorder	0.1
Eating Disorders	0.1



Gambling Disorder Severity[1]

At the time of admission, clients undergo a comprehensive psychosocial assessment, which typically includes an assessment of Gambling Disorder, currently based on the DSM-5 Diagnostic Criteria. Overall, 23.1% of clients were diagnosed with Moderate severity (compared to 27% from last year) and 48.1% with Severe severity (compared to 53% in the previous year). Females were diagnosed at lower rates than males for Mild and Moderate severity levels while their rate of Severe diagnoses was comparable to that of males.

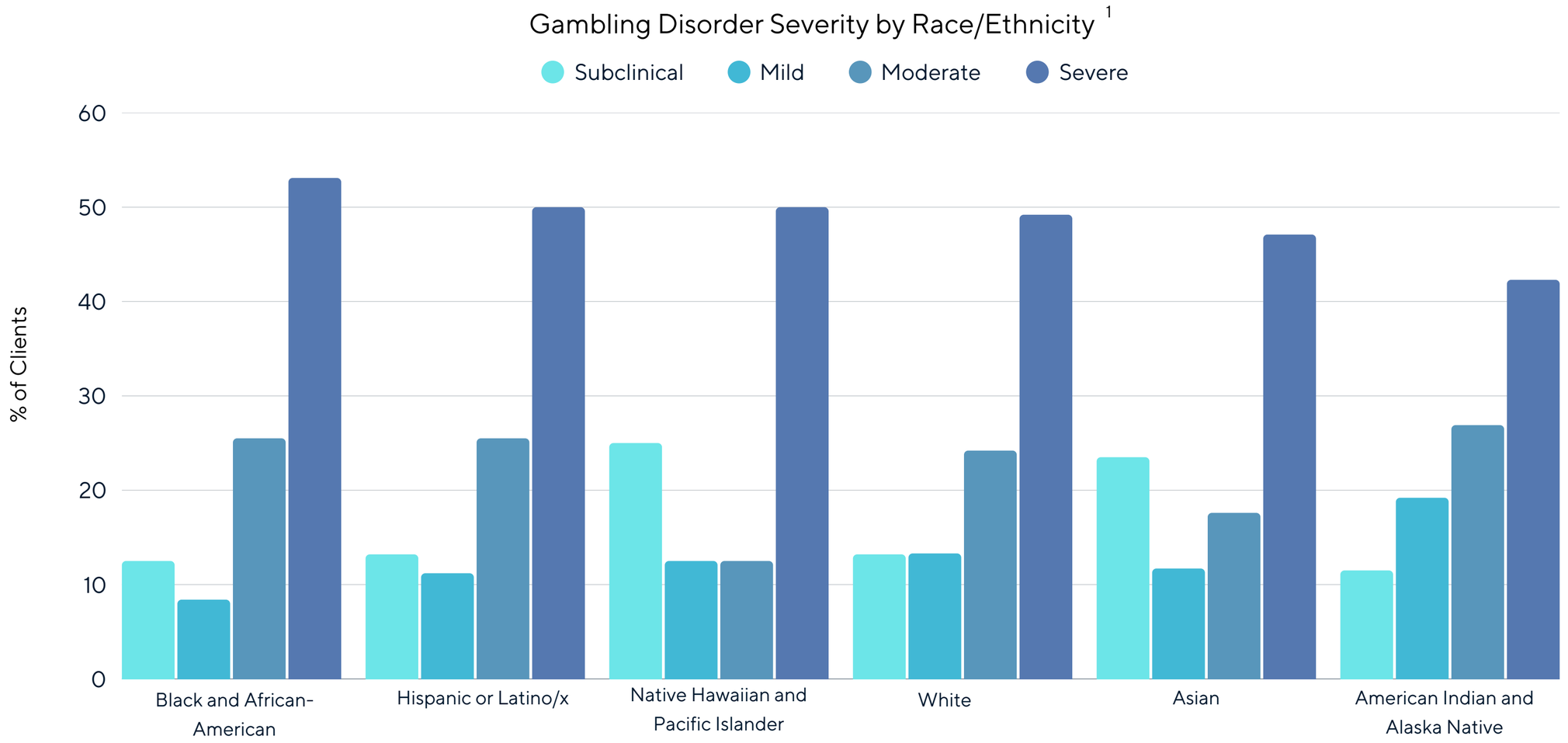
DSM-5-TR Diagnostic Criteria: Gambling Disorder

1. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress as indicated by the individual exhibiting four or more of the following in a 12-month period:
   a. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
   b. Is restless or irritable when attempting to cut down or stop gambling.
   c. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
   d. Is often preoccupied with gambling.
   e. Often gambles when feeling distressed.
   f. After losing money gambling, often returns another day to get even.
   g. Lies to conceal the extent of involvement with gambling.
   h. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
   i. Relies on others to provide money to relieve desperate financial situations caused by gambling.
2. The gambling behavior is not better explained by a manic episode.

Specify if: Episodic or Persistent; Specify if: In early remission
Mild: 4-5 criteria met; Moderate: 6-7 criteria met; Severe: 8-9 criteria met

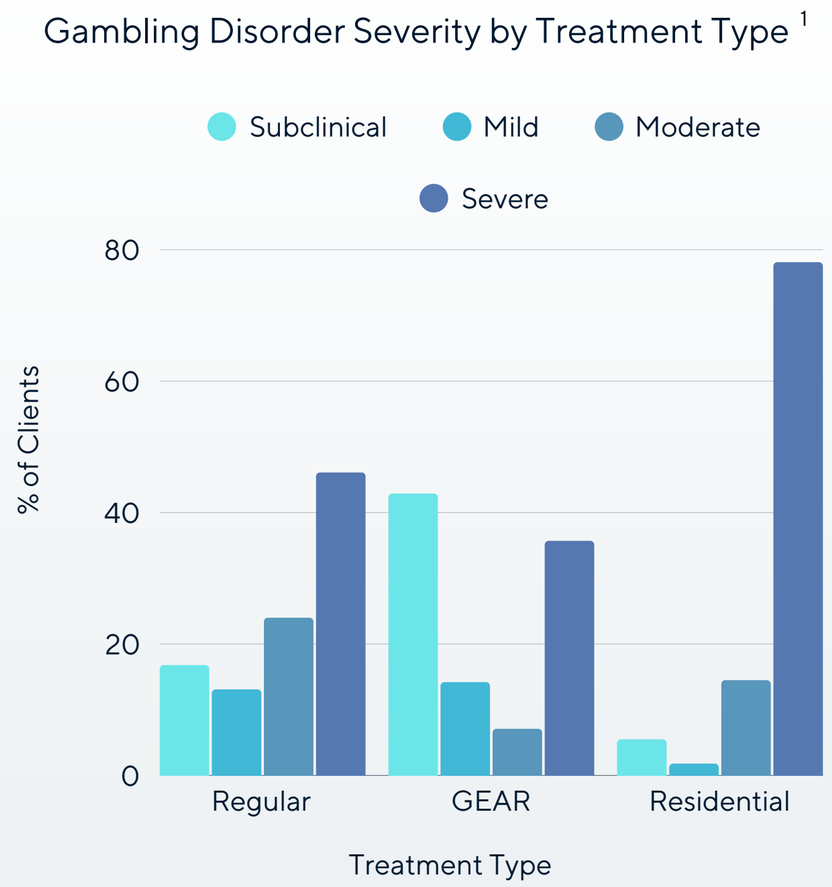
1. Based on Gambling Disorder DSM5 Diagnostic Criteria.

With regard to race/ethnicity, Black and African American clients had the highest rate of Severe Gambling Disorder (53.1%), followed closely by Hispanic or Latino/a/x clients (50%) and Native Hawaiians (50.0).



1. Based on DSM5-TR diagnostic criteria

Among treatment types, residential clients had the highest severity rate (78.1%), followed by Regular Treatment (46.1%) and GEAR (35.7%). Clients aged 40–49 had the highest rate of Severe Gambling Disorder assessments (58.5%), followed by those aged 50–59 (53.2%) and 30–39 (51.8%). Collectively, the 30–59 age group represents 69.5% of the treatment population, indicating disproportionately lower rates of Severe Gambling Disorder. In contrast, 7.1% of clients aged 18–20 were assessed as having Severe Gambling Disorder, despite representing only 1.6% of the treatment population. Similarly, clients aged 21–29 were assessed at 39.1% Severe Gambling Disorder but accounted for just 8.1% of the treatment population.



Age	Severity (%)[1]			
	Subclinical	Mild	Moderate	Severe
18 – 20	57.1	35.7	0.0	7.1
21 – 29	18.7	10.1	31.9	39.1
30 – 39	14.6	10.9	22.8	51.8
40 – 49	8.1	10.5	22.4	58.8
50 – 59	18.0	9.0	19.7	53.2
60 – 69	20.8	14.0	25.2	40.0
70 or older	26.2	27.9	27.9	18.0

1. Based on DSM5-TR diagnostic criteria

TREATMENT DISCHARGE DETAILS

REASONS FOR DISCHARGE

Overall, 37.9% of clients completed problem gambling treatment programs. This represents an increase of two percentage points compared to FY2022-23, where the completion rate was 35.9%. The most common discharge reason was clients stopping treatment against their counselor's advice, accounting for 44.9% of cases. This represents a three-percentage-point increase from last year's rate of 42.0%. Other discharge reasons, such as clients no longer benefiting from the program, moving, or refusing treatment, comprised the remaining 17.2%.

Males had a 19% higher completion rate than females, with rates of 40.7% and 34.2%, respectively. Asians had the highest completion rate at 55.6%, followed by White clients at 39.1%. Hispanic and Hawaiian clients shared the same completion rate of 36.5%.

Clients in residential treatment had the highest completion rate (45.6%), while Regular Treatment had a success rate of 37.1% and GEAR programs 23.5%. GEAR clients had the highest rate of discharges against counselor's advice – 52.9% compared to 45.4% for clients in Regular Treatment and 40.4% in residential programs.
Concerned others had a higher success rate compared to gambling clients (44.4% compared to 37.2%),

Insights from the Follow-Up Research Project

A small number of participants (n = 12) shared their reasons for disengaging from outpatient services.

- One-third expressed receiving sufficient support or feeling they achieved their gambling-related goals within their timeframe; in one case, this was after only one session.
- Another third described logistical barriers to continued engagement in services, such as having moved out of their service area or having trouble accessing services outside of their work schedule.
- The remaining third described negative experiences, whether related to the client-clinician match, confusing or incomplete transfer of care, or feeling overwhelmed by recovery courses, that led to their withdrawal from services at that time. Although several were offered, one of these participants accepted a referral from the interviewer back into the system for services that may be a better fit.

Discharge reason	%
Stopped coming (against counselor's advice)	44.9
Successful completion	37.9
Further treatment not appropriate	4.4
Moved	4.4
Refused further treatment	3.1
Administratively closed	1.1
Non-compliance with rules and regulations	1.1
Illness	1.1
Evaluation Only	0.8
Scheduling conflict	0.4
Deceased	0.4
Incarcerated	0.4

FACTORS ASSOCIATED WITH SUCCESSFUL COMPLETION[1]

- Successful completion: Defined as individuals who have: (a) achieved at least 75% of their short-term treatment goals; (b) completed a continued wellness plan (i.e., relapse prevention plan); and (c) a lack of engagement in problem gambling behaviors for at least 30 consecutive days before completing services
- Adjusted successful completion rate: When factoring out reasons for discharge that are not treatment process related (client moved, became ill, where seen only for an evaluation, etc.) the successful completion rate increases from 38%, as categorized in PG Net, to 43%.

Successful problem gambling treatment is a complicated issue involving many different factors and is highly specific to individuals. However, it is possible to draw several general observations from the discharge data and other information collected about the client.

Gambling Disorder severity

- Non-residential clients meeting criteria for Severe Gambling Disorder are less likely to successfully complete treatment, compared to clients who received a mild rating.
- The success rate for clients with severe Gambling Disorder was 41.0% compared to 52.1% for clients who were evaluated as having mild Gambling Disorder.

Treatment encounters

- Clients who completed 20+ treatment encounters are 3.7 times more likely to successfully complete treatment, compared to those who completed 9 or fewer (68.3% versus 18.3%*).
- About 44.9% of clients stopped attending against their counselors' advice. Maintaining client treatment program participation is a challenge; 10.3% of clients stopped treatment after only 1 encounter.

Co-occurring disorders

- The coexistence of other psychiatric disorders introduce additional layers of complexity. Each condition can exacerbate the others, creating a complicated clinical picture.
- Clients who had been previously treated for Substance Use Disorder were 37.7% less likely to successfully complete.
- If a client reported a previous mental health treatment episode, then the successful completion rate was reduced by 30.0%.

1. Discharges unrelated to a client's willingness to complete treatment, such as illness, incarceration, moving out of the service area, etc. have been removed.

Gambling-related problems

- The presence of gambling-related problems further complicates the treatment process and creates bidirectional influences – e.g., Gambling Disorder influencing relationship problems, and vice versa.
- Clients who reported relationship problems or job or school problems were 48.0% less likely to successfully complete treatment.

Demographic characteristics

- Being fully employed or having annual incomes greater than $30K both increased success rates by a factor of 2.
- High educational attainment has a positive association with treatment success; clients with post-graduate education are 23% more likely to successfully complete treatment compared to clients with lower educational attainment.

Gambling Treatment System Implications

Treatment Type	% Successful Completion
Residential	45.6
Regular Treatment	37.1
GEAR	23.5

Cost and Encounter Characteristics Associated with Successful Program Completion

Overall, clients with successful treatment completion averaged 23 encounters (median is 15) between the time of admission and last service (encounter) date. Residential treatment had the larger number of average encounters (40), followed by Regular Treatment (21), and then GEAR (19). 226 days was the average length of service, with GEAR programs reporting the highest average of 287 days, followed by 257 days for Regular Treatment, and 36 days for residential care.

The overall average cost of service was $4,098. Residential treatment had the highest cost of $12,905, more than 3 times the average cost. GEAR had the lowest cost of $2,133. At a per client

Metric	Successful Client Treatment Type			
	All	Regular Treatment	GEAR	Residential
Average number of encounters	23	21	19	40
Average length of service (days between admissions and departure)	226	257	287[2]	36
Average cost per client treatment episode[1]	$4,098	$2,685	$2,133	$12,905

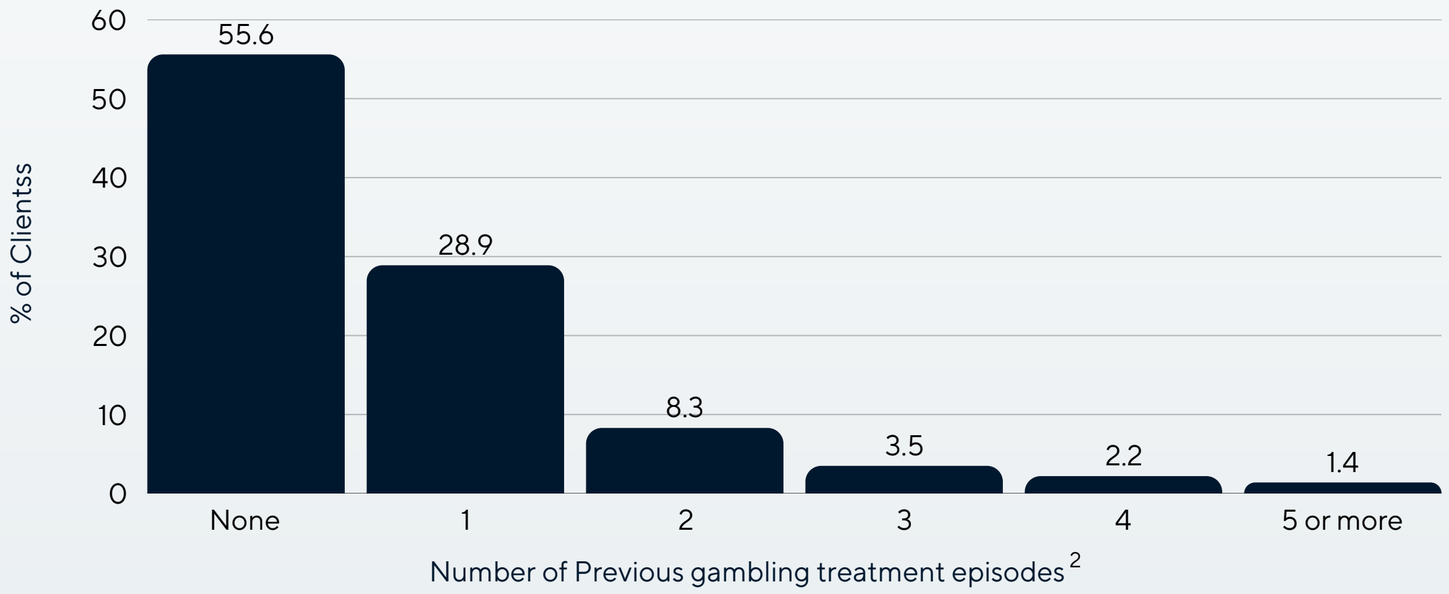
1. The average cost per client encounter was computed by dividing the average cost per client episode by the average number of encounters. There are other ways of computing the average, e.g., dividing the total cost by the total number of encounters. 2. The sample size consists of 4 data points, so caution should be exercised when interpreting the result.

Referred to organization	% of clients with successful treatment discharge
Gamblers Anonymous	65.1
Problem Gambling Outpatient	39.2
Other Community Recovery Group	24.2
None	12.9
Other	10.8
MH Outpatient	8.1
Other Community Recovery Services	7.0
Peer Run Organization	6.5
SUD Outpatient	5.9
Private Practitioner	4.3
GEAR- Minimal Home-Based Intervention	1.1
Problem Gambling Residential	0.5

Client Referral Following Program Successful Treatment Discharge[1]

Gamblers Anonymous had the highest referral rate (65.1%), followed by Outpatient treatment (39.2%). 44.4% of FY2023-24 clients had at least one previous gambling treatment episode and 15.4% had 2 or more. These numbers suggest that it is not uncommon for clients to reenroll into gambling treatment programs, providing evidence for careful consideration of organizations to which clients are referred. 12.9% of clients had no reported organization to which a client was referred.

It is generally considered a best practice to provide a referral for additional supportive services following the completion of addiction treatment. For successfully completed treatment clients, best practice may be a referral to peer or community group support for continued recovery support.



1. Some clients may have received multiple referral types. 2. Analysis of FY2022-23 clients receiving treatment

FOLLOW-UP TREATMENT EVALUATION

MOTIVATION TO SEEK HELP

Additional insights from the follow-up evaluation are presented in this section. These data points represent the experiences and perspectives of a subset of clients enrolled in the treatment system who agreed to participate in the gambling treatment follow-up research project.

Participants were asked what led to their decision to seek help for gambling. The most common theme reported was loss of control over gambling behavior, endorsed by 32% of participants. Participants described feeling “powerless” and “out of control”, resulting in financial harm and other consequences. 17% of participants reported that losing significant money led them to seek help. Some described “spending too much money” in general, leading to difficulty maintaining financial stability. Others described experiencing a stressor of some kind, leading to a gambling binge and significant, sudden loss of money. Another motivation described by several participants (15%) was realizing that they had a gambling problem, some stating that they had been struggling for years. Some noted that they had sought help previously but recognized that they were not in the place they were now to accept the assistance. Participants reported a range of gambling-related consequences that led them to seek help, including detrimental impacts on their finances (13%), familial relationships (9%), mental or emotional health (7%), and housing stability (6%). Another theme in responses to treatment motivation included realizing they needed more help after trying to make changes on their own (9%). Some participants described reaching a breaking point (7%), leading to seeking help, while others cited someone else, like a family member or mental health counselor, suggesting they seek gambling-specific help (6%). Lastly, 6% of participants described involvement with the justice system as a result of their gambling, motivating them to seek help.

Reasons Participants Sought Help for Problem Gambling

1. Loss of control
2. Spending too much money
3. Self-identified having a problem
4. Impacting finances
5. Impacting family
6. Realizing they needed more help
7. Affecting mental health
8. Got to a breaking point
9. Impacting housing stability
10. Someone else brought it up
11. Criminal behavior

INTERVENTIONS AND TREATMENT FACTORS

Homework & Goals

While the same general principles tend to be present across types of therapies, the nuances in how treatment looks can vary depending on a provider's theoretical orientation (i.e., how they understand and treat a problem) and the client's needs. To establish a sense of what counseling services look like among participants in this initiative, participants were asked whether their counselor assigned them exercises to practice outside of their sessions and if their counselor works with them to create goals and objectives for between sessions. Across surveys, homework was assigned two-thirds of the time, and between-session goals were created three-fourths of the time. The practices varied over time, with homework being assigned to 55%, 75%, and 67% of participants and between-session goals established for 80%, 63%, and 81% of participants at the 30-day, 90-day, and 180-day surveys, respectively.

Peer Support

Peer support services are available to clients at select service agencies as well as a stand-alone peer support organization, whose services are available to Multnomah County residents struggling with or in recovery from problem gambling. By the time of the first survey, 42% of participants were simultaneously receiving peer support services. Engaged participants rated the helpfulness of their peer support as 4.3, where zero means 'not at all helpful' and five means 'very helpful'.

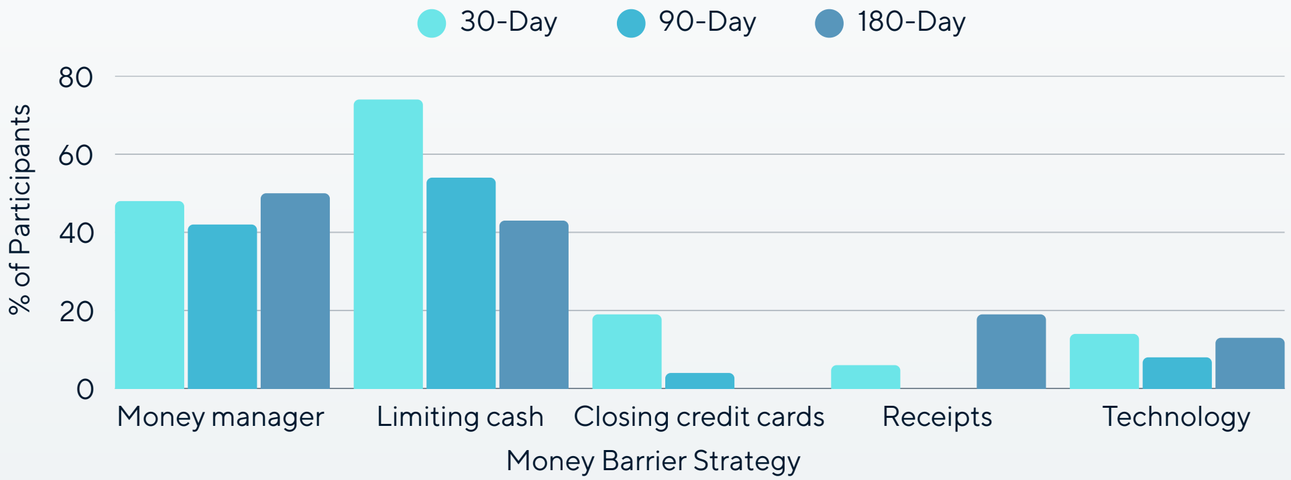
Community-Based Support

46% of participants reported simultaneously attending at least one community-based recovery support group by the time of the first survey. On average, respondents attended groups between two and three days per week, though the frequency ranged from once per week to daily. Some participants live in regions that do not have gambling-specific community groups and have found support in other types of groups, while others are in recovery for multiple reasons and attend several types of groups. Of those attending groups, 61% attend Gambler's Anonymous (GA), 22% attend Narcotics Anonymous (NA), and 22% attend Alcoholics Anonymous (AA). Overall, community recovery groups were rated as a helpful factor in recovery, with an average of 4.2 out of five, where five means 'very helpful'. At both 90- and 180-day surveys, half of the participants were engaged with recovery groups, and the helpfulness rating maintained an average of 4.2.

Other mentioned groups throughout the various surveys include Dual Diagnosis Anonymous (DDA), SMART Recovery, Recover Me, Celebrate Recovery, Recovery Dharma, Wellbriety, and general recovery support groups.

Money Barriers

Money barriers, also referred to as financial safety strategies, are practices or restrictions that an individual can implement to protect their money from being lost to gambling. By the time of the first survey being administered, 75% of participants had talked with their counselor about money barriers. The type of money barriers being practiced varied across time points. Limiting the amount of cash one carries was the most common barrier reported, followed by having someone else manage their money.



Participants who reported using money barriers were also asked to rate their perceived helpfulness of each endorsed strategy in their recovery using a numerical scale from zero (i.e., 'not at all helpful') to five (i.e., 'very helpful'). Across three time periods (30-, 90-, and 180-day surveys), limiting cash received an average rating of 4.5, having someone else manage one's finances was rated 4.4, and using technology was rated 4.1. Slightly less helpful, providing receipts on purchases received a 2.9 in perceived helpfulness, and closing credit cards was rated at 2.6.

Limiting the amount of cash being carried, having someone else manage money, and utilizing technology (e.g., recovery apps, site blockers) were perceived as the three most helpful money barriers.

Participants shared additional strategies to safeguard their money, including:

- Storing cash away in a loved one's lockbox or safe or in an emergency-only designated spot
- Prohibiting or lowering withdrawal limits with the bank
- Sticking to a budget and tracking money spent
- Finding ways to barter for necessities that reduce the need for cash
- Using credit cards exclusively so cash cannot be withdrawn and bets cannot be placed
- Keeping themself busy to reduce downtime
- Voluntary self-exclusion

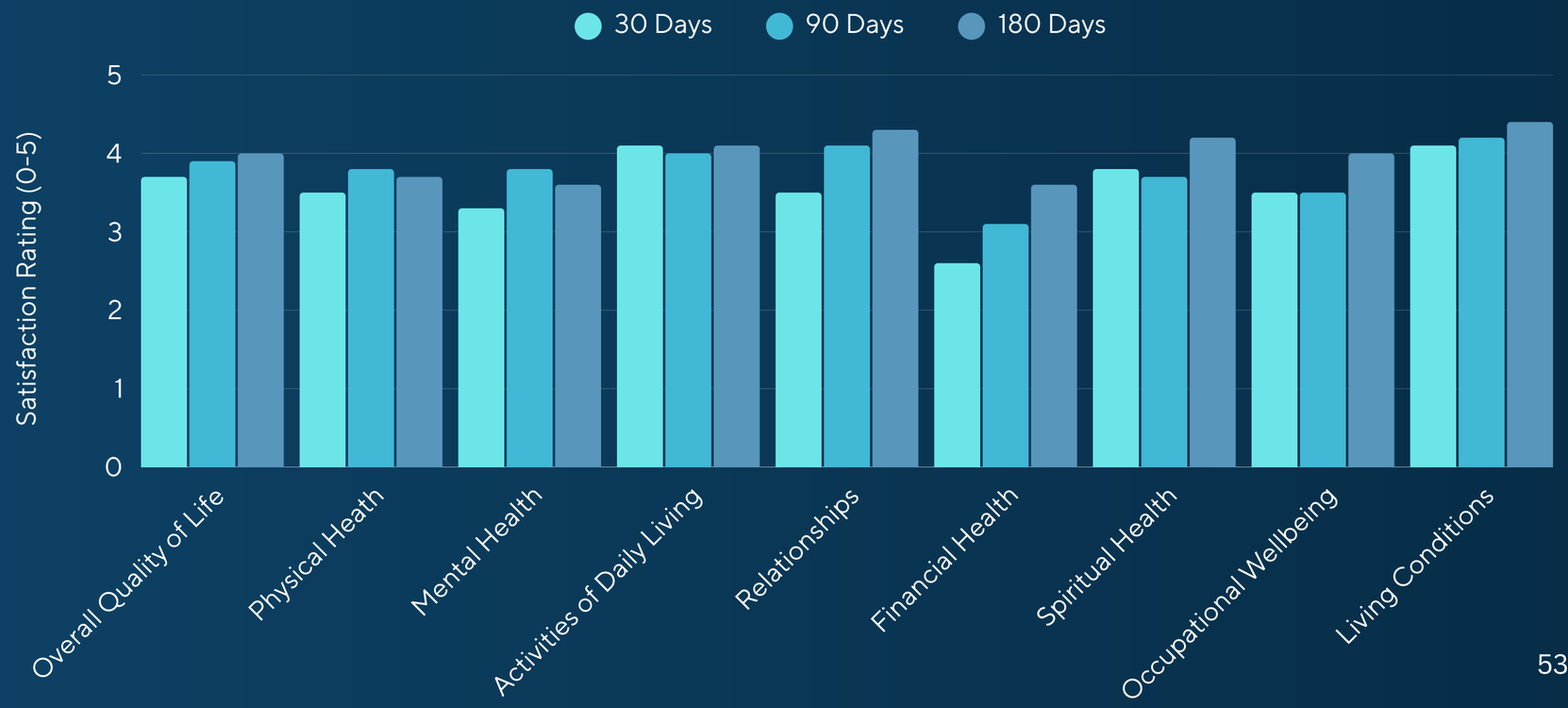
Goals for Recovery

Recovery goals vary from person to person and may naturally change over time. At the start of engaging with treatment services, 83% described their goal for gambling recovery to be abstinence., while 17% wanted to set limits for themselves, such as only spending a predetermined amount for a specific frequency (e.g., no more than $10 per week) or limiting the types of games played. By the 90-day survey, 74% were aiming to abstain, and by 180-day it fell to 53%. The decreased goals for abstinence came with an increase in wanting to have more control and set limitations over gambling behaviors. Even by the first survey, 74% of participants felt they were at least somewhat meeting their recovery goals. By the 90-day survey, this increased to 92%. By 6 months, the subjective success rate remained high, at 87%.

At the time of the first survey, 48% of participants identified being in active recovery for something else or beginning to make changes. Of these, 39% described striving to be “clean and sober”. In addition to those, 32% identified alcohol as a concern. Others named cannabis, tobacco products, and drugs broadly. Outside of recovery from substances, overeating was named as a goal for recovery by one participant. Importantly, having a co-occurring recovery did not impact perceived success with gambling goals.

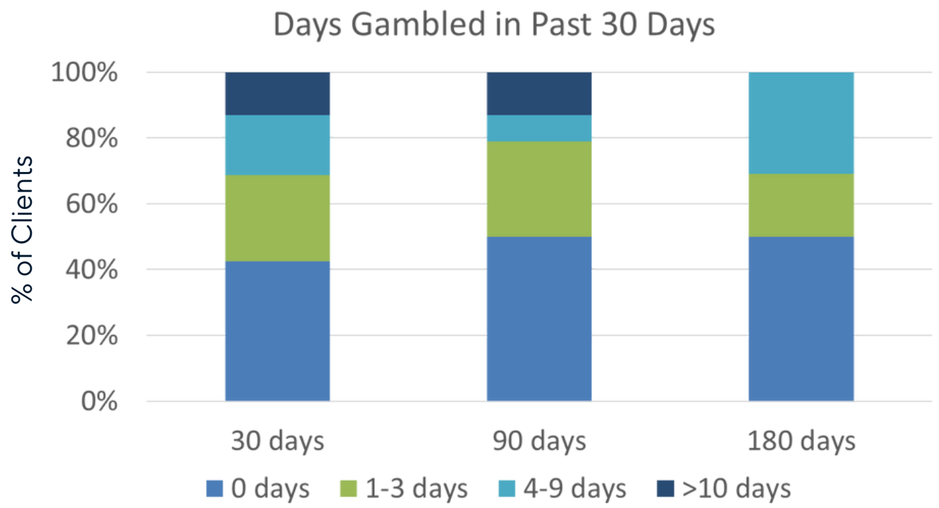
Quality of Life

Factors related to quality of life were also assessed at each time point. Participants were asked to rate the overall quality of life and eight unique domains on a scale from zero (completely dissatisfied) to five (completely satisfied) over the previous 30 days. For the most part, there were no substantial changes in quality of life ratings over the course of treatment, with the exception of financial health, which increased by one full point between the first and last rating, and relationships, which increased by 0.8 of a point.



Gambling Behavior

Actual reported gambling behavior varied at each time point. Across the board, most participants reported not gambling any days in the past 30 days from their interview; this was the case in half of the participants at the 90- and 180-day surveys.



What Helped Clients Not Gamble?

Participants who reported no gambling in the 30 days prior were asked what had helped them to abstain. The following is a list of actions participants reported that helped them not gamble:

1. **Reminders**: Participants most often mentioned reflecting on the positive changes they have made, as well as the negative aspects of gambling
2. **Services**: Individual and group counseling, community support groups, and classes offered through their agencies were all cited second most frequently as what had helped them remain abstinent in the past 30 days.
3. **Determination**: Next most commonly, participants stated they "had to stop", noting that it is difficult but with continued motivation, hard work, and focus, they found success.
4. **Money Barriers**: Strategies like limiting access to their funds or keeping themselves too busy to gamble were also described as helpful.
5. **Life Enhancement**: A handful of participants described having supportive family members, health practices, and/or a strong faith as primary factors in not gambling.

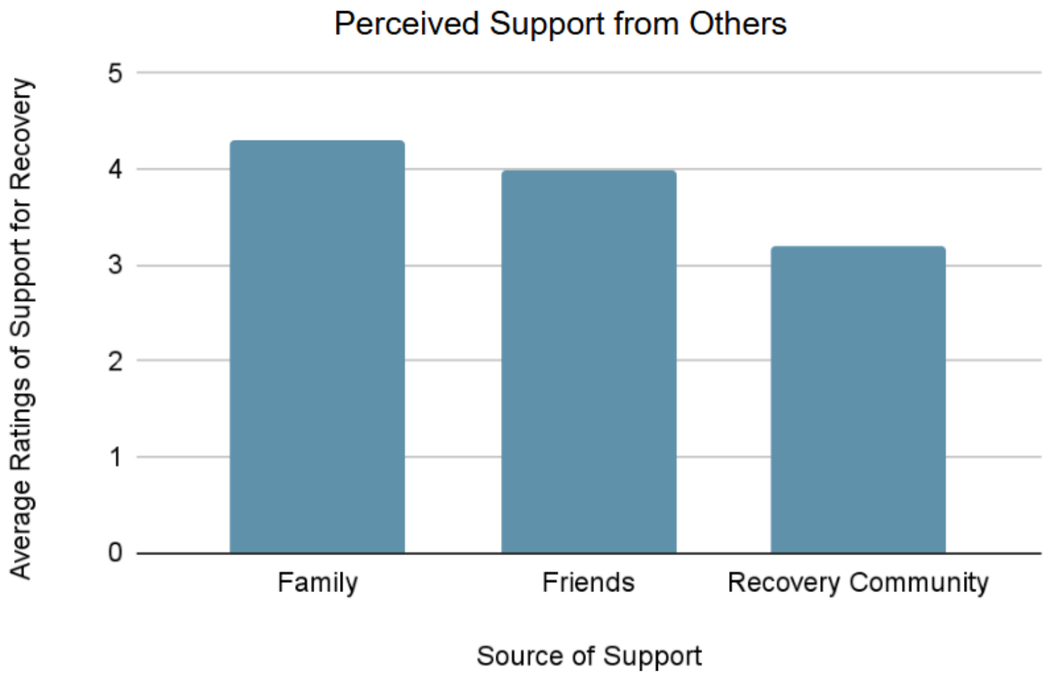
SOURCES OF SUPPORT

Co-occurring Disorder Treatment

62% of participants simultaneously received separate treatment for mental health or substance use disorders at some point during their engagement with gambling treatment services. This includes separate counseling or medication provided by a different provider than their gambling counselor. A small percentage (4%) reported receiving co-occurring substance use disorder treatment from their gambling counselor. Commonly reported co-occurring disorders that were treated alongside their gambling disorder treatment include depressive disorders, anxiety disorders, post-traumatic stress disorder, bipolar disorder, substance use disorders (e.g., alcohol, amphetamines, opioids), attention-deficit/hyperactivity disorder, and compulsive behaviors.

Supportive Others

Family was, generally, a consistent source of support for participants. On average, looking across time points, respondents rated their agreement with the statement, “I am very supported by my family”, a 4.3 out of five possible. Support from friends earned an average rating of 4.0, and feeling supported by a community of other people in recovery was the lowest, at 3.2. Average ratings tended to increase across time points, but this was most evident for feeling supported by a recovery community. From the first to the third survey point, family support increased from 4.0 to 4.4, friend support increased from 3.6 to 4.5, and community support increased from 3.0 to 3.7.



SATISFACTION WITH SERVICES

A handful of questions about the therapeutic alliance, overall satisfaction ratings, and open-ended questions about experiences assessed counseling service satisfaction. Overall, counseling services received high satisfaction ratings across the board.

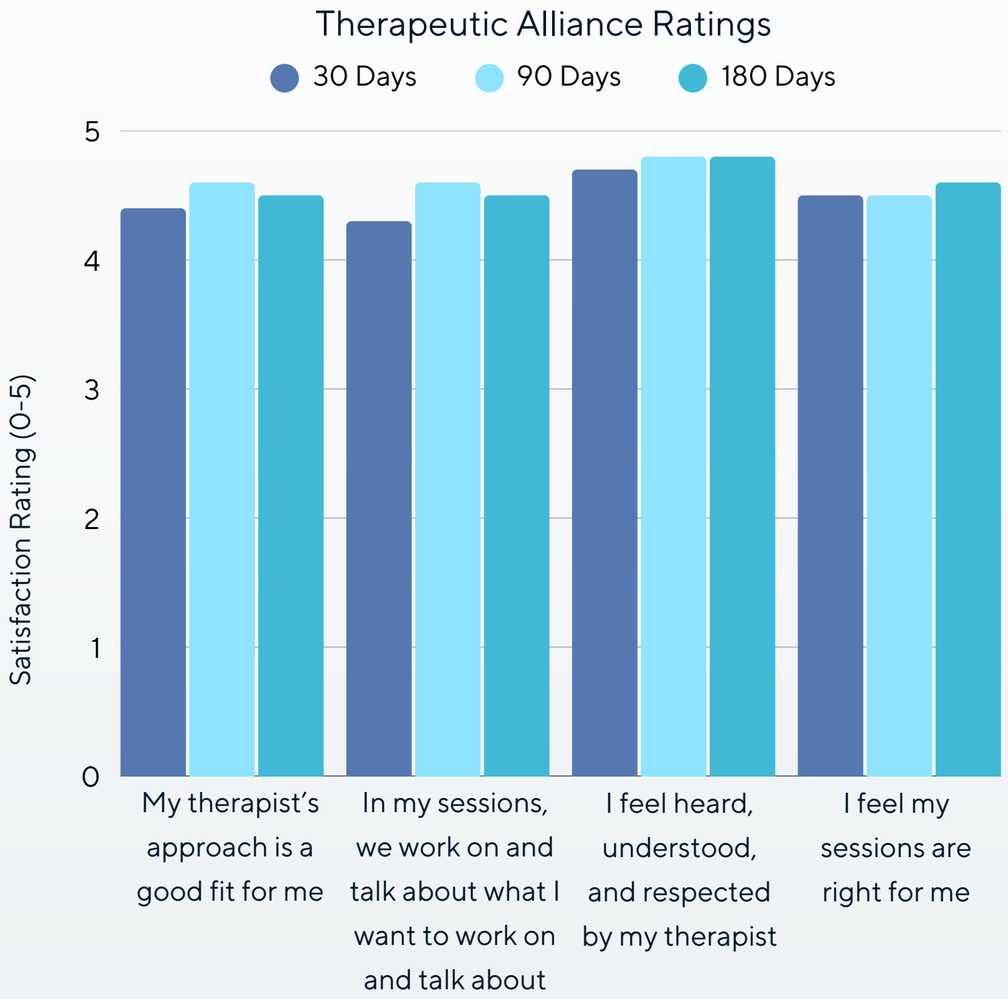
Therapeutic Alliance

Participants were asked to rate four dimensions of therapeutic alliance with their gambling counselor. They were asked to rate their level of agreement on a scale of zero (“completely disagree”) to five (“completely agree”) with statements about therapist fit, session content, treatment from their therapist, and session feel. There was little variation in therapeutic satisfaction; average ratings began high and were maintained across time points.

Overall Satisfaction

Similarly, participants were asked to rate their overall satisfaction with treatment up to the point of the survey, using a scale from zero (“very unsatisfied”) to five (“completely satisfied”). The average rating across time points was 4.5. At 30 days, the average rating was 4.3, at 90 days it was 4.2, and at 180 days 4.6.

92% of the time, participants stated they would recommend the same services to a loved one if they needed help with gambling.



Most Helpful Part of Treatment

At each survey point, participants were given the opportunity to share what they felt had been most helpful in their treatment or recovery so far. Most frequently (in 36% of cases), clients shared that the characteristics of their counselor made the biggest difference in their treatment progression. Specifically cited, were nonjudgmental support, empathetic listening, guiding perspective-taking, a strong therapeutic alliance, passion for the work, challenging clients, and creating space for processing.

> ***"I think not being judged, being in a safe space...I feel comfortable being able to be honest... My counselor is really easy to talk to".***
>
> ***"I feel like my gambling counselor has guided me [to] exactly where I need to be".***

Mentioned 20% of the time, was the acquisition of knowledge pertaining to problem gambling, addiction, and skills for behavior change. Helping clients get to the root cause and understand their brain chemistry was described as removing shame and inspiring change. Helping clients come up with a plan to address urges, implement financial safety strategies, and understand environmental cues were also specifically described.

Clinical services, including individual counseling, group therapies or classes, integrated care where other mental health needs could be addressed simultaneously, and culturally specific counseling, were all cited as the most helpful factor in 9% of cases. Similarly, factors related to these clinical services were cited 6% of the time. For example, the flexibility in scheduling options, consistency, and structure provided with the services were noted as helpful. The accountability clinicians provided clients with for moving toward their goals was mentioned 9% of the time.

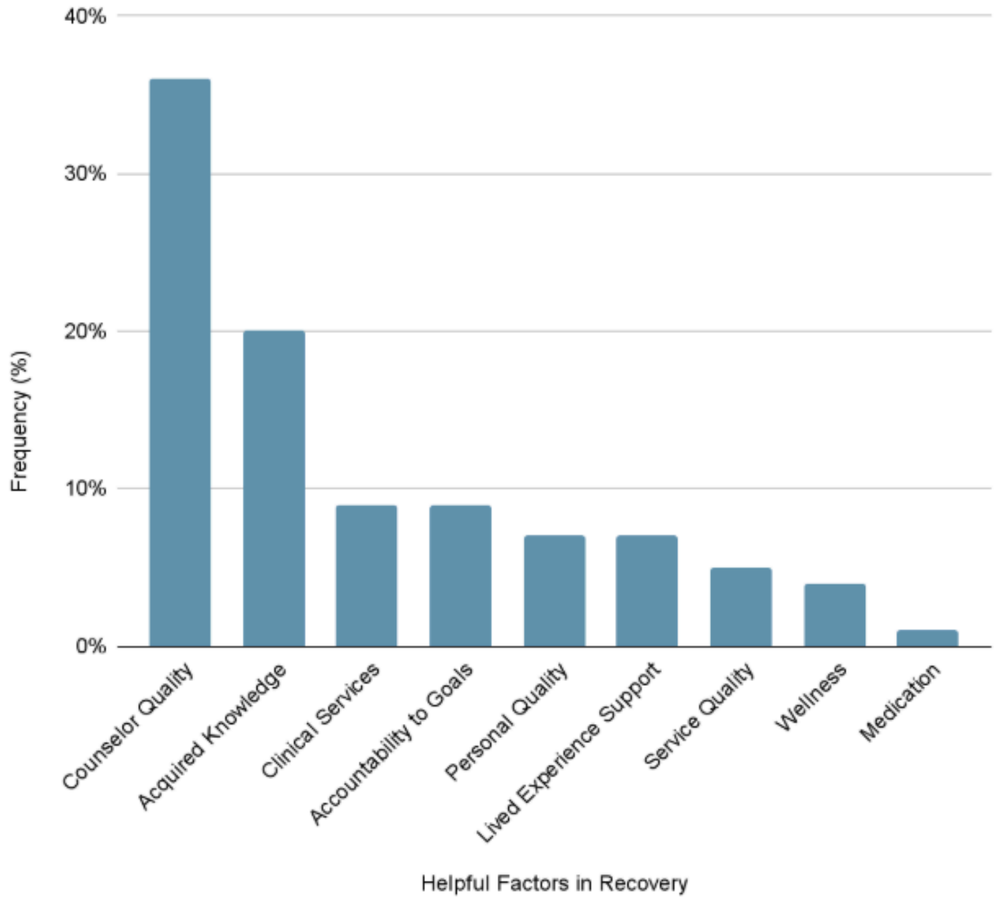
7% of the time, participants mentioned that personal qualities, such as self-determination, willpower, and intrinsic motivation were the primary factors in their treatment success. 7% also noted the powerful impact of support from others with lived experience specific to problem gambling, whether through formal peer support services or community support groups (e.g., Gambler's Anonymous).

"Getting more involved with these people, knowing I am not the only one. This is fixable, but you have to give yourself [time]... talking to the right people".

"Siempre [estoy] en comunicado con otras quien estan tomando el programa... no estoy solo en mi recuperacion". [I am always in communication with others who are in the program... I am not alone in my recovery].

On a few occasions, 4% of the time, other facets of wellness were mentioned, such as support from family, balance in life, and taking care of one's emotional health. Additionally, one individual cited medication (Naltrexone) to be the most helpful factor in their treatment.

Response Themes to, *"What has been most helpful in your treatment so far?"*



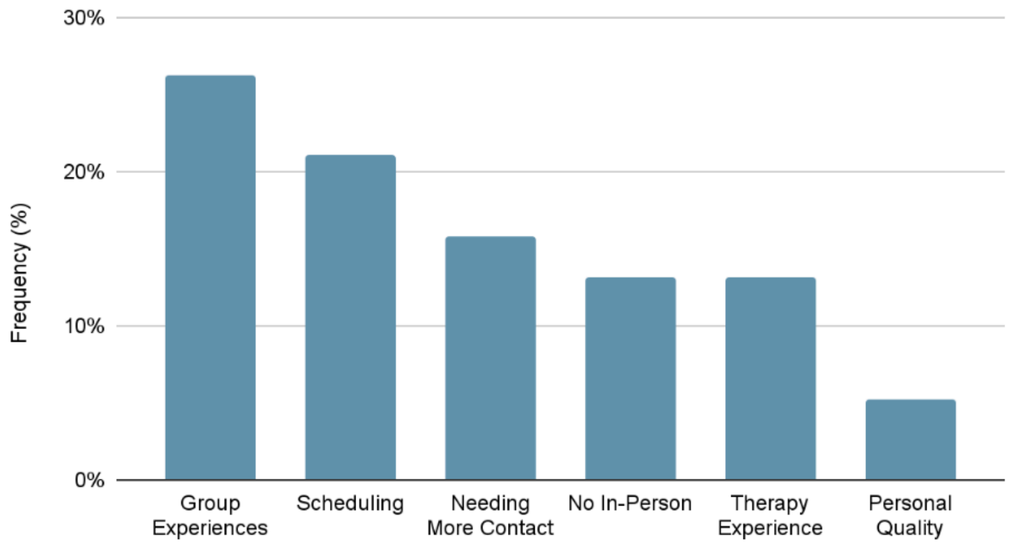
Least Helpful Part of Treatment

Similarly, participants were given the opportunity to share what they felt had been least helpful in their treatment or recovery so far. Most commonly described, 26% of the time, were poor group experiences. These included feeling disconnected from other recovery group members, negative interactions with group members, feeling like groups were not well-facilitated when difficult members were present, or just not having in-person groups available in their community. Gambling-specific recovery groups are unavailable locally in some agencies' geographical service areas. In these cases, in-person community support means utilizing other group offerings (e.g., Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, etc.). Some participants reported that being the only participant with problem gambling made them feel isolated from the rest of the group. In a similar theme, 13% of reports mentioned wishing there were in-person counseling services available near them, as well. Only 1 participant reported wishing that they had telehealth available to them; in this case, the participant was referred to the helpline to discuss service options.

21% of the time, participants described scheduling frustrations that they felt impacted their recovery process. In some cases, it was described as being difficult to make appointments with their counselors at the frequency they wished they could. In other cases, it was noted that available appointments or group meetings conflicted with their work schedule. 16% of the time, participants said they needed more support or contact from their agencies. Some stated they were waiting for a callback to schedule the next appointment or be referred for mental health treatment, others were dissatisfied with the lack of available information about residential treatment, or not being eligible to enroll in residential services. Additionally, some participants described confusing care coordination experiences for housing support and wished for more clarity in the process.

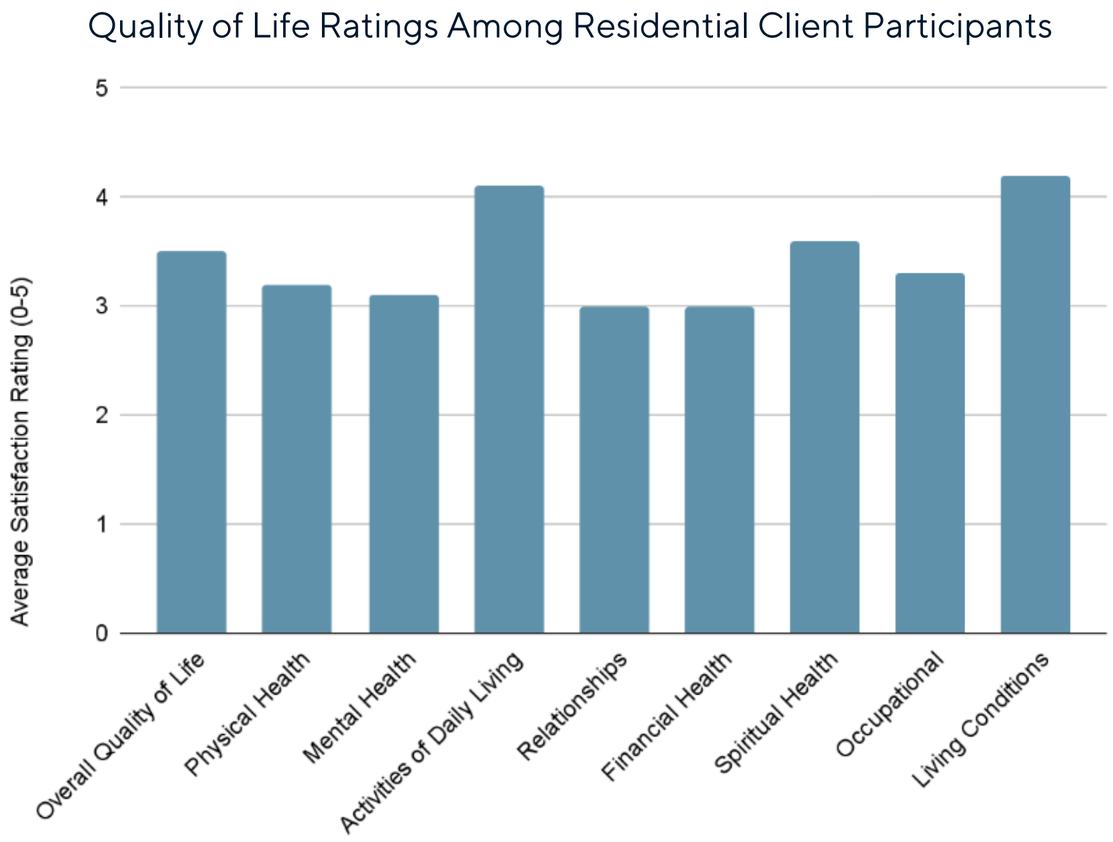
Broadly, experiences in therapy were cited 13% of the time. These included not having a good client-clinician match with the first counselor they were matched with, feeling progress was too slow, or not finding their workbook or screening questionnaires to be helpful. A few times (5%), participants described personal qualities getting in the way, such as not taking their counselor's advice or just feeling unready for change. Lastly, on one occasion, a participant described struggling with a lack of support from their friends, who continued to invite them to the casino.

Response themes to, *"What has been least helpful in your treatment so far?"*



RESIDENTIAL TREATMENT

A small number of participants (n = 11) had involvement in residential gambling treatment and shared their experiences with this service. Seven of the participants (64%) had initiated services with an outpatient agency for gambling before being referred to residential treatment; others asked specifically for a referral when they called in for help or were engaged in substance use treatment at Bridgeway prior to their referral. Participants described various reasons for enrolling in residential gambling services, including losing control of gambling, losing too much money, fear related to mental health symptoms secondary to problem gambling, finding oneself engaging in criminal activity to fund gambling, and needing more support than outpatient counseling or peer support services could offer.



Similar to those engaged in outpatient services, 82% of respondents reported their goal for recovery was to abstain from gambling entirely. The remaining described wanting to limit their gambling to avoid certain activities or reduce the frequency. Of note, residential treatment participants completed their interview at some point after residential services had ended, and therefore their responses do not have a unique timeline. 64% of participants described recovery goals outside of gambling, as well, including other substances or compulsive behaviors. This is a larger proportion compared to outpatient participants (48%). Perceived success rates of meeting goals for recovery were similar, with 73% of residential respondents feeling like they were meeting their goals at the time of the interview.

Gambling urge was low among respondents, rated at an average of 1.4 on a scale of zero (‘no urges’) to five (‘strong urges’). Quality of life was generally rated moderately, with relatively lower financial health, emotional health, and relationships, and higher abilities to perform activities of daily living and quality of their living place.

Participants described feeling supported by a community of other people in recovery, rating an average of 4.1 on a scale of zero to five. On average, family support was rated at a 3.8 and support from friends at 3.7.

Therapeutic alliance domains received moderate ratings; however, these ratings reflect an overall experience with potentially multiple staff and counselors, rather than the relationship between a client and one counselor over time.

Overall, residential participants provided an average rating of 4.2 on a scale of zero to five for the cultural responsivity of the program based on their identities. 100% of participants stated that they would refer a loved one to the Santiam House, the only residential gambling treatment facility in the PGS system, if they needed help for problem gambling, and overall rated their satisfaction with the experience as 3.8 on a scale from zero to five.

SUMMARY

Oregon's publicly funded gambling treatment services are making a difference. In state fiscal year 2023-2024, close to 850 individuals received counseling services to address gambling-related issues at no out-of-pocket costs to them. The majority of participants reported decreased urges, fewer days gambled, and increased quality of life as time engaged in services went on.

Findings detailed in this report provide valuable insights into the population that obtains gambling treatment services. For the first time in many years, evaluation efforts of the OHA Problem Gambling Treatment System included a client follow-up component. This component involved client interviews with evaluators at various time points across their recovery journey. These efforts helped us better understand what was least and most helpful to clients in their recovery and further our efforts to continually improve OHA-funded gambling treatment services.

" I feel really fortunate... I would probably be dead if I was not engaged in recovery, I am forever grateful for [the State of Oregon] ... I hope this investment will continue if they are going to continue to create this problem".

FINDING SUCCESS IN OREGON GAMBLING TREATMENT SERVICES

Individuals treated in fiscal year 2023-2024

849

35%

Received an appointment the same day as their first call for help

68%

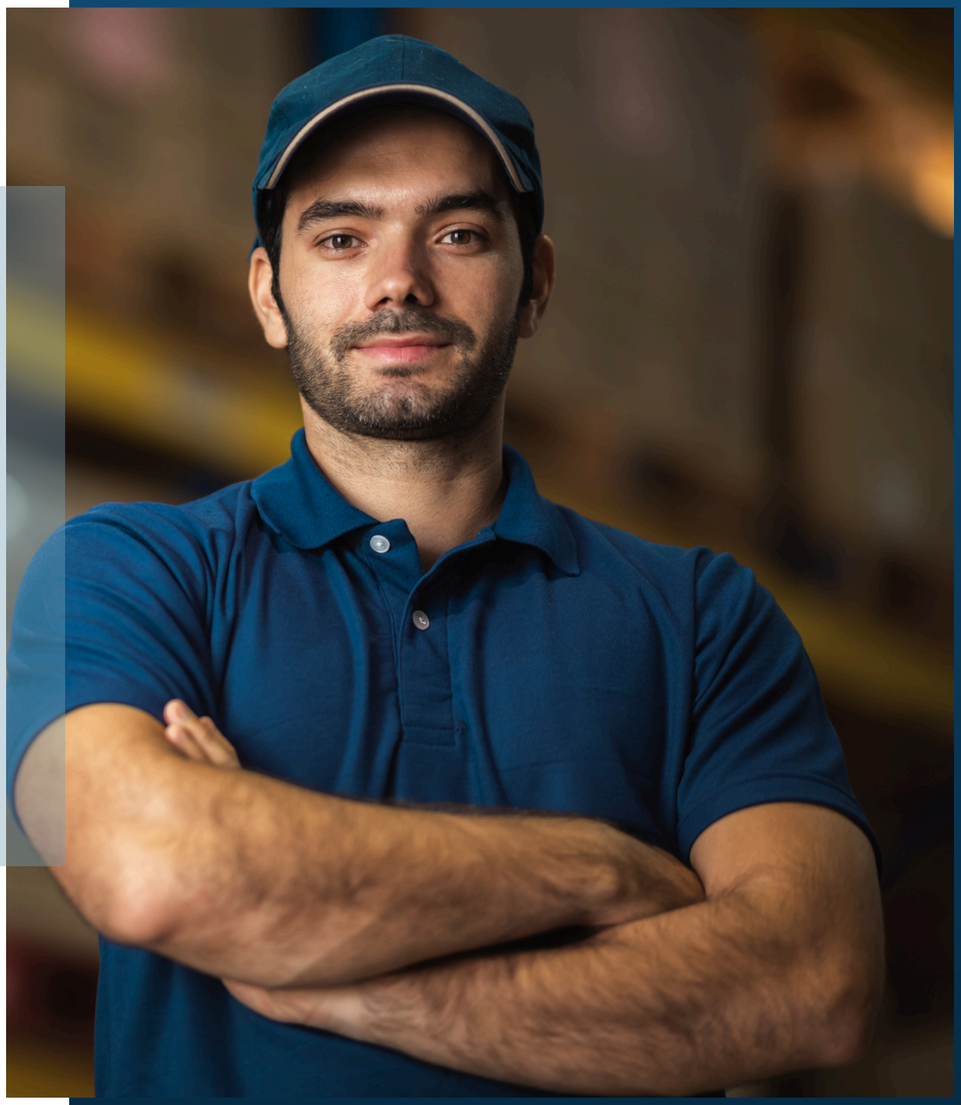
Treatment success when completing 20+ sessions

PROGRAM EVALUATION KEY FINDINGS

- A total of 10,788 encounters were delivered by a network of 44 problem gambling treatment programs, treating 849 individuals. Most clients were treated in outpatient programs. 7% received residential treatment, 3.3% from GEAR, and 0.1% received crisis-respite center treatment.
- Over half of clients referred themselves to treatment. Referrals from other treatment providers and referrals from the helpline each accounted for 11%
- Treatment is available quickly, with more than one-third of clients enrolling the same day they made contact with a program. On average, there was a 4.5 workday lag between contact and first available appointment.
- Telehealth continued to decrease from a high of 55% of encounters in July 2022 to 32% in June 2024.
- About 25% of individuals utilizing the PGS gambling treatment system had no prior behavioral health treatment experience, including no past treatment for gambling problems, other addictions, or other psychiatric conditions.
- 38% successfully completed their treatment program. This represented an increase of two percentage points compared to the previous year. Males had the highest rate of successful completion of 41%, compared to 34% of females. Overall, 45% of clients stopped attending their treatment programs against their counselors' advice.
- Severe gambling disorder, co-occurring disorders, and the presence of a greater number of gambling-related problems were associated with less of a likelihood to successfully complete treatment. On the other hand, staying engaged in treatment for 20 or more encounters (compared to nine or fewer), full employment, and earning above $30,000 annually, were all associated with greater likelihood of successful treatment completion.
- The majority of follow-up evaluation participants reported decreased urges, fewer days gambled, and increased quality of life as time engaged in services went on.

Population Served

- Overall, clients were more likely to identify as male, White, with an average age of 47. Females seeking treatment tended to be older than males, and GEAR tended to attract older clients. Fewer than half of clients had completed more than a high-school degree.
- Fewer than 6% of clients were connected to the military. About one-third of clients were married, one-third never married, and one-third previously married but currently not (e.g., separated, divorced, widowed).
- 79% of clients reported one or more dependents relying on them financially. About half of clients were employed at least part-time, and about two-thirds of clients earned less than $30,000 annually. In fact, 20% of clients earned no income.
- 8% of clients were loved ones of a person with a gambling disorder seeking concerned others supportive counseling, and 92% were individuals addressing their own gambling concerns.
- Of clients who sought treatment for gambling, electronic gaming was by far the most frequently reported primary gambling activity (88%). Wagering on sports-related events has grown to 8.5%. Males were 8 times more likely to report sporting events as their primary activities compared to females (13.2% versus 1.6%, respectively). Video lottery retailers were the most common primary gambling venue (70%).
- A large proportion of people entering gambling treatment had a complicated clinical profile: 44% of clients had 2 or more co-occurring conditions, 48% presented with a very high level of problem gambling severity, and 26% were experiencing suicidal thoughts, threats or engaging in associated actions or plans.



OHA PGS PROBLEM GAMBLING TREATMENT SYSTEM

STRENGTHS

- Cost-free treatment programs that are widely available with short wait times (in most cases).
- Wide range of treatment programs that align with clients' diverse therapeutic needs.
- Culturally-specific and linguistically appropriate services for multiple ethnicities.
- Treatment programs delivered by certified problem gambling treatment counselors.

AREAS TO IMPROVE UPON

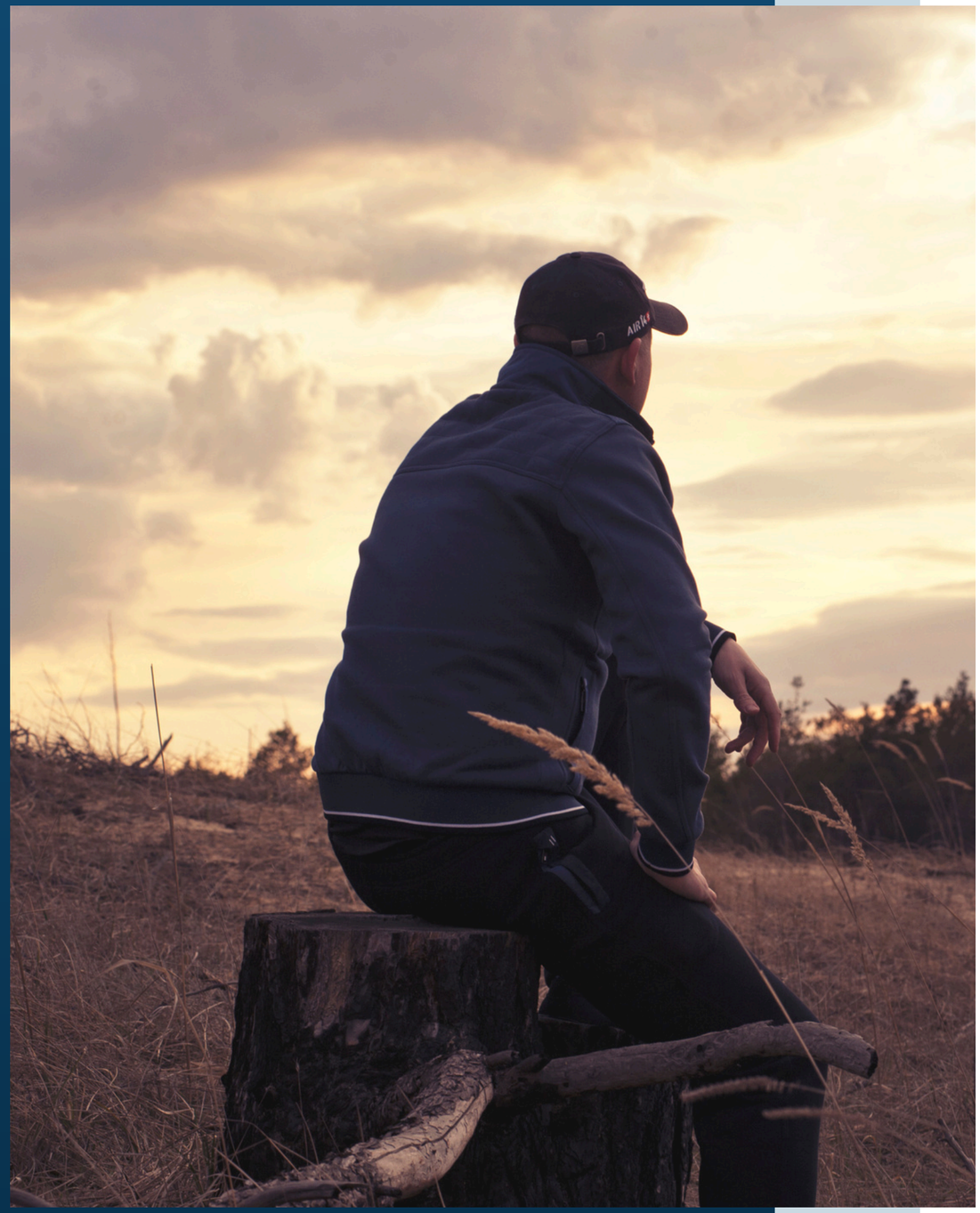
- Retention. A large proportion of clients leave treatment early.
- Follow-up engagement. Most clients are not participating in the follow-up program.
- Data collection compliance rates of treatment providers need improvement.
- Need to find ways to serve more persons in need.
    - The system appears low-income centric, with average client income less than half the state's average per-individual income.

OPPORTUNITIES

- Expansion of problem gambling treatment services in the criminal legal system, following success of current programs.
- Program improvement using data to inform system development.
- Utilization of gambling treatment data at provider level.
- Increased access to technologies and tools to support gambling treatment and recovery.

THREATS

- Increase in problem gambling due to the rapid growth of sports betting.
- Increase in problem gambling on account of technological advances.
- Co-occurring behavioral health problems. Oregon is ranked fourth worst state regarding mental health wellness and access to care.



CONTACTS AND RESOURCES

Oregon Health Authority, Problem Gambling Services

www.oregon.gov/PGS

Greta Coe, Problem Gambling Services Manager

Greta.L.Coe@oha.oregon.gov / (503) 602-4444

Oregon Problem Gambling Helpline (24/7 toll free)

1-877-MY-LIMIT / Es: 1-844-888-2537

Oregon Problem Gambling Resources

www.opgr.org/

Change starts here.
Help is free and confidential.