OREGON HEALTH AUTHORITY

OREGON'S PROBLEM GAMBLING TREATMENT AND SUPPORT SERVICES:

EVALUATION REPORT

Fiscal Year 2024-25

OREGON HEALTH AUTHORITY
PROBLEM GAMBLING SERVICES

ACKNOWLEDGMENTS

Special thanks go to the staff at Oregon Health Authority (OHA), 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

Since legislation created the Problem Gambling Treatment Fund in 1992 (ORS 409.430), Oregon has been committed to offering publicly funded gambling treatment. Addressing gambling related harms in Oregon has evolved over the years from supporting only gambling treatment into a comprehensive system. The Oregon Lottery operates responsible gambling programs, supports research, and runs problem gambling public awareness campaigns while the Oregon Health Authority (OHA) efforts focus on building strong partnerships for collaborative efforts to drive prevention, education, and treatment initiatives. In state fiscal year 2024-25, approximately eight million dollars in Oregon Lottery revenues were transferred to the OHA for administering their Problem Gambling Services (PGS).

The present report focuses on state fiscal year 2024-25 (July 1, 2024, to June 30, 2025) gambling treatment and support services 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 person 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, along which individuals can move back and forth 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. Entities contracted by OHA to address gambling harm provide an array of services from early intervention, treatment, treatment supplements, and support for ongoing recovery, which are covered in this section.

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

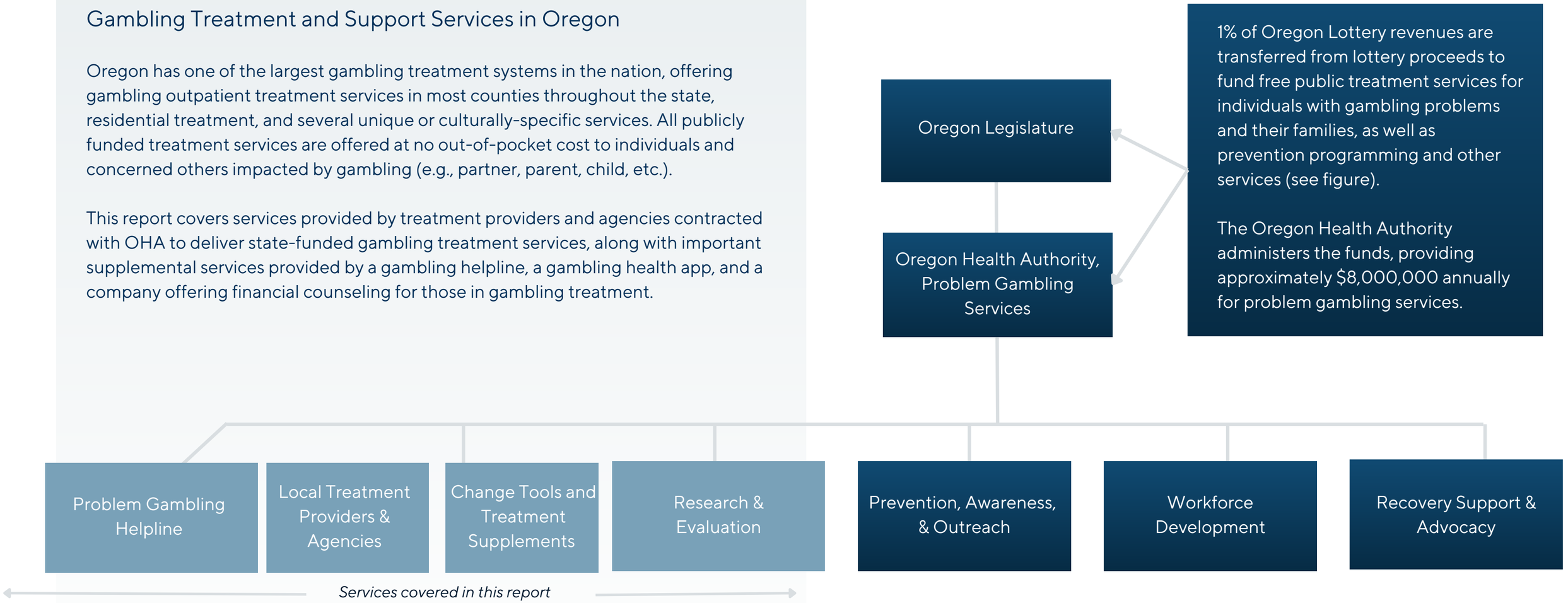
Spectrum of engagement in problem gambling services

PUBLICLY FUNDED GAMBLING TREATMENT & SUPPORT SERVICES

Gambling Treatment and Support 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 important supplemental services provided by a gambling helpline, a gambling health app, and a company offering financial counseling for those in gambling treatment.



TYPES OF PROBLEM GAMBLING TREATMENT AND SUPPORT SERVICES

Funded by the Oregon Health Authority's Problem Gambling Services (PGS), interventions are designed to address a range of gambling-related problems using a level-of-care approach. In this model, individuals are offered the most effective and least restrictive intervention approach before being "stepped up" to a higher level of care if needed, and "stepped down" to a lower level of care when appropriate. Evive, a digital health app, and GEAR, a minimal intervention program, are the lowest levels of care, followed by outpatient treatment (which includes culturally-specific programs), and residential treatment, 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 a home-based minimal intervention.

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

Gambling Reduction and Recovery for Incarcerated Populations (GRIP)

GRIP is a program delivered within Oregon Department of Corrections facilities consisting of a 12 session structured psychoeducational group designed for incarcerated adults electing to address gambling related issues

Outpatient Gambling Treatment

In FY2024-25, 97 problem gambling counselors from 42 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.

Residential Gambling Treatment

There is one residential treatment facility located in Marion County that is designed exclusively for gambling disorder 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.

Financial Counseling (GamFin)

GamFin provides financial counseling and recovery tools for individuals and loved ones in financial distress that is gambling related.

Digital Health App (Evive)

A digital option for those interested in using a health app designed to support changes in gambling behavior. The app allows users to set their gambling management or stop goal. It offers education, behavior monitoring tools, cognitive behavioral lessons, and a digital support community.

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.

Peer Support

Five programs provided peer support services in FY2024-25.

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

EVALUATION OVERVIEW

The OHA problem gambling treatment system includes a robust evaluation program composed of two primary components: (1) A data collection system that collects intake, discharge, and encounter data inputted directly from gambling treatment providers, and (2) a follow-up treatment evaluation that collects longer-term client outcome data collected by an independent researcher. The data collection system used in FY2024-25 was an OHA PGS-developed system named 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. In FY2024-25, OHA PGS contracted with Problem Gambling Solutions, Inc. to provide PG Net data analysis and reporting functions, along with administering a gambling treatment follow-up evaluation. These two evaluation components are described in greater detail later in this section.

The current report reflects data captured from two primary sources for FY2024-25:

- 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 FY2024-25 include:

- Information gathered from Oregon's Problem Gambling Helpline.
- A GamFin report outlining OHA PGS client participation, activities, and program benefits.
- A report on OHA PGS client use of the Evive Digital Health Application.
- Information on activities and client profiles of individuals receiving problem gambling treatment services under Medicaid.

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 with 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

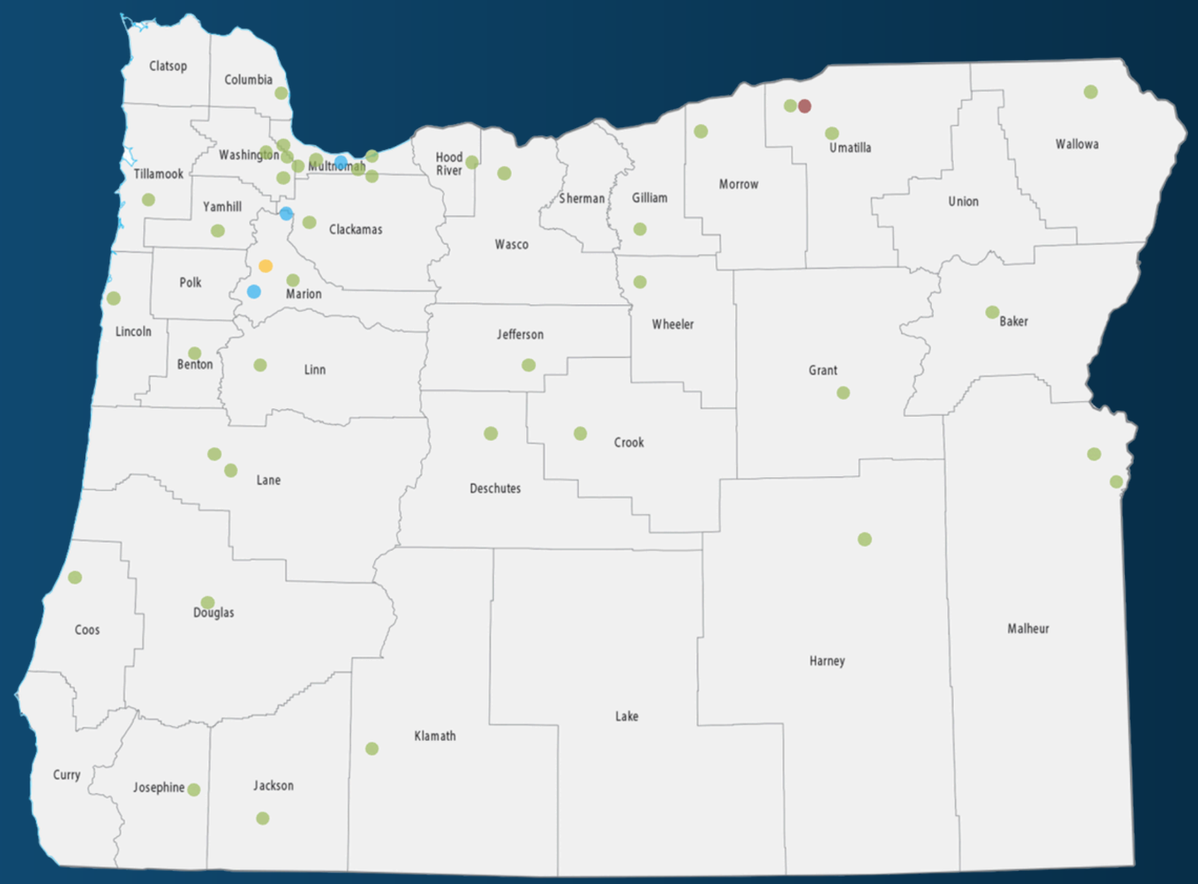
The primary scope of this analysis includes all clients who had an encounter during the FY2024-25 period and whose activities were reported in the PG Net data management system or collected through phone-based surveys. This includes clients admitted to the program in a previous fiscal year who had at least one encounter in FY2024-25, as well as those who were either admitted or discharged within FY2024-25. Notably, these results do not include clients receiving treatment through private insurance, unless otherwise stated. Limited analysis of Medicaid activities with clients diagnosed with a gambling disorder is conducted using a non–PG Net data source.

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.

FY2024-25 GEOGRAPHIC LOCATION OF PROBLEM GAMBLING TREATMENT SERVICES IN OREGON



Key

- Outpatient treatment locations
- Residential treatment locations
- Correctional locations
- Tribal behavioral health 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

Well-being and Concerned Others Attitudes
(a) Measures of well-being, and (b) Attitudes

Substance Use, Treatment Characteristics, and Problem Gambling-Related Problems
(a) Substance use, (b) Prior treatment episodes, (c) Client-reported problem behaviors related to gambling, (d) Counselor diagnostic impressions, (e) Diagnostic Profile of Medicaid clients, and (d) Gambling disorder severity

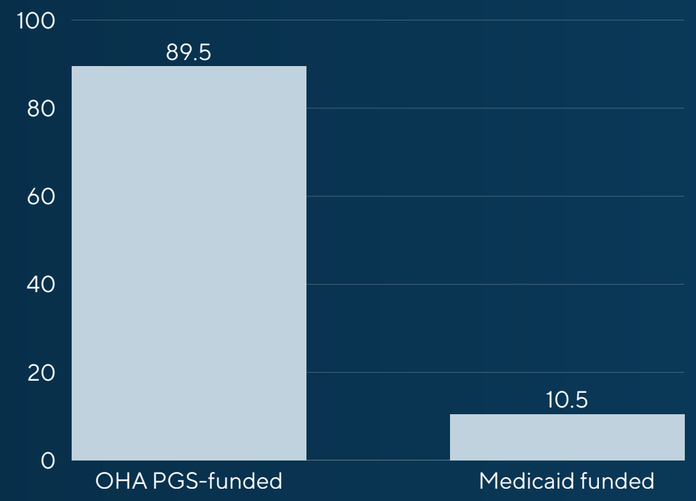
Treatment Discharge Details
(a) Reasons for discharge, (b) Behavioral indicators, (c) Factors associated with successful program completion, (d) Cost and encounter characteristics associated with successful program completion, and (e) Referrals following program discharge

OVERALL TREATMENT & SUPPORT SERVICES

OVERALL TREATMENT SERVICES DELIVERED

Client Services Delivery

During FY2024-25, the OHA Problem Gambling Services (PGS) system delivered a total of 17,634 encounters to approximately 833 clients. The majority of encounters (89.5%) were funded by OHA, with the remaining 10.5% funded through Medicaid-funded PG services and Medicaid-funded integrated PG specific services. In addition, OHA PGS provided access to the Evive problem gambling harm-reduction digital support app to 211 Oregonians and facilitated free financial consultations through GamFin for approximately 42 Oregonians.*



* The number of Oregonians receiving GamFin services is an estimate based on total clients receiving services.

Definitions

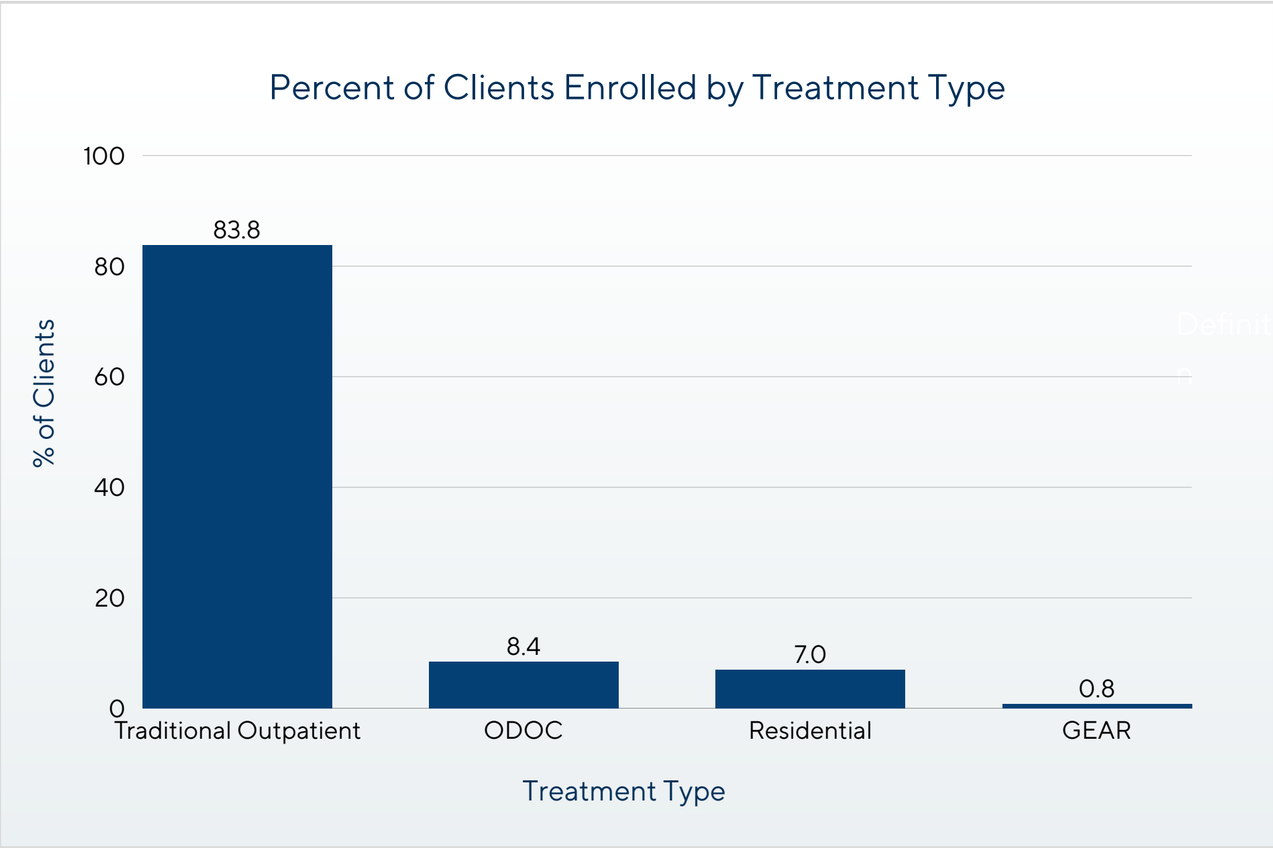
An ***encounter*** is a unit of direct client contact (e.g., a session between a client and a provider). The length of an encounter varies by treatment service type.

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.

OHA PGS FUNDED TREATMENT PROGRAMS

The network of problem gambling services funded by OHA PGS offers a wide range of treatment options tailored to individual needs. The majority of clients were enrolled in Traditional Treatment, while 8% received services through the ODOC program, 7% received Residential Treatment, and 1% participated in the GEAR program.



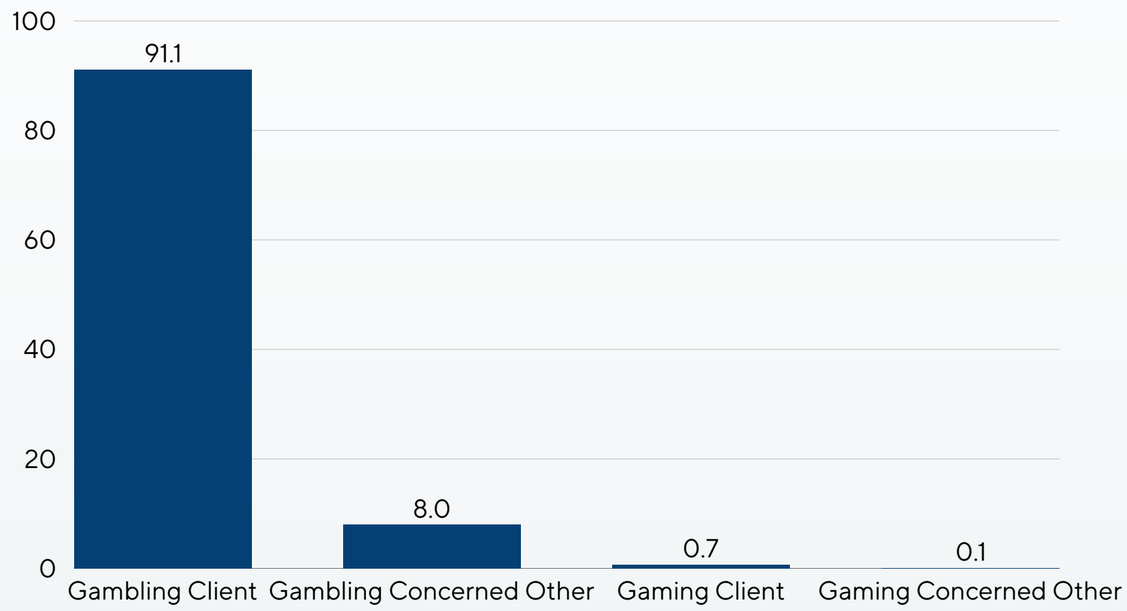
Treatment Types

- **Traditional Outpatient:** Traditional outpatient treatment is typically delivered in a community mental health and/or addiction treatment setting and may include individual and family counseling, group therapies, peer support, and outpatient counseling, delivered by a certified gambling addiction counselors who are also mental health or substance abuse professionals. This service is available to any Oregon resident with gambling or gaming related concerns.
- **Oregon Department of Corrections (ODOC):** OHA PGS supports the Gambling Reduction and Recovery for Incarcerated Populations (GRIP) Program, available at Coffee Creek Correctional Facility and Columbia River Correctional Institution. GRIP is a psychoeducational group consisting of 12 sessions specifically designed for incarcerated adults who are concerned about their gambling behavior, either as a current issue or as a threat to their post-release success.
- **Residential:** Treatment that involves individuals staying at a treatment facility that provides an immersive and comprehensive gambling disorder treatment program.
- **GEAR:** A telehealth 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.

CLIENT TREATMENT TYPES

In FY2024-25, 91% of clients received services for their own gambling behaviors, 8% were individuals affected by another persons gambling (concerned others), and less than 1% received services related to social gaming, either for themselves or as concerned others. In FY2023-24, the distribution of gambling-related clients was similar.

In FY2024-25, OHA PGS began treating clients for issues related to social gaming. Social gaming issues involve excessive play of electronic games that interfere with daily functioning, relationships, or well-being and do not necessarily involve gambling or gambling-like features.



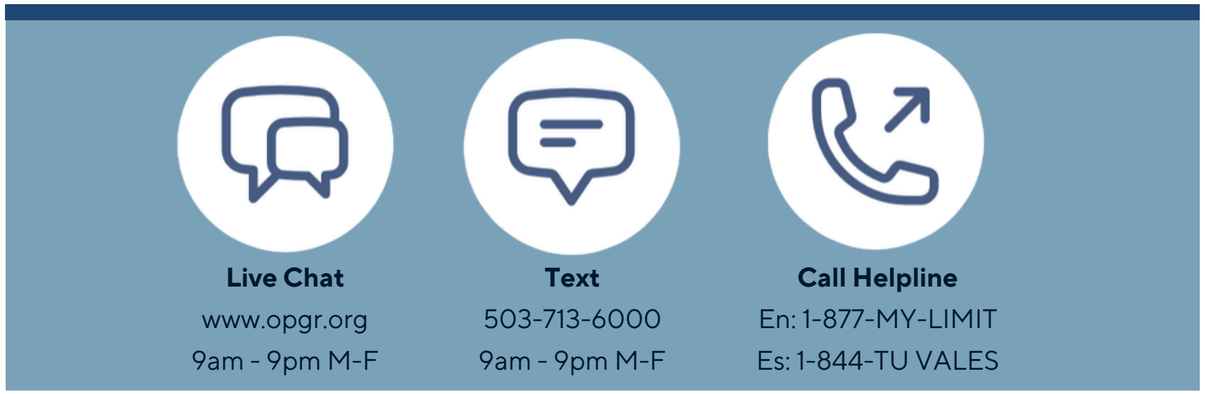
HELPLINE CALL CLIENT SERVICES

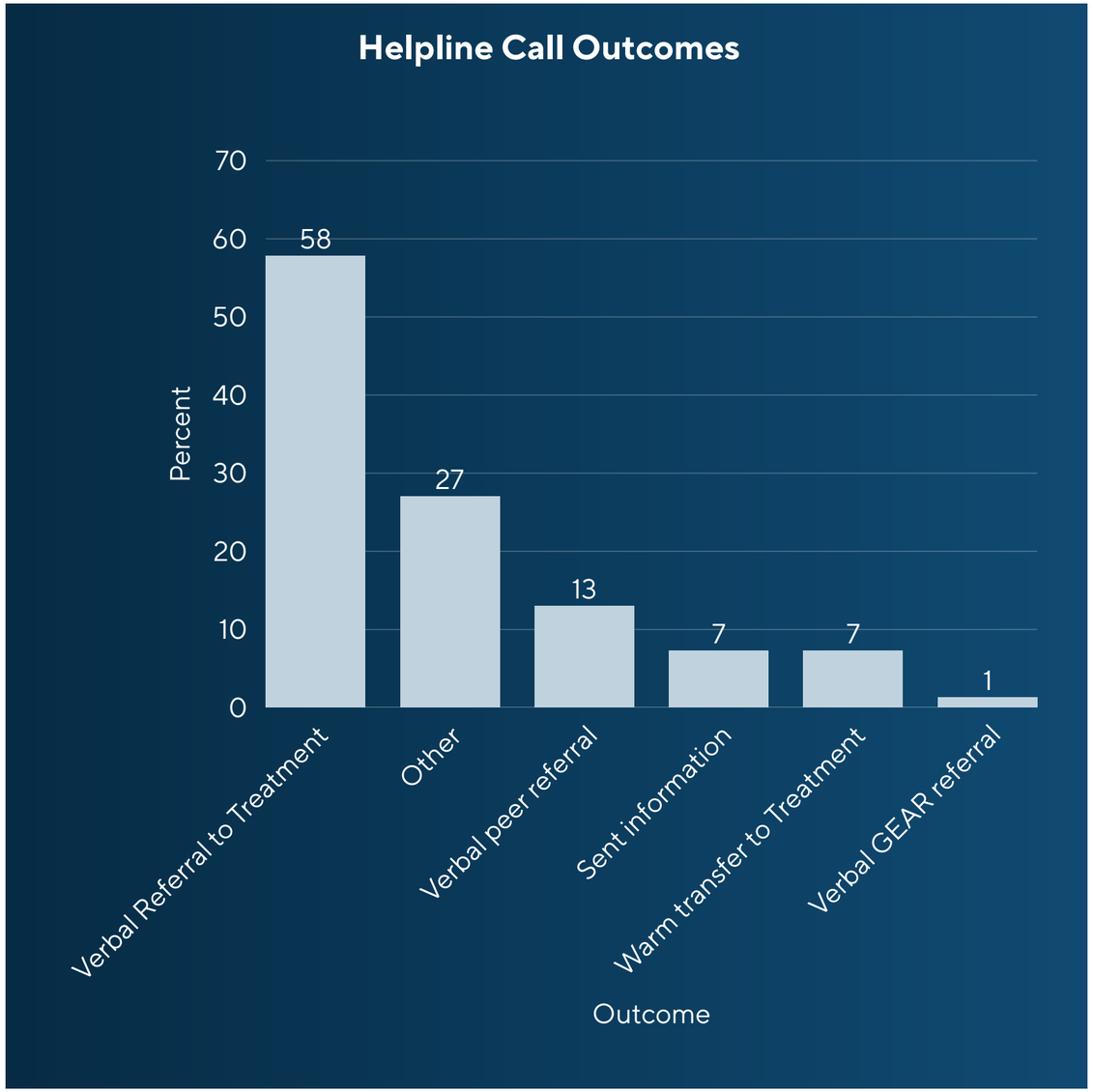
8% of callers reported their primary language was Spanish. 1-844-TU VALES

OHA contracts problem gambling helpline services via phone (1-877-MY-LIMIT, available 24/7), chat (opgr.org, 9:00 AM–9:00 PM, Monday through Friday), and text (1-503-6000, 9:00 AM–9:00 PM). In FY2024-25, the helpline received 564 calls from individuals seeking support for their own gambling behaviors or from concerned others. This volume was virtually unchanged from the 560 calls received in FY2023-24.

Of these calls, 72% resulted in verbal referrals to treatment counselors, peer support specialists, or the GEAR program, and 7% involved a warm transfer to crisis counseling services. Additionally, 7% of callers were provided with informational resources, while 27% received other types of support services. (Note, callers may receive multiple services during a single contact; therefore, percentages do not sum to 100%.).

Eighty-nine percent of callers were seeking help for their own gambling behaviors, while the remaining 11% were concerned others. In addition, 8% of callers reported Spanish as their primary language.

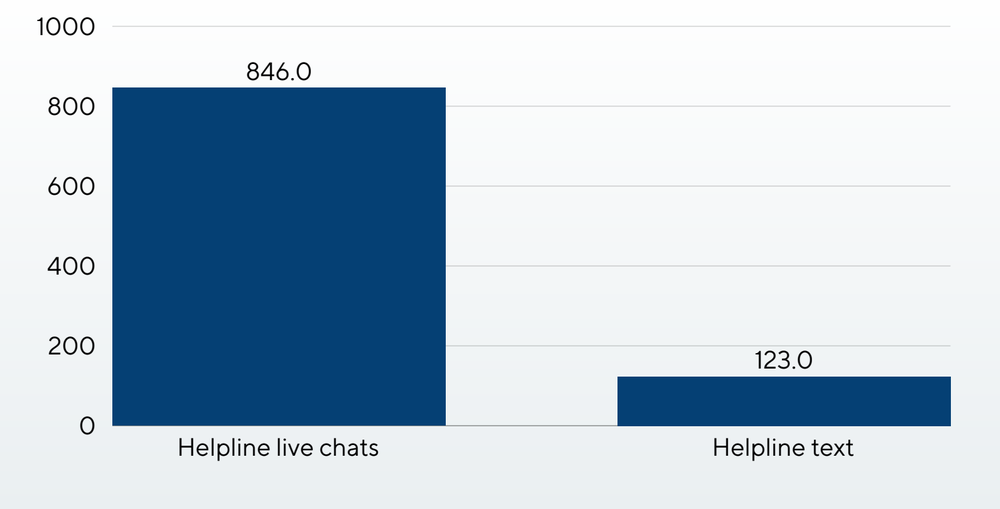




HELPLINE ONLINE CLIENT SERVICES

During the 2024 calendar year, the Oregon Problem Gambling Resource website (opgr.com) recorded 644,000 site sessions, a 126% increase from the previous year. In addition, 16,856 site visitors engaged in an action (e.g., live chat, search for a community meeting, such as Gamblers Anonymous, and learn about Evive), a 9% increase from the previous year.

The website also facilitated 123 helpline text interactions and 846 helpline chats, resulting in 404 referrals to treatment services.



TRADITIONAL TREATMENT SUPPORT SERVICES

TRADITIONAL TREATMENT SERVICES DELIVERED

Client Services Delivery

Through its network of 42 problem gambling treatment programs, the PGS Traditional Treatment programs conducted 12,288 treatment encounters, serving 698 unique clients during FY2024-25. Compared to the previous year, the number of encounters increased by 46%, however, the number of unique clients served decreased by 16%. The increase in total encounters may be partially explained by improved data submission practices, leading to more complete capture of service encounters, as well as the inclusion of peer service encounters that were not previously recorded in the PG Net system.

When the 2024-25 fiscal year began on July 1, 2024, there were 285 clients currently enrolled in Traditional Treatment. Over the course of the year, an additional 553 clients were admitted, while 443 were discharged, resulting in a net gain of 110 clients by the end of the fiscal year (June 30, 2025).

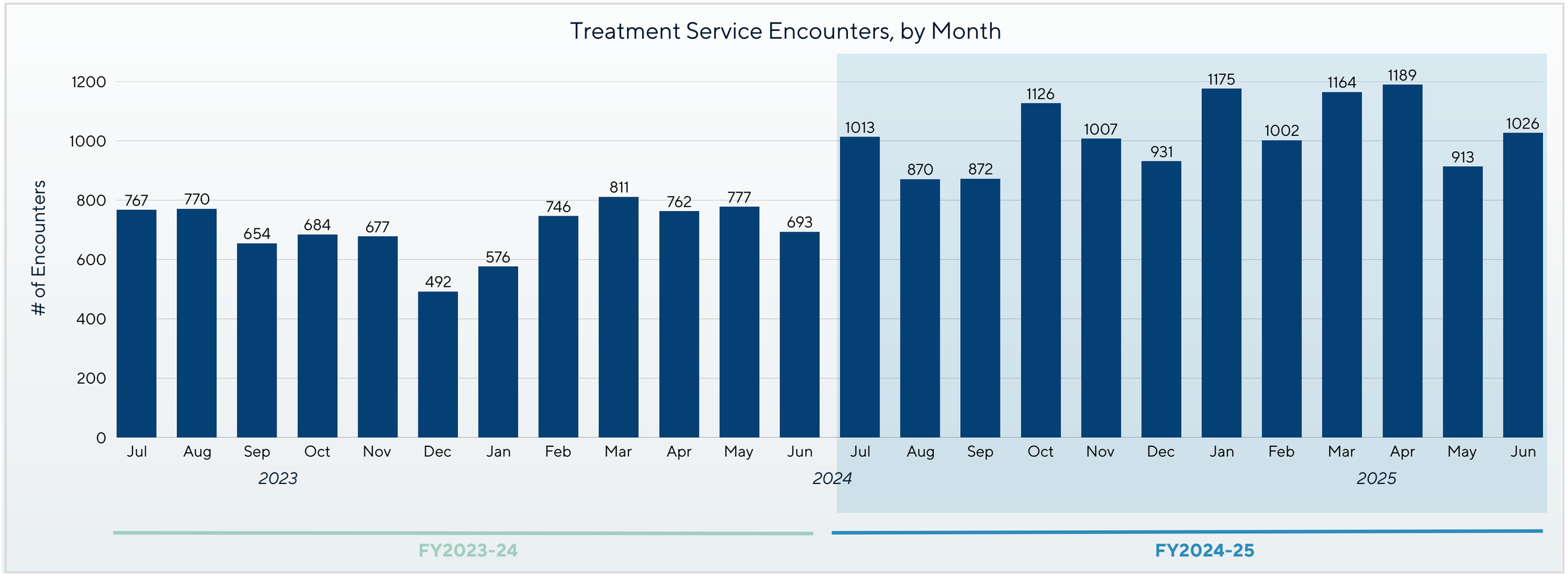
Eighty-nine percent of clients received services for their own gambling behaviors, 10% were concerned others, and 1% received services related to social gaming. This distribution of clients was similar to that in the previous fiscal year.

During FY2024-25, 698 Oregon adults received outpatient gambling treatment services through PGS-funded programs, and an additional 159 clients received Medicaid-funded treatment.

MONTHLY PGS DELIVERED SERVICES

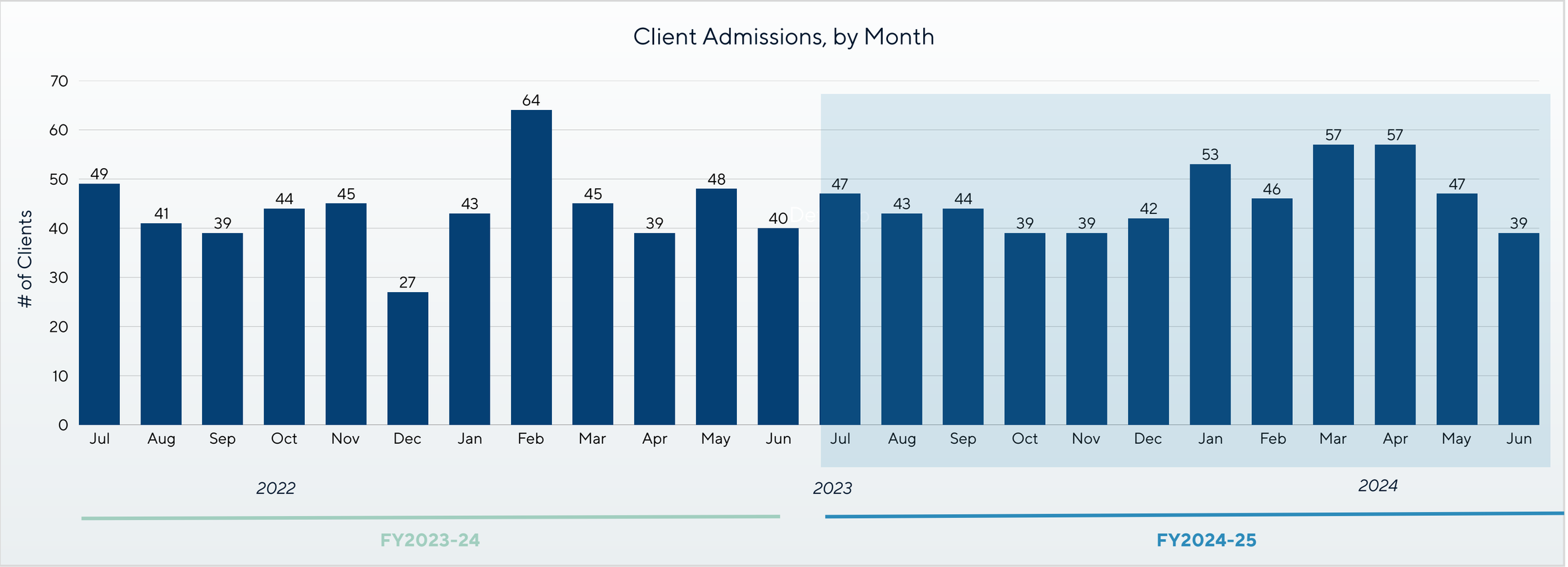
On average, the PGS PG Net system recorded 1,024 encounters per month during FY2024-25, compared to 899 per month in FY2023-24. The increase observed this fiscal year may reflect more accurate reporting of encounters, as well as the inclusion of peer service encounters that were not previously captured in the PG Net system.

In FY2024-25, January and April recorded the highest monthly encounter counts, while August and September recorded the lowest. Monthly encounter patterns in FY2024-25 were not correlated with those observed in FY2023-24. FY2024-25 Medicaid encounters followed similar patterns to those observed in Traditional Treatment activities.



MONTHLY PGS TRADITIONAL TREATMENT CLIENT ADMISSIONS

Approximately 46 clients per month were admitted into the OHA PGS Traditional Treatment system in FY2024-25. Within FY2024-25, March and April recorded the highest number of admissions, while June, October, and November had the lowest. Similar to encounter volumes, monthly admission patterns showed no correlation between FY2023-24 and FY2024-25.



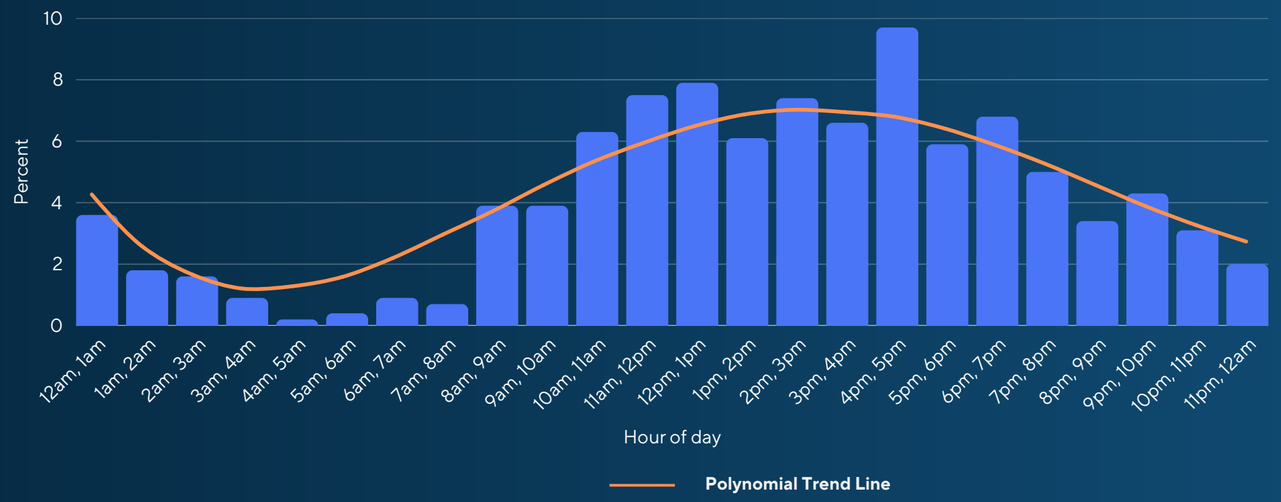
Note: Oregon Department of Corrections clients included under "Traditional Treatment" in FY2023-24 and were not included within this category in FY2024-25

HELPLINE CLIENT SUPPORT ACTIVITIES

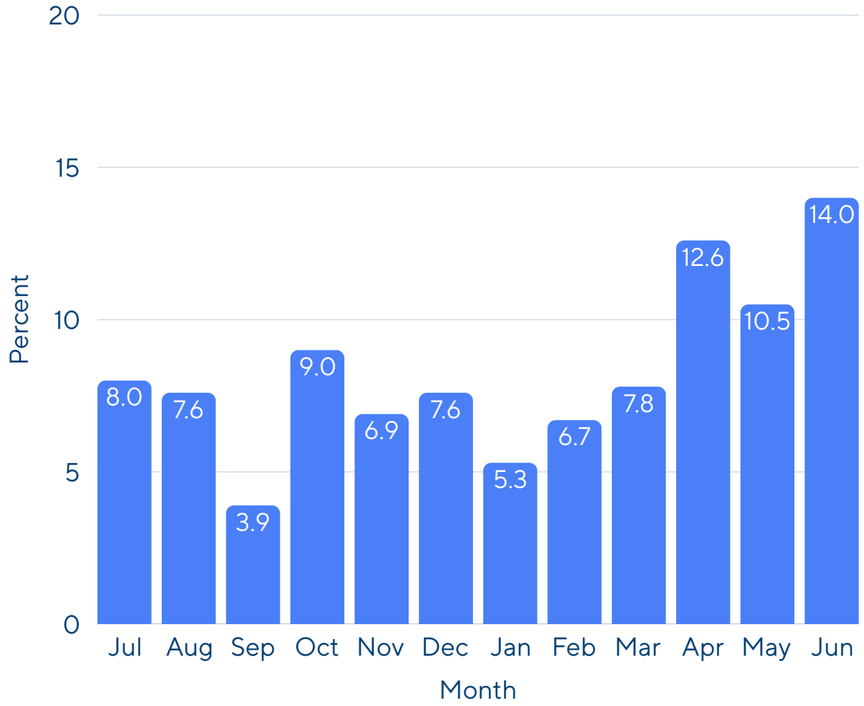
Helpline calls during FY2024-25 followed a different monthly pattern than both treatment encounters and admissions. A disproportionate share of calls occurred during the spring months (April, May, and June), approximately 50% higher than would be expected if calls were evenly distributed across the year. Mondays and Fridays were the most common days for calls, while Saturdays and Sundays were the least common.

Call volume increased around 8:00 a.m., peaked between 1:00 and 3:00 p.m., and declined during the evening and overnight hours.

Helpline Call, by Time of Day



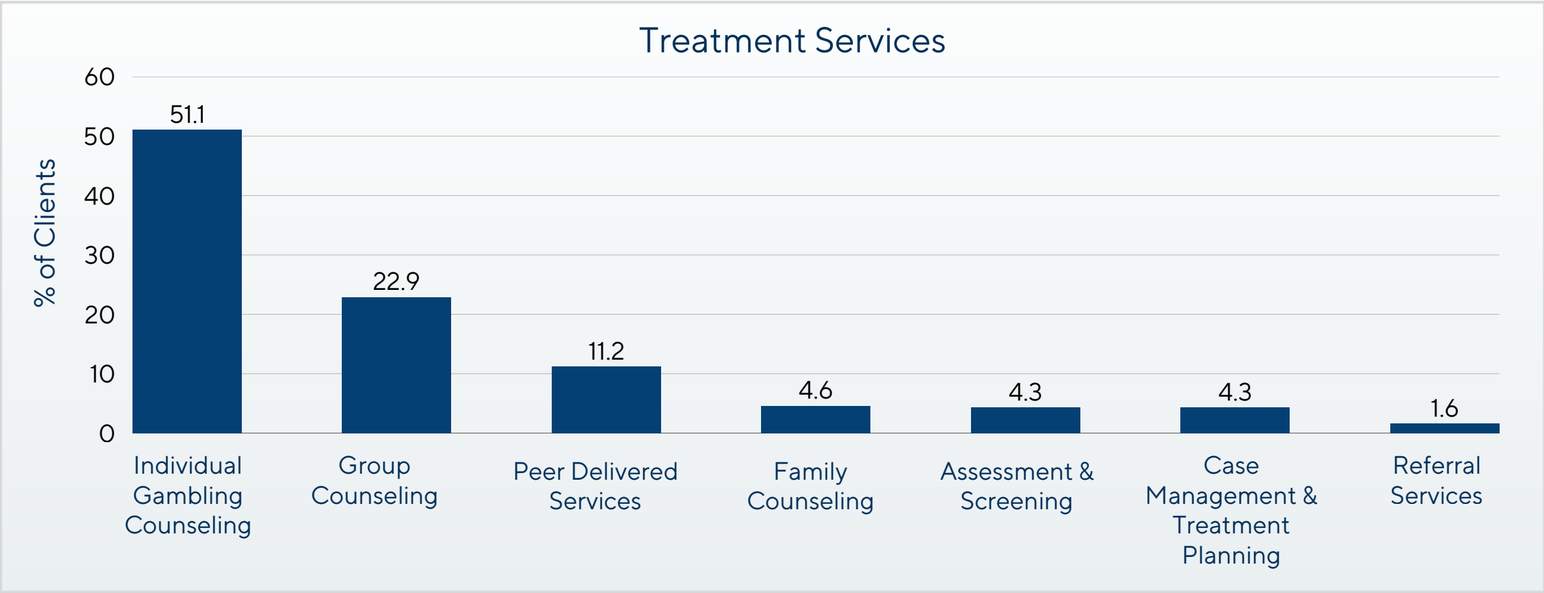
Helpline Calls, by Month



TREATMENT SERVICES DELIVERED

The most common treatment service delivered was Individual Gambling Counseling followed by Group Counseling. Group Counseling includes both group work while in active treatment and continuing care for individuals who have completed their primary problem gambling treatment. During FY2024-25, 20 clients received continuing care, a large decline from the 34 clients who received such services in FY2023-24. Peer-delivered services were the third most common type of treatment service delivered.

The largest year-over-year change was the increase in reported peer services, which accounted for 1.7% of all Regular Treatment services in FY2023-24. This increase is largely attributable to the inclusion of the HOPE Peer Mentoring Program, the program that delivers the majority of peer services, which was not included in the PG Net data system in FY2023-24 and therefore was not reflected in that year's reporting. In FY2024-25, five agencies delivered some level of peer-delivered services, compared to eight agencies in the previous year.



Continuing Care Services

Support services provided in a group setting to individuals who have completed treatment for their problem gambling related challenges. These services are designed as an aftercare support to help clients maintain the progress they made during treatment and continue their recovery journey. Services include skill reinforcement, long-term recovery focus, and emotional support.

Medicaid

The distribution of the two most common service types among Medicaid-covered clients was similar to that of clients receiving non-Medicaid-funded services, with 45% allocated to Individual Gambling Counseling and 21% to Group Counseling.

CLIENT LOCATION

County	% of clients in PGS treatment population	% of Oregon population (1)	% over or under represented (2)
Multnomah	24.3	18.9	28.5
Washington	19.2	14.5	32.2
Lane	12.3	9.1	35.4
Marion	9.5	8.4	13.3
Clackamas	7.7	10.1	-23.9
Josephine	2.9	2.1	38.2
Deschutes	2.8	5	-44.3
Umatilla	2.6	1.9	35.9
Linn	2.3	3.1	-26.9
Crook	2.2	0.6	238.7
Jackson	2	5.3	-62
Yamhill	1.7	2.6	-35.5
Columbia	1.7	1.3	32.3
Out of Oregon	1.2	0	NA
Other	7.8	17	-54

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 most populous counties, Multnomah, Washington, Lane, and Marion, made up 66% 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, Multnomah County represents 24.3% of the Regular Treatment population but only 18.9% of the state's population, indicating that it had a disproportionately larger share of the treatment population than expected. Similarly, Umatilla County accounted for 2.6% of the treatment population but only 1.9% of the state population. In contrast, counties such as Jackson, Deschutes, and Yamhill had treatment population shares that were smaller than their relative shares of the overall state population. Specifically, these counties are underrepresented by 62%, 44%, and 36%, 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 fewer 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 higher rates of gambling problems.

CLIENT REFERRAL SOURCE

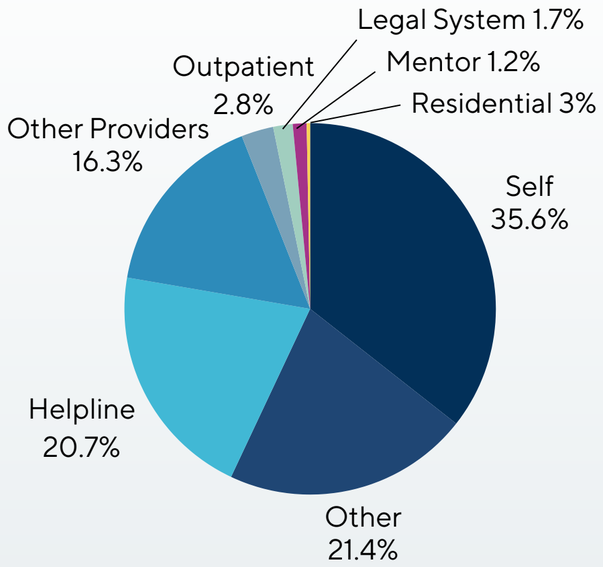
About one in three clients treated in the Traditional Treatment program in FY2024-25 reported self-referring to the program. Referrals from other sources (e.g., schools and interventions) were the second most common, followed by helpline referrals. This distribution differs markedly from FY2023-24, when more than 60% of clients reported self-referring into treatment.

36% **of clients referred themselves to gambling treatment**

21% **were referred by the gambling helpline: MYLIMIT (1-877-695-4648)**

16% **were referred by behavioral health providers**

Gambling Referred From Code



Insights from the Follow-Up Project

Readiness to engage in treatment services is an individual process. Participants in the follow-up evaluation tended to describe their decision to reach out for help as a result of growing consequences. Common stressors that motivated treatment-seeking included severe financial loss, realizing that they had lost control, strain on important relationships, and serious negative impacts on mental health.

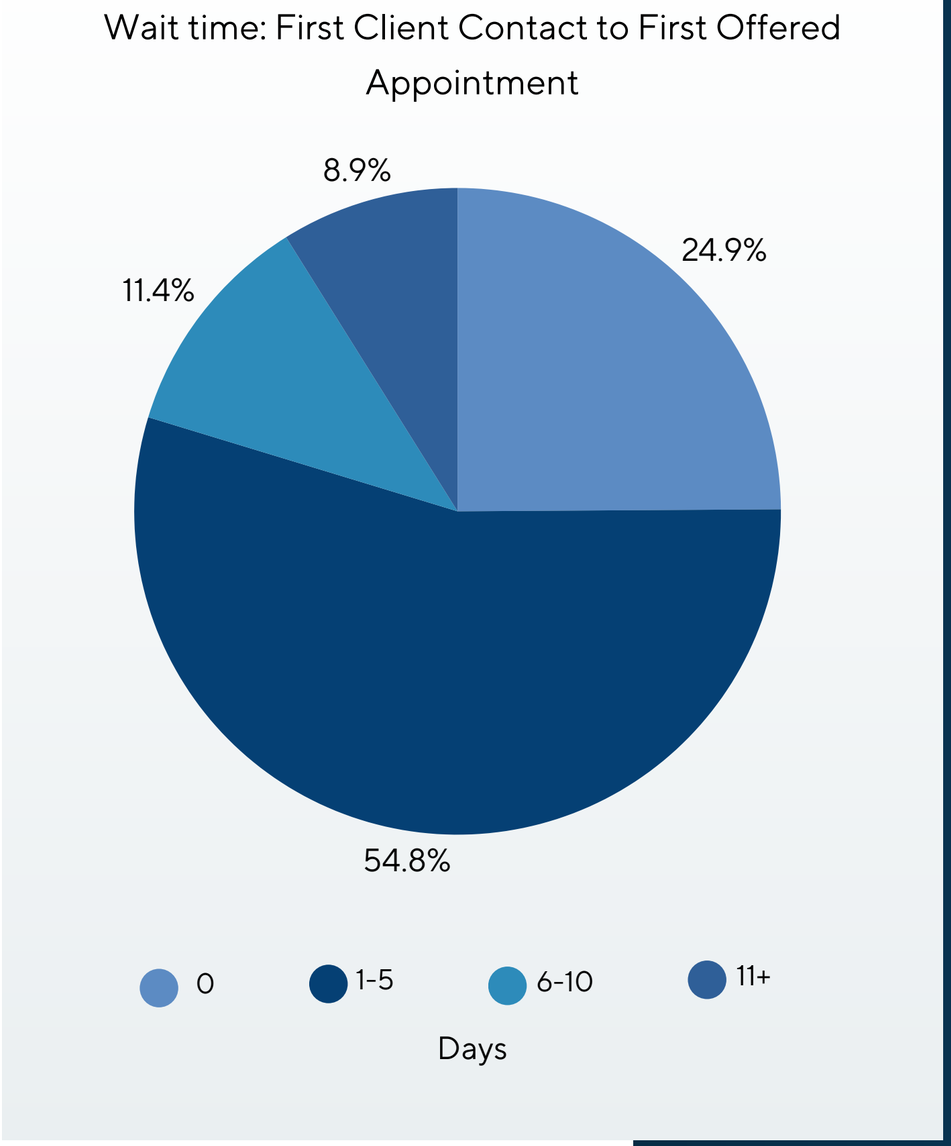
WAIT TIME

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.

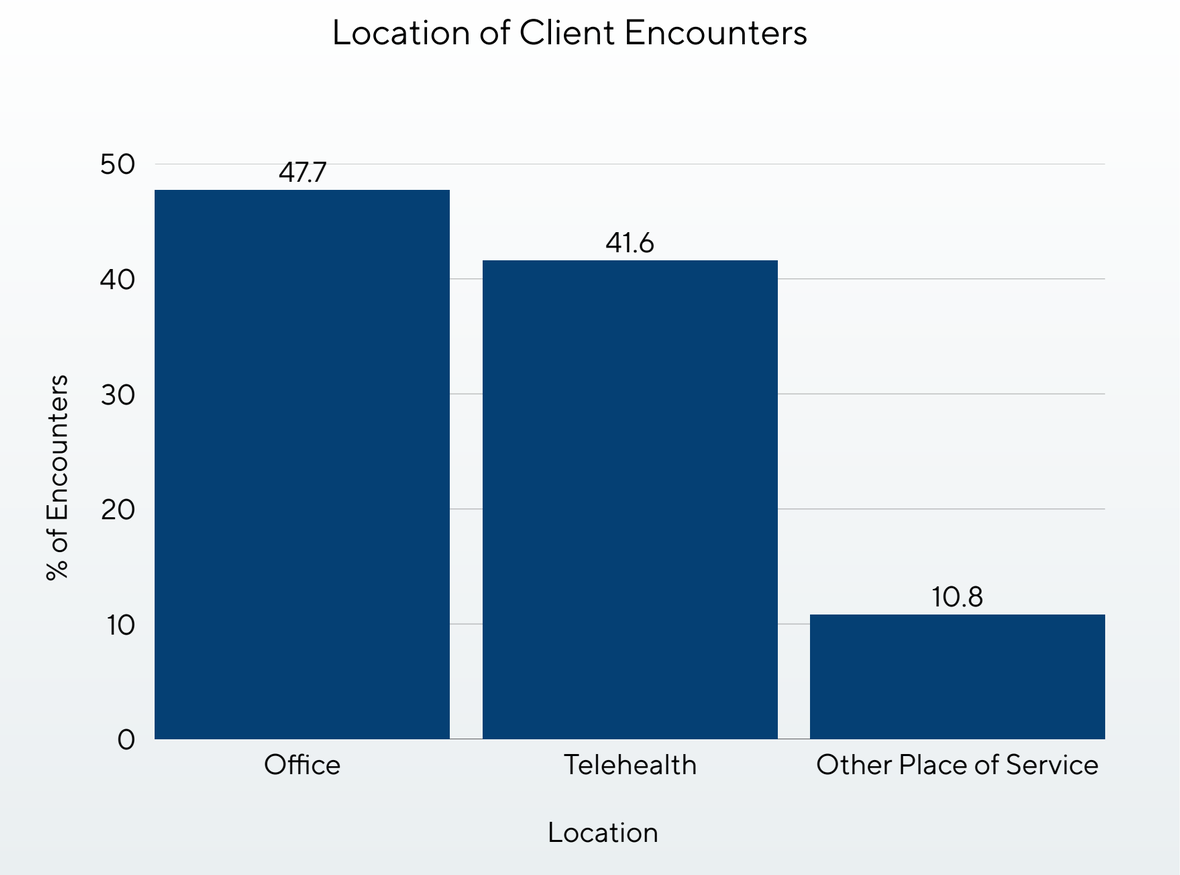
For admissions to Traditional Treatment that took place during FY2024-25, the PGS system had an average wait time of 4.5 workdays (median of 2 workdays). About a fourth of individuals seeking treatment were able to see a treatment provider without delay (same-day appointment).

Short Wait Times Get People Into Treatment Quickly

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



ENCOUNTER LOCATION

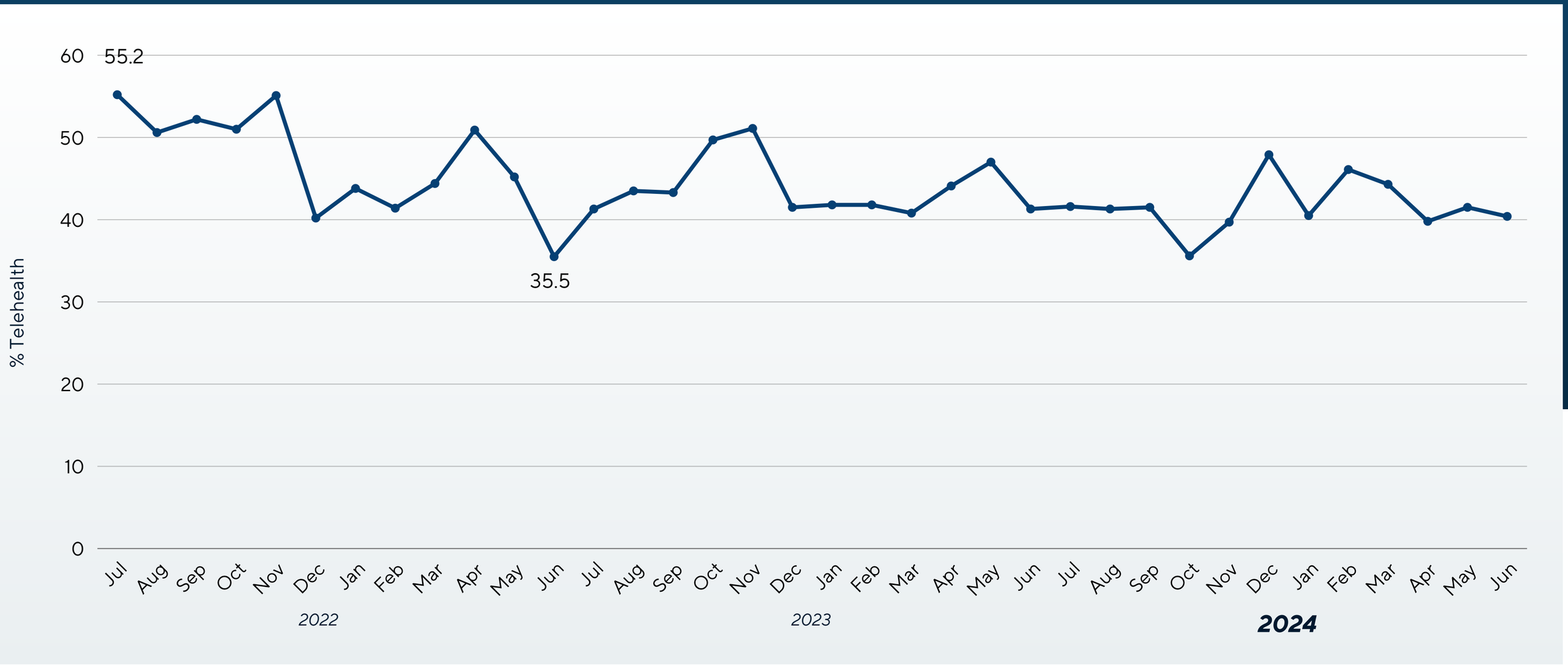


Office encounters were the most common location for client treatment in FY2024-25, accounting for about half of total FY2024-25 encounters. Telehealth was the second most common method of delivering encounters, followed by other places of service. The decrease in telehealth encounters over time has stabilized since its peak during the COVID-19 pandemic. (see graph presented on the following page entitled, "*Trends in Telehealth Service Delivery*".)

Telehealth accounted for 42% of client encounters. Compared to FY2023-24, telehealth encounters declined by 5%, reflecting stabilization of the downward trend since their peak during the COVID-19 pandemic.

TRENDS IN TELEHEALTH SERVICE DELIVERY

The use of telehealth has declined over time, ranging from a peak of 55.2% in July 2023 to a low of 35.5% in June 2023. Telehealth utilization has stabilized since the pandemic peak, averaging about 42% over the past 18 months.



TRADITIONAL GAMBLING TREATMENT

CLIENT DEMOGRAPHICS

GENDER IDENTITY

In FY2024–25, 53% of Traditional Treatment clients were male, 46% were female, and 1% identified as transgender or another unspecified gender. According to 2024 U.S. Census estimates, Oregon's population is 49% male and 51% female.* Thus, males appear overrepresented in Traditional Treatment by approximately 9% relative to their proportion in the general population. However, the most recent Oregon gambling behavior survey** found that males scored in the Problem Gambling "High-Risk" range (8+) on the Problem Gambling Severity Index at twice the rate of females (8.3% vs. 4.1%). When treatment participation is considered relative to estimated clinical need, males are in fact underrepresented in gambling treatment, while females appear to be accessing state-supported gambling treatment at roughly twice the rate of males with comparable levels of risk.

Clients in the Medicaid population were also disproportionately male, with 57% males and 44% female.

Females were more likely to be concerned other clients, accounting for 83% of this group. They were also more likely to use telehealth services, with a participation rate of 57%, compared to 50% for males. While females were more likely than males to rely on the helpline as a referral source, this difference was not statistically significant.

- 53% of clients identify as **male**.
- 46% of clients identify as **female**.
- Less than one percent (1%)*** of clients identify as transgender or another unspecified gender.

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

Helpline

Calls in FY2024-25 exhibited a gender identification distribution similar to that of the OHA PGS treatment system, with 58% identifying as male and 42% as female.

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

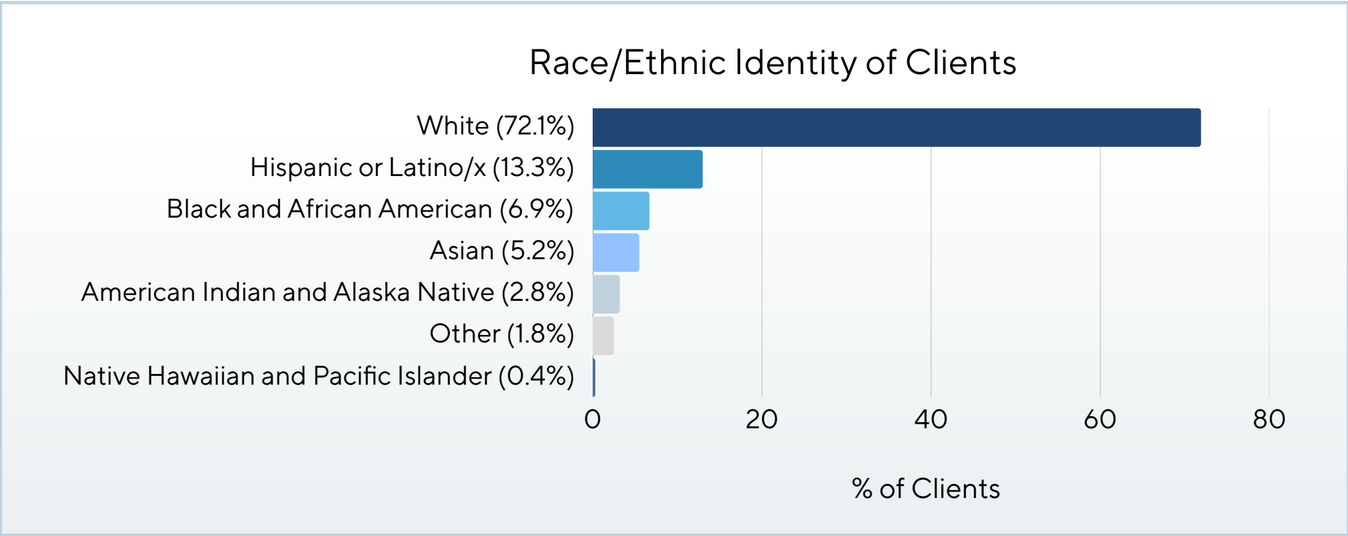
**Marotta, J., Yamagata, G., & Vasquez, P. (2025). 2024 Oregon Adult Gambling Attitudes, Behavior, and Health Survey. Hillsboro OR: Oregon Council on Problem Gambling

RACE/ETHNICITY

Clients are asked to report all race and ethnicity categories with which they identify, consistent with the REALD framework (see sidebar). About 2% identified with multiple race or ethnicity categories, which is roughly half the rate observed in FY2023-24.

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 85% of Oregonians were classified as “White Alone” as of 2024. In contrast, 70% of clients receiving Regular Treatment identified as “White Alone,” indicating a greater representation of racial and ethnic minority groups in the PGS system.

It is important to note that 33% 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.

Helpline

In FY2024-25, 65% of callers identified their primary race and ethnicity as White, followed by Hispanic or Latino/x (17%), Black or African American (7%), Asian (6%), and Other (6%). Overall, this distribution closely mirrors that of clients in the OHA PGS treatment system.

* The difference is statistically significant at the 5% level of significance. ** Source: https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/reald.aspx

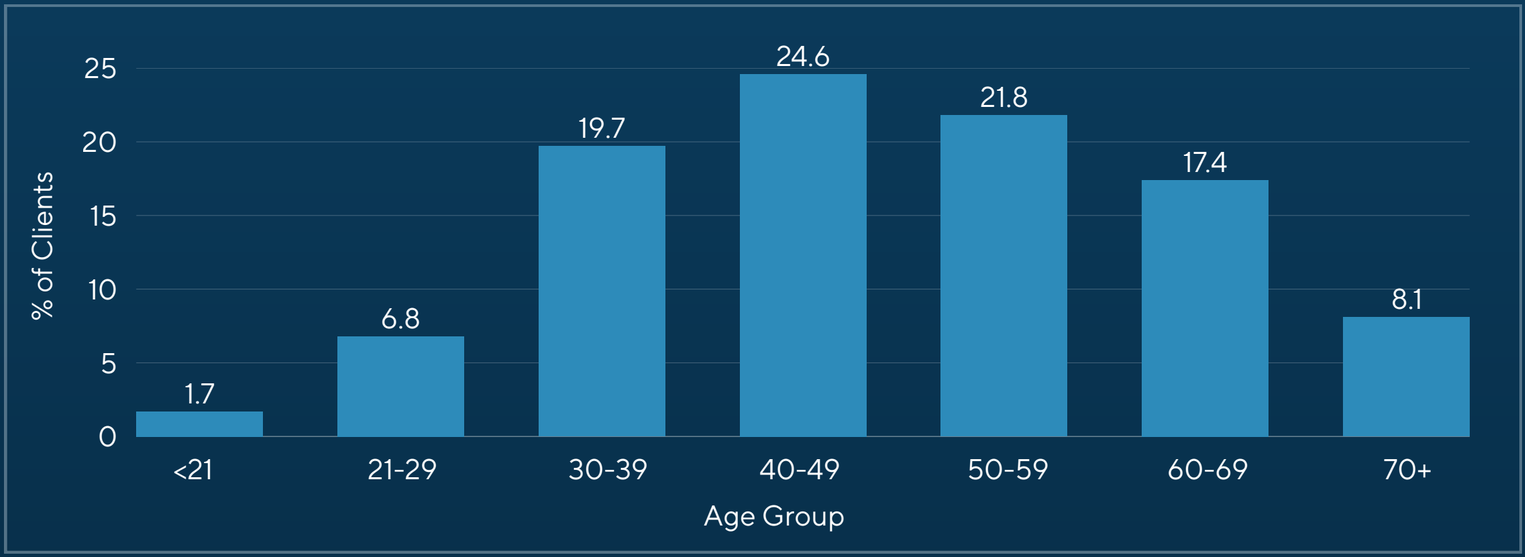
CLIENT AGE & MILITARY STATUS

Client Age

Overall, the average age of clients at the time of admission was 49, with females being older than males (53 versus 46).* This age profile was very similar to that of the previous year, which also had an average age of 49 (54 for females and 45 for males). Medicaid clients were slightly younger, with an average age of 42 (46 for females and 39 for males).

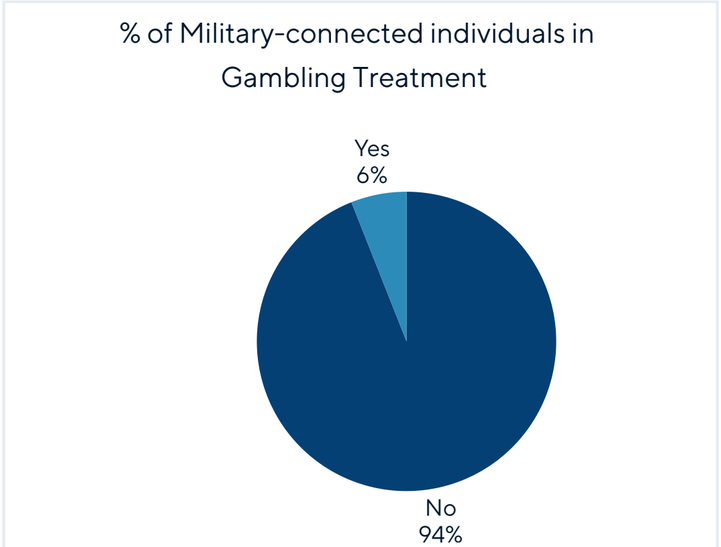
Only 1.7% of clients were under the age of 21, while the majority (66%) were between the ages of 30 and 59. By comparison, a recent 2023 census report indicated that just 39% of the general population falls within this age range,** highlighting the older age profile of individuals who seek gambling treatment.

In FY2024–25, 11% of clients reported first gambling before age 18, 11% between ages 18 and 21, and 78% at age 21 or older.



Client Military Service Status

6% of clients were connected to the military, compared to an estimated 7.4% of Oregonians who were veterans in 2022.*** 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 PG Net data.



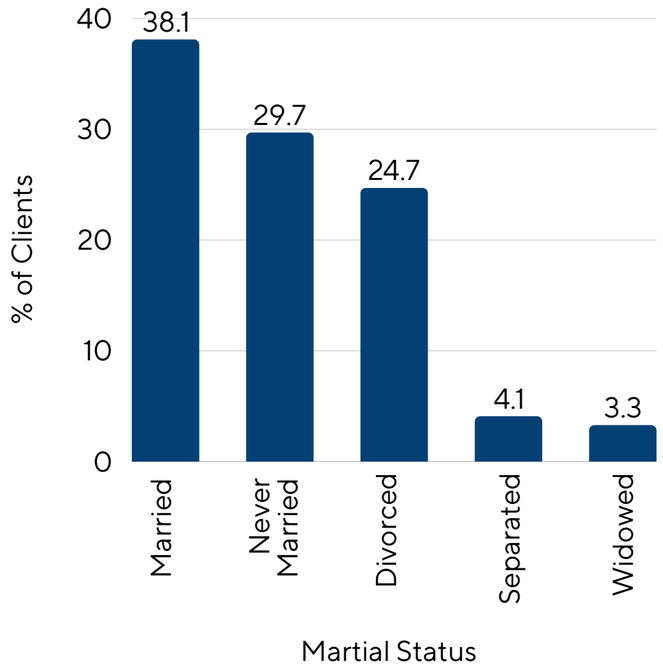
* The difference is statistically significant at the 5% level of significance.
** https://censusreporter.org/profiles/04000US41-oregon/.
*** https://usafacts.org/topics/veterans/state/oregon/#:~:text=The%20population%20share%20of%20a,nonveteran%20populations%20in%20Oregon%20compare?%E2%80%9D.

MARITAL STATUS, DEPENDENTS, & EDUCATION

Client Marital Status

At the time of admission, the most common marital status among Traditional Treatment clients was married, followed by never married and divorced.

Males were more likely than females to have never married.*



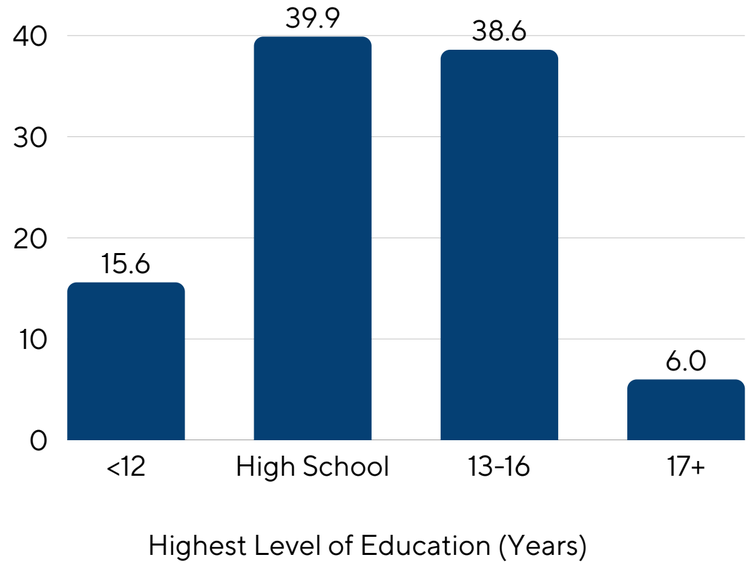
Age of Client Dependents

More than half of the clients (80%) have one or more dependents relying on them financially.

- 28% have one or more infant or children dependents
- 70% have one or more adult dependents
- 11% have one or more older adult dependents (65 or older)

Educational Attainment

Slightly over one-half (53%) of Traditional Treatment clients reported having a high school education or less. An additional 39% reported having a four-year degree (four years of post-secondary education), which aligns with recent estimates indicating that 38% of Oregonians aged 25 and older hold a four-year degree.** There was no statistically significant difference in post-secondary educational attainment between male and female clients.



* The difference is statistically significant at the 5% level of significance.

**https://www.oregonlive.com/business/2024/11/record-number-of-oregonians-have-college-degrees.html

CLIENT INCOME

Nearly two-thirds (approximately 67%) of Traditional Treatment clients reported being employed full-time or part-time. The remaining clients were retired, unemployed, or reported another employment status, such as no longer being in the labor force.

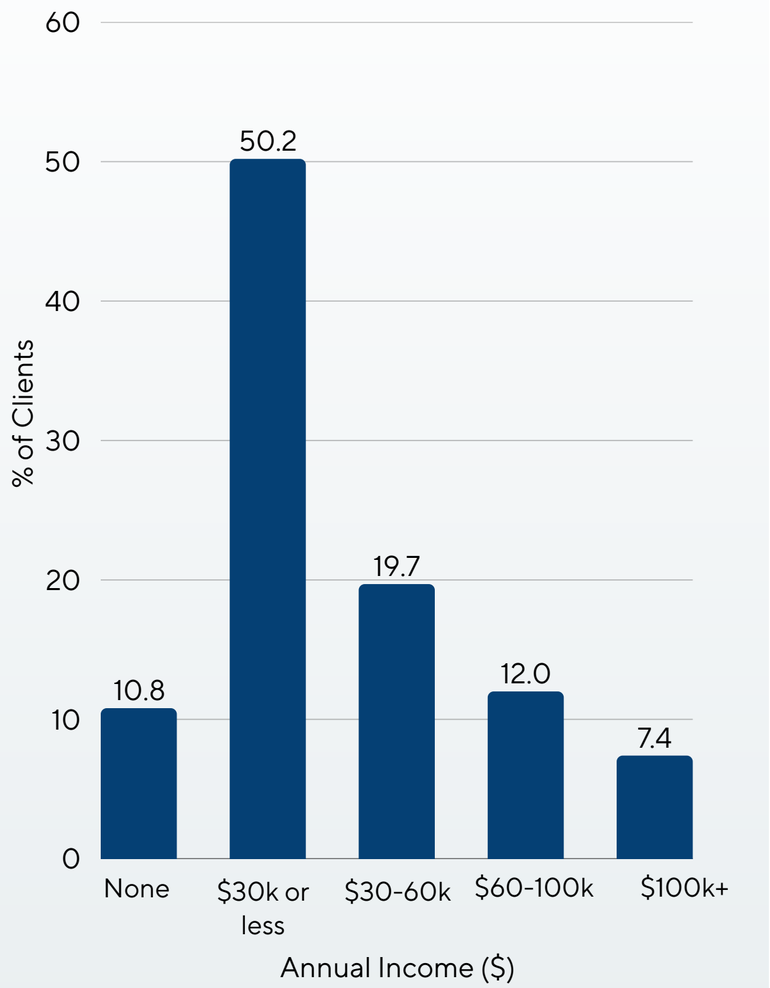
The average annual individual income was $38,704 (median: $18,672). Slightly less than two out of three clients (62%) earned less than $30,000 per year, including 11% who reported no individual income. Compared to the prior fiscal year, average income increased by 7%, up from $36,255, while median income increased by 4%.

Additionally, 23% of clients reported receiving income from fixed sources, such as pensions, disability benefits, or public assistance.

It should be noted that these financial measures reflect individual client income only and do not include household finances, such as income from partners or other family members.

Financial Challenges are Not Uncommon for Clients

About 11% of clients in treatment reported having no income, and 50% earned less than $30,000 annually. Additionally, 13% were uninsured.



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.

TRADITIONAL GAMBLING TREATMENT

GAMBLING BEHAVIOR

PRIMARY GAMBLING ACTIVITIES

Clients reported their problematic gambling activities, with the option to select multiple choices. On average, Traditional Treatment clients reported 1.3 problematic gambling activities, and 2.4% reported three or more activities. Males engaged in a higher average number of problematic gambling activities (1.4) than females (1.2).*

Electronic gaming was by far the most prevalent problematic gambling activity (82%), making it nearly six times more common than the general Other category of activities (which includes games such as bingo). Table and card games were the third most commonly reported problematic gambling activities.

Wagering on sports-related events has grown substantially in popularity over the past five years. Ten percent of clients reported sports-related wagering as a problematic gambling activity. Males were nearly eight times more likely than females to report sports-related wagering (15.4% vs. 2.1%, respectively*).

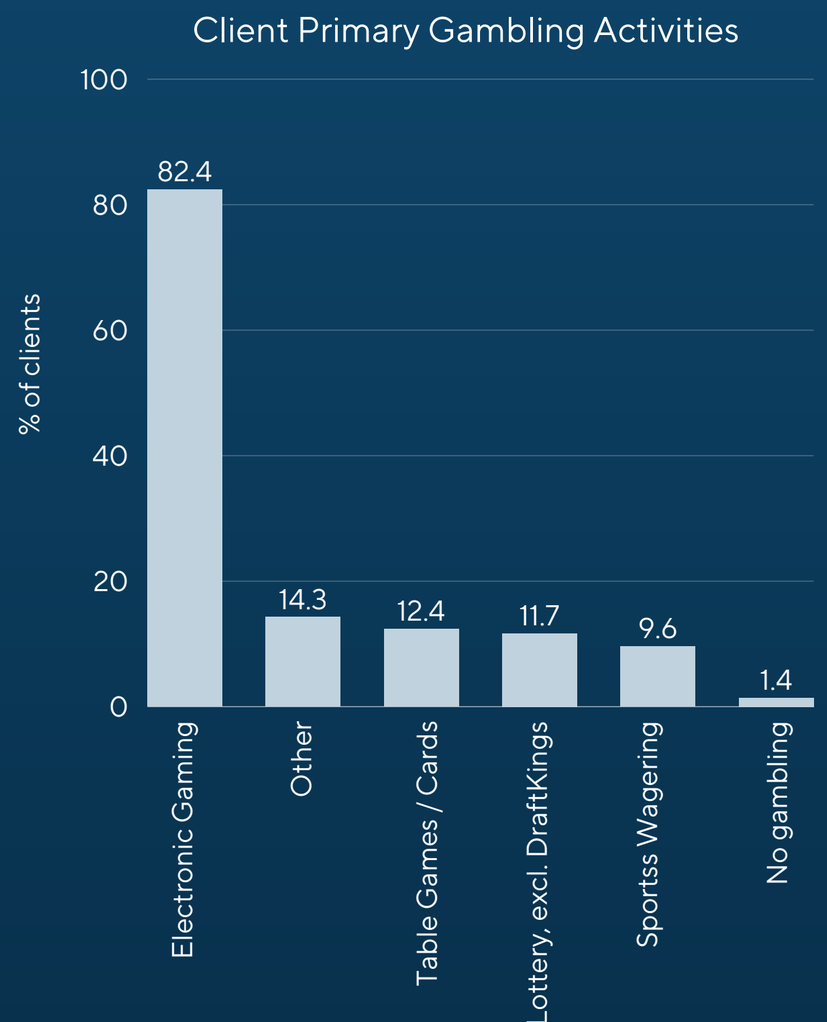
Gaming Devices

Clients being treated for social gaming issues reported the devices and game genres they most commonly used. The most frequently reported game genre was sandbox games, and the most commonly used device was the smartphone.

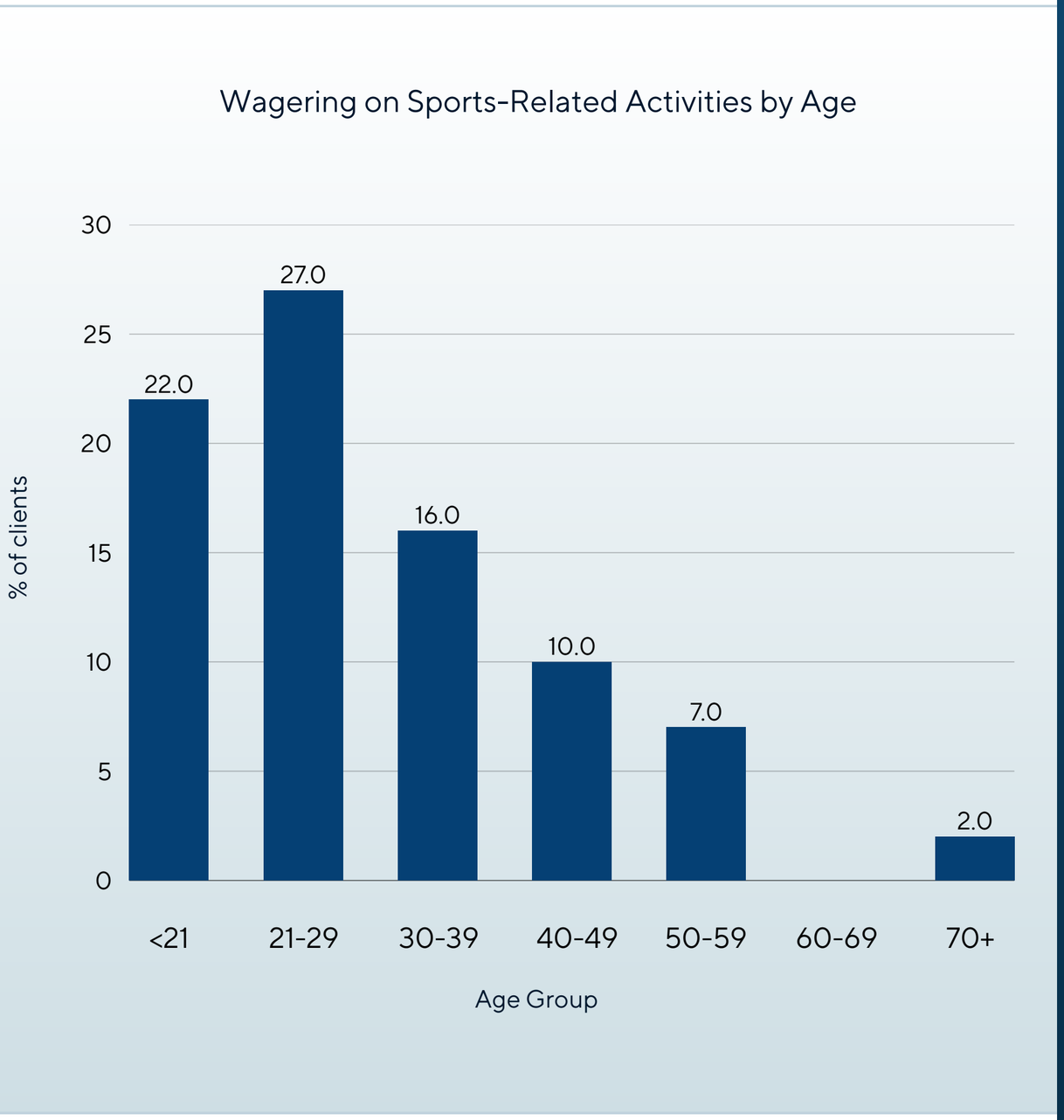
Sports Betting is Most Common in Males

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

81% of callers to the gambling helpline reported Electronic Gaming as their most problematic form of gambling activities.



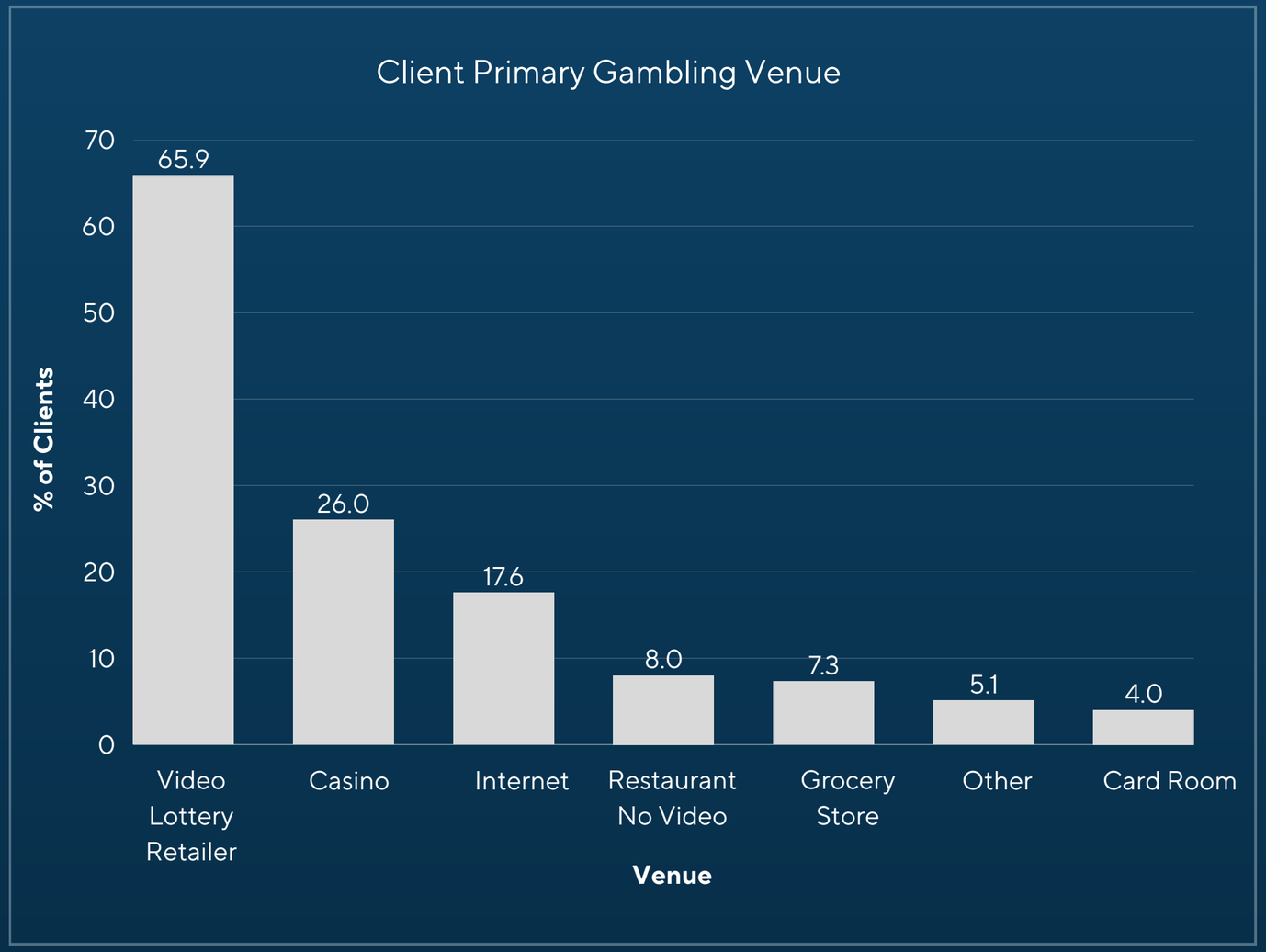
* The difference is statistically significant at the 5% level of significance.



Younger Adults Sports Gamble the Most

The popularity of betting on sporting events was significantly associated with age. Clients aged 29 and under reported the highest participation rate, while very few clients aged 60 and over reported sports-related primary gambling 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, followed by casinos.

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.

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.

* The difference is statistically significant at the 5% level of significance.

TRADITIONAL GAMBLING TREATMENT

WELL-BEING SELF-ASSESSMENTS, CONCERNED OTHERS, & ATTITUDES

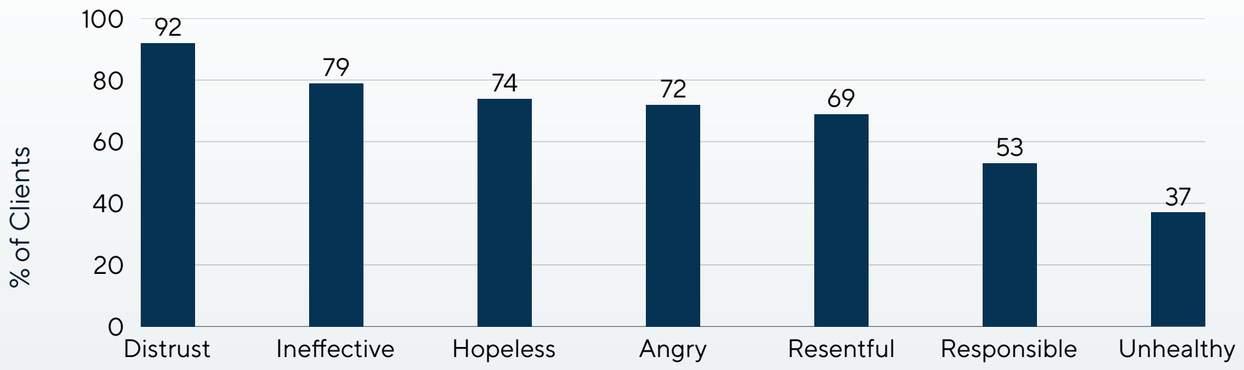
WELL-BEING

During the intake process, clients are asked to rate their satisfaction with ten well-being measures over the past 30 days. Responses are recorded using a three-point Likert scale (Dissatisfied, Neutral, and Satisfied). The chart displays the proportions of Dissatisfied and Satisfied responses only; Neutral responses are omitted to improve interpretability. Measures are ordered by the highest levels of dissatisfaction.

Client dissatisfaction is highest in the financial domain, with nearly three out of four clients reporting dissatisfaction, followed by emotional and relationship well-being. This pattern suggests that individuals entering treatment commonly experience challenges across multiple life domains.

Males and females reported similar levels of dissatisfaction across all domains, with no statistically significant differences observed.

CONCERNED OTHERS: FEELINGS AND ATTITUDES



During the intake process, concerned other clients are asked about their feelings toward the person in their life experiencing gambling problems. The data show very high agreement with negative emotional and cognitive states, particularly those associated with loss of trust, reduced self-efficacy, and emotional distress. In addition, about one in three concerned other clients have experienced physical health issues associated with the gambling issues in their lives.

Key

Resentful: Feels resentful towards the person in their life experiencing gambling problems

Anger: Feels anger toward the person with a gambling problem

Distrustful: Feels distrustful of the person with a gambling problem

Guilty: Feels guilty or responsible for causing or contributing to the gambling

Hopelessness: Feels hopeless about the gambling problem

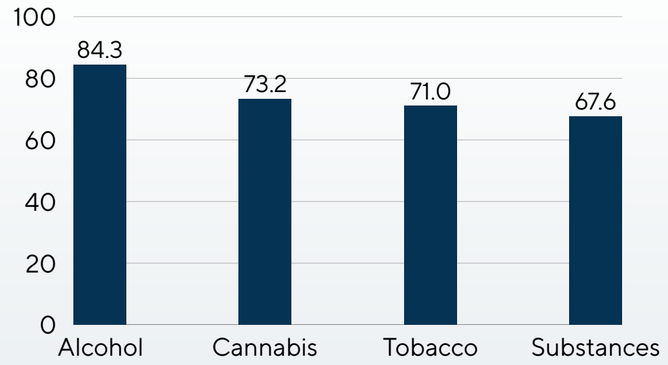
Ineffective: Feels ineffective as a support person to the person with the gambling problem

Unhealthy: Has experienced physical health problems due to the stress of the situation

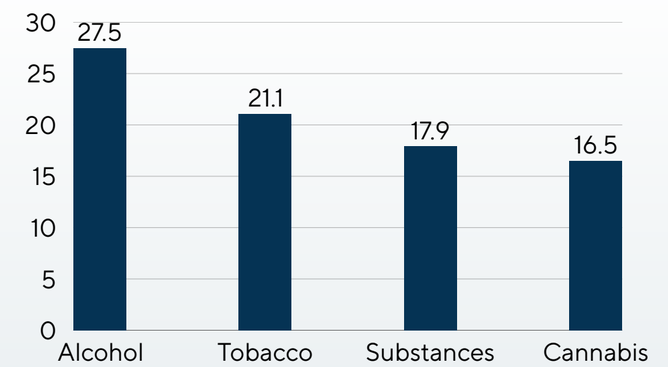
TRADITIONAL GAMBLING TREATMENT

TREATMENT CHARACTERISTICS, SUBSTANCE USE, & GAMBLING-RELATED PROBLEMS

SUBSTANCE USE AND ISSUES



Clients were asked about their substance use within the six months prior to entering gambling treatment. On average, clients reported using three substances. Although alcohol was the most commonly reported substance, high levels of use were observed across all substances assessed.



Clients were also asked whether they had experienced problems related to their substance use within six months before admission. Among clients who used the respective substances, alcohol was associated with the highest rate of reported problems, followed by tobacco, other substances, and cannabis. Males reported higher rates of alcohol-related problems than females (31% vs. 22%, respectively), while females reported higher rates of tobacco-related problems (24% vs. 19%, respectively). However, both results were marginally statistically insignificant. Both males and females reported similar rates of problems related to cannabis and other substances.

TREATMENT CHARACTERISTICS

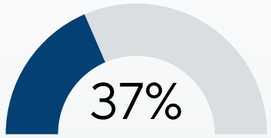
Prior Treatment Episodes

68% 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 TraditionalTreatment system. These episodes represent professional counseling for at least one of these areas. Among these, mental health treatment was the most common (44%), followed closely by gambling (37%), and substance use (28%). These results were comparable to the previous year.

Gender-specific trends indicate that females were more likely than males to have received prior treatment for mental health issues,* while males were more likely to have sought treatment for substance use.* During FY2024-25, 157 clients reported having been treated for a substance use disorder (SUD) before or concurrently with their admission into gambling treatment; of these clients, 23% were female, and 32% were male.

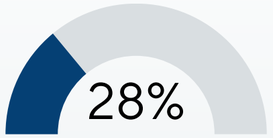
* The difference is statistically significant at the 5% level of significance.

Gambling Treatment Clients are Likely to Have Sought Behavioral Health Treatment Before



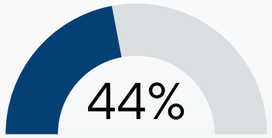
had previously received treatment for gambling

34% for males compared to 41% for females.



had previously received treatment for substance use

32% for males compared to 23% for females.



had previously received treatment for mental health

38% for males compared to 49% for females.

Client-Reported Problems Related to Their Gambling

Upon intake, clients are asked whether they experience specific problems related to their gambling. Twelve percent reported no problems, 16% reported one, 32% reported two, and 40% reported three or more problems. Financial problems were the most prevalent, with about four out of five clients reporting them. Relationship-related issues were a close second, with three out of four clients reporting relationship problems. These patterns were similar to those observed in FY2023–24.

Overall, clients reported an average of 2.2 problems, with no statistically significant differences between males and females.

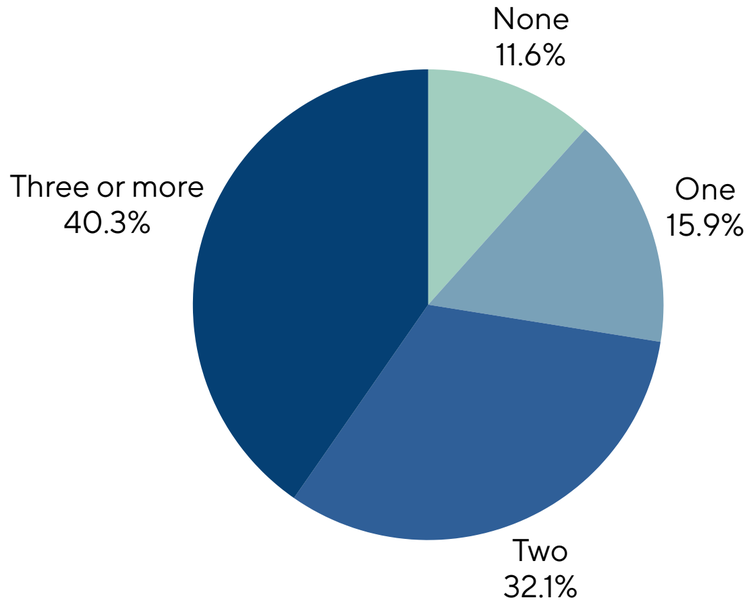
Financial problems are the most reported problem among clients.

82% report financial problems

Suicidal thoughts or actions affects **one out of three** Traditional Gambling Treatment clients.

Gambling-Related Problem	% of Clients Endorsing
Financial	82
Relationship	75
Job or school	33
Suicidality*	33
Banktuptcy	11
Legal	10

Number of Gambling-Related Problems Reported by Clients



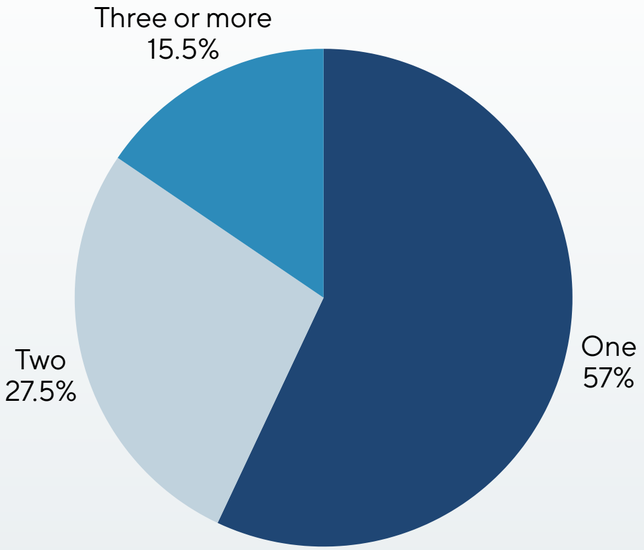
*Suicide threat was positive if client reported suicidal thoughts, threats, actions, or plans.

Counselor Diagnostic Impressions For Traditional Treatment Clients

The most common primary diagnostic impression was Gambling Disorder, which was assigned to 97% of clients. The most common secondary diagnoses were substance-related disorders, followed by mood disorders, each affecting approximately one in five Traditional Gambling Treatment clients.

Most clients received a single diagnostic impression, although 40% received two or more. On average, clients received 1.6 diagnostic impressions, with no meaningful differences between males and females.

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.



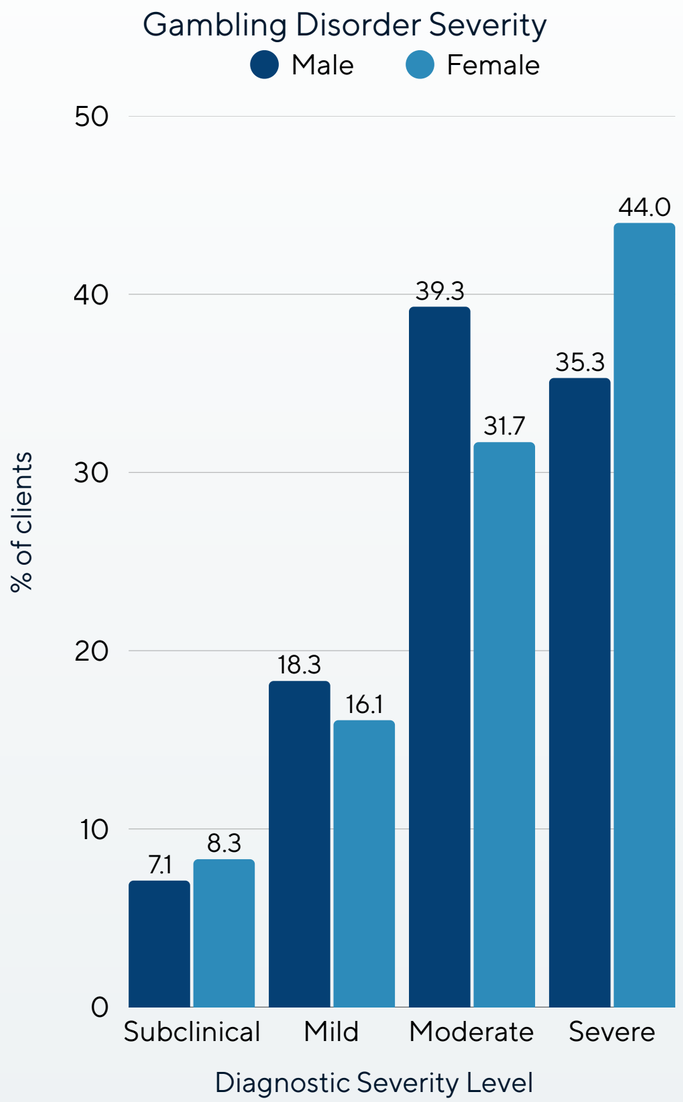
Clients Funded by Medicaid

In FY2024-25, among clients diagnosed with a Gambling Disorder in the Medicaid system, 84% had Gambling Disorder as a primary diagnosis, 14% had it listed as a secondary diagnosis, and the remaining 2% had it listed as a tertiary or quaternary diagnosis. The five most common co-occurring diagnoses among clients with Gambling Disorder were Alcohol Use Disorder (13%), Amphetamine-Type Substance Use Disorder (9%), Generalized Anxiety Disorder (7%), Post-traumatic Stress Disorder (7%), and Disruptive Behavior Disorders (2%).

Clients Funded by Medicaid Within the Integrated Co-occuring Disorder Program (ICD)

In FY2024-25, slightly less than half of ICD clients had Gambling Disorder as the primary diagnosis, approximately one-third had it listed as a secondary diagnosis, and the remaining 21% had it listed as a tertiary or quaternary diagnosis.

The most common pairs of diagnoses are Gambling Disorder and Substance Use Disorder (22%), Gambling Disorder and Mental Health (8%), Substance Use Disorder and Mental Health (7%), and Gambling Disorder and Other (0.7%).



Gambling Disorder Severity

At admission, clients undergo a comprehensive psychosocial assessment that typically includes an evaluation of Gambling Disorder severity based on DSM-5 diagnostic criteria. Overall, 18% of Traditional Treatment clients were diagnosed with Mild severity, 36% with Moderate severity, and 39% with Severe severity in FY2024-25. In comparison, during FY2023-24, the proportion of clients diagnosed with severe Gambling Disorder was 31%, which is statistically significantly lower than in FY2024–25.

Females exhibited a higher rate of Severe severity diagnoses compared to males.*

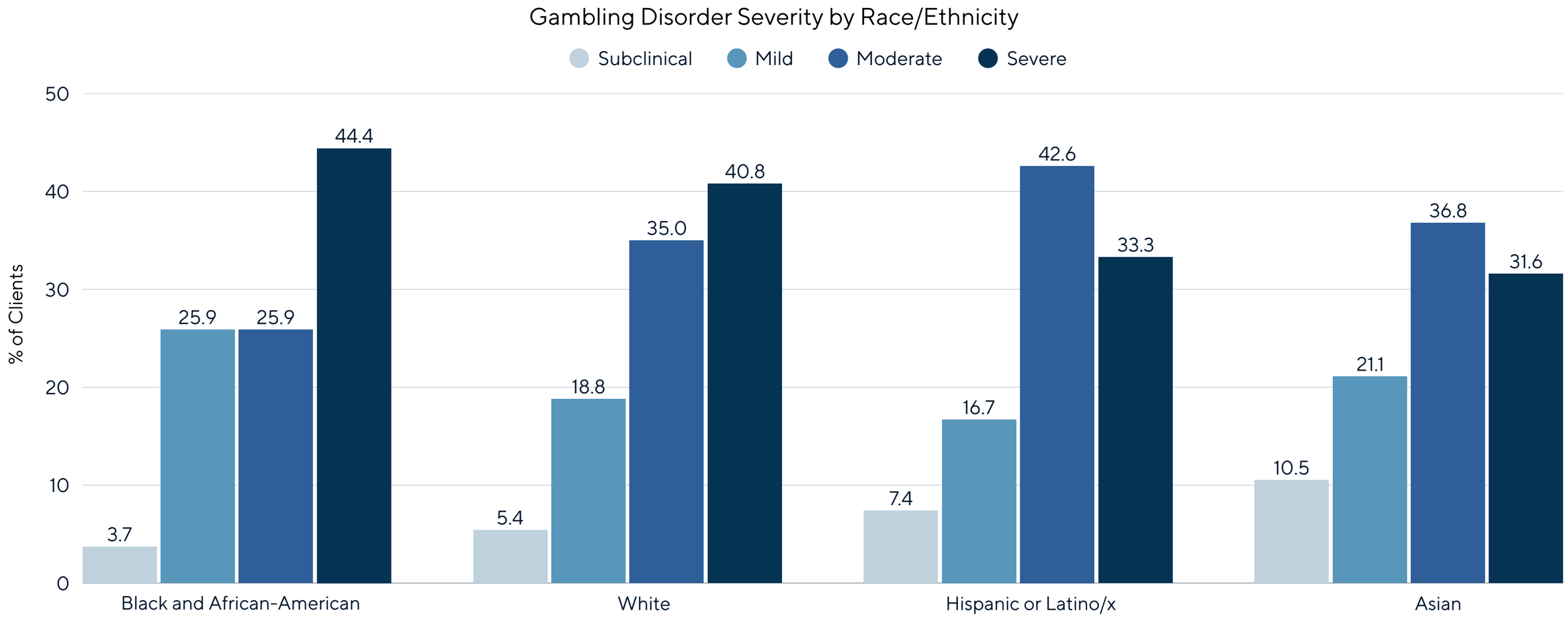
DSM-5-TR Diagnostic Criteria: Gambling Disorder

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

* Based on Gambling Disorder DSM5 Diagnostic Criteria. ** The difference is statistically significant at the 5% level of significance.

With respect to race and ethnicity, clients identifying as Black or African American had the highest rate of severe Gambling Disorder, followed by White, Hispanic or Latino/x, and Asian clients.

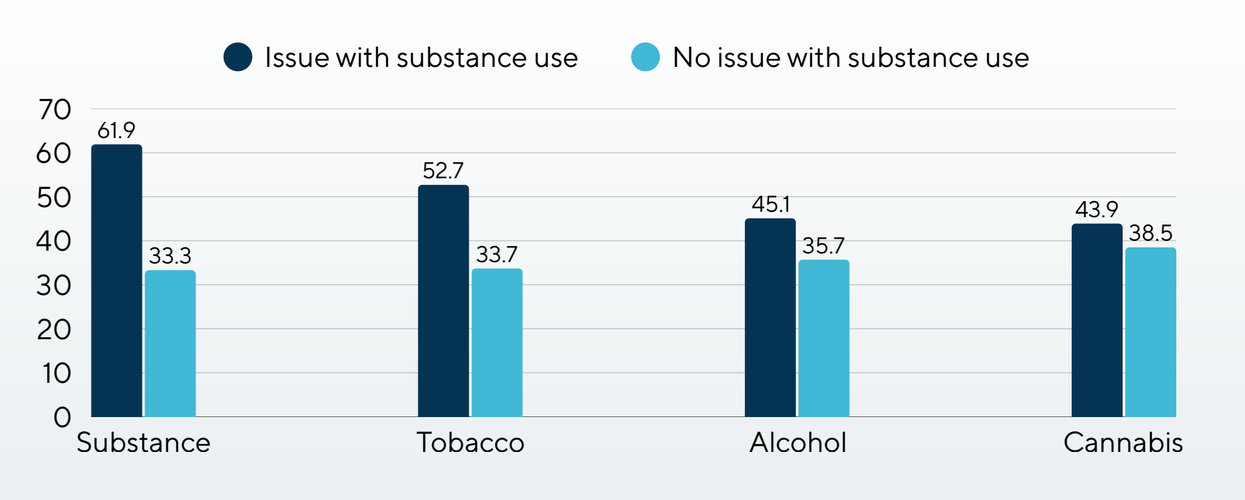


Traditional Treatment Clients aged 50–59 had the highest rate of severe Gambling Disorder assessments,* followed by those aged 30–39, and 40–49. Collectively, clients aged 30–59 accounted for 66% of the treatment population, indicating that severe Gambling Disorder was most prevalent within this age range.

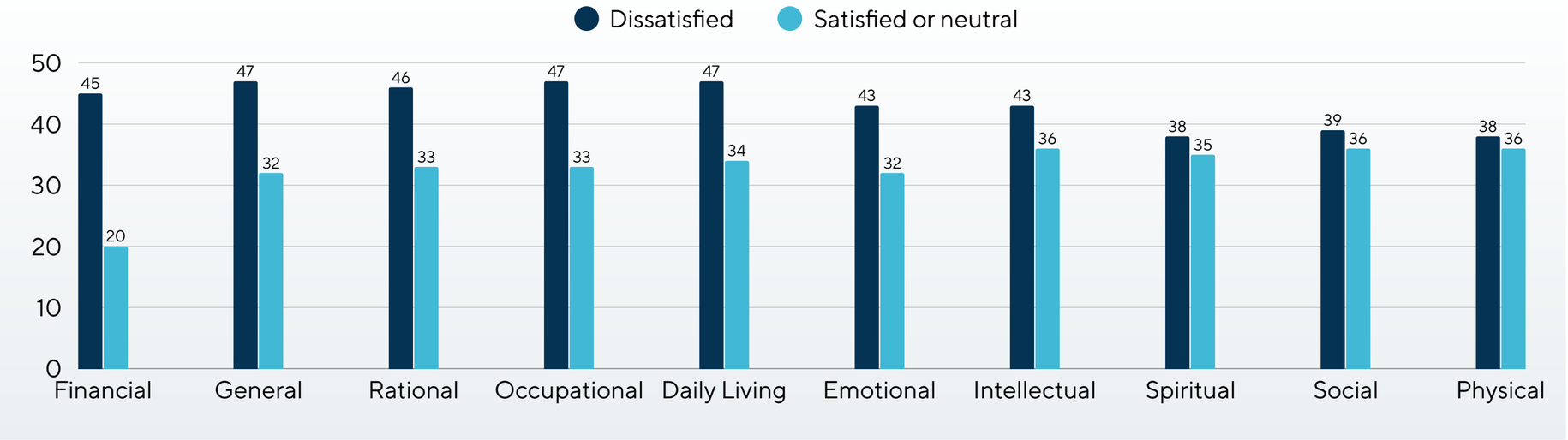
Age	Severity (%)			
	Subclinical	Mild	Moderate	Severe
Under 21	0	66.7	33.3	0
21-29	12.1	15.2	39.4	33.3
30-39	4.9	17.5	35	42.7
40-49	7.5	16.5	39.8	36.1
50-59	5.4	11.7	28.8	54.1
60-69	11.7	14.9	40.4	33
70 or older	10.5	39.5	31.6	18.4

*The difference is statistically significant at the 5% level of significance

GAMBLING SEVERITY AS RELATED TO WELLNESS ISSUES



Traditional Treatment clients who use and report issues with substances and tobacco have statistically significantly higher rates of severe Gambling Disorder than those who do not report such issues. For example, clients reporting substance-related issues had rates of severe Gambling Disorder nearly twice as high as those who did not report such issues. No statistically significant differences were observed for issues related to alcohol or cannabis.



A similar pattern was observed across well-being domains. Clients who reported dissatisfaction with financial, general life, relational, occupational, daily living, and emotional well-being had significantly higher rates of severe Gambling Disorder.

TRADITIONAL GAMBLING TREATMENT

TREATMENT DISCHARGE DETAILS

REASONS FOR DISCHARGE

Clients seeking treatment for gambling behaviors:
Overall, in FY2024-25, 39% of clients successfully completed treatment based on OHA PGS criteria for program completion. This represents a 4% increase from the previous fiscal year.

The second most common discharge reason was clients stopping treatment against staff advice (36%). Together, successful completion and discontinuation against staff advice accounted for 76% of all treatment outcomes. The third most common discharge reason was further treatment not appropriate (6%).

There was no statistically significant difference in program completion rates between male and female clients.

Concerned Other related to gambling behaviors:
Concerned Other clients had significantly lower treatment completion rates, with fewer than one in three completing treatment. Slightly less than half stopped treatment against staff advice.

Oregon Health Authority, Problem Gambling Services
Successful completion: Client-

- Achieves at least 75% of their short-term treatment goals
- Completes a continued wellness plan (i.e., relapse prevention plan)
- Experiences a lack of engagement in problem gambling behaviors for at least 30 consecutive days before completing services

	Gambling Client	Concerned Other
Treatment Completed	39.4	28.3
Stopped Coming, Against Staff Advice	36.2	47.8
Further Treatment Not Appropriate at this Program	6.3	15.2
Client Refused Services	6.2	4.3
Moved from Catchment Area	4.8	2.2
Non-Compliance with rules and Regulations	2.9	0
Physical/Mental Illness	1.5	2.2
Evaluation Services Only	1.2	0
Conflicting Hours	1.2	0
Incarcerated	0.4	0

REASONS FOR DISCHARGE

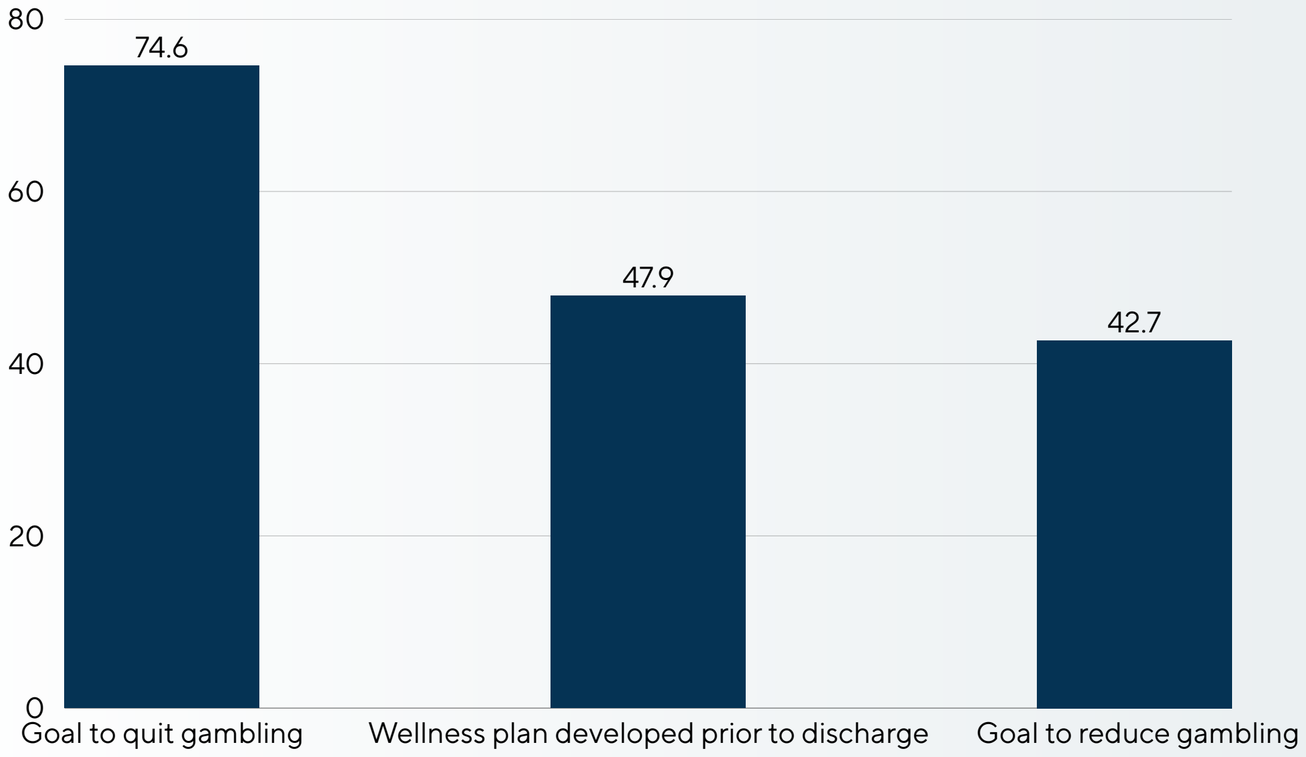
Insights from the Follow-Up Research Project

Previously, “treatment success” from counseling services has been measured by a client meeting predetermined outcome metrics followed by a collaborative termination between a client and counselor. However, people leave treatment for a variety of reasons that can be difficult to capture. A small number of participants (n = 16) shared their reasons for disengaging from treatment services.

- Participants’ decisions to leave treatment reflected a combination of personal readiness, logistical barriers, and program fit. The majority of respondents stated that they were discharged from treatment due to their perceived completion, or getting what they wanted out of treatment. Many felt they had met their goals or gained the tools and knowledge they needed to continue in their recovery independently. Others reported an impact of life transitions or logistical challenges, such as moving to a new city, changes in their schedules, or not being able to attend during the available appointment times.
- Several participants described barriers related to treatment accessibility or format, including limited scheduling flexibility, lack of telehealth options, or discomfort in shared spaces (e.g., waiting rooms with individuals in distress or acute intoxication). A few mentioned that they did not feel connected to their therapist or get what they wanted out of treatment, prompting them to disengage.
- 63% of participants expressed a desire to reenroll in services when they were called to discuss their reasons for exiting treatment.

Sample Details: 16 total participants shared their reasons for terminating services. Two participants were enrolled in services as a concerned other (i.e., have a loved one struggling with gambling), and 14 were in services for their own gambling. Of those who had received services for gambling, all expressed a goal to abstain from gambling altogether, 83% of whom felt like they were meeting their goal at the time of the interview. Notably, the two participants who did not feel that they were meeting their goals for recovery were the only two who reported an additional recovery goal, one being cigarettes and the other alcohol use.

CLIENT GOAL SETTING AND WELLNESS PLAN COMPLETION



Clients seeking treatment for gambling are asked several questions regarding behavioral change. One question asks about their gambling goal. Clients can indicate whether their goal is to quit gambling or to reduce their gambling. Some clients selected both options, presumably because they intended to quit certain forms of gambling while reducing their overall gambling behavior. Approximately three out of four clients reported a goal of quitting gambling, while 43% reported a goal of reducing their gambling.

In terms of successful program completion, clients whose goal was to quit gambling were more likely to complete treatment successfully than those who did not.*

One of the criteria for clients to be considered to be successfully discharged was the completion of a wellness plan. Slightly less than half of the clients had completed a wellness plan prior to discharge. Clients aged 60 or over were more likely to have a wellness plan prior to discharge compared to clients aged 30 or younger.*

*The difference is statistically significant at the 5% level of significance.

FACTORS ASSOCIATED WITH SUCCESSFUL COMPLETION

Adjusted successful completion rate.

When discharge reasons not related to the treatment process (e.g., client relocation, illness, or evaluation-only encounters) are excluded, the successful completion rate for Regular Treament is 40%. This adjusted rate also excludes records with excessive missing or suspect data to support more reliable identification of factors associated with Traditional Gambling Treatment program success.

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. When removing discharge categories external to the treatment process and focusing of the resulting adjusted successful completions, we can identify several factor associated with treatment success.

Treatment encounters

- Clients who completed 7+ treatment encounters are nearly five times more likely to successfully complete treatment,* compared to those who completed 7 or fewer (51% vs 11%).**
- 43% of clients discontinued treatment against their counselors' advice. Maintaining client engagement in treatment programs remains a challenge.

Co-occurring issues

- The data suggest that both a prior history of substance use disorder treatment and current substance-related issues are associated with lower treatment success rates. Specifically, Regular Treatment clients who reported one or more prior substance use disorder treatment episodes had a success rate of 28%, compared with 45% among those with no prior treatment history.** In addition, clients who did not report current tobacco use or use of substances other than alcohol or cannabis were approximately 2.75 times more likely to successfully complete treatment.**

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

** The difference is statistically significant at the 5% level of significance.

Gambling-related problems

- Clients were asked if they experienced the following gambling-related problems: Financial, Relationship, Job or school, Suicidality, Bankruptcy, and Legal. Because the presence of gambling-related problems further complicates the treatment process and creates bidirectional influences we expected those reporting more gambling related problems would have lower successful completion rates. For example, Gambling Disorder can contribute to relationship problems, which in turn may exacerbate gambling behavior. However, we found only job or school related problems was statistically related to outcome. Clients who reported job- or school-related problems were 33% less likely to successfully complete treatment.*

Well-being indicators

- Clients who reported greater satisfaction across multiple well-being domains were more likely to successfully complete treatment. Specifically, clients who reported dissatisfaction in any of the 10 well-being domains discussed earlier in this report were significantly less likely to successfully complete treatment.

Exploring How Multiple Factors Relate to Treatment Success

To move beyond single-variable analyses and account for potential interactions among predictors, a decision tree model was used to identify variables most strongly associated with treatment completion. The three most influential variables were having seven or more treatment encounters, reporting no dissatisfaction across any of the 10 well-being metrics, and having no prior substance use disorder treatment episodes.

These variables were subsequently included in a regression model to estimate their independent associations with treatment success. Having seven or more encounters was the strongest predictor of successful completion (odds ratio = 9.97)*, indicating that clients who remained in treatment for at least seven encounters had nearly ten times the odds of successful completion compared with those with fewer encounters, after adjusting for the other significant factors. Clients who reported no dissatisfaction across the well-being metrics had 6.5 times higher odds of successful completion,* while those with no prior substance use disorder treatment history had 2.6 times higher odds of success.*

* The difference is statistically significant at the 5% level of significance.

Referred to organization	% of clients with successful treatment discharge
Gamblers Anonymous	53.6
Other Outpatient Services	38.5
None	32.7
Other	15.3
Peer Run Organization	9.9
Evive	2.8
Residential	2.4
GEAR	1.2
GamFin	1.0

Client Referrals at Treatment Discharge

At discharge, clients are provided with referrals to other organizations that align with their individual needs. In FY2024-25, Gamblers Anonymous was the most common referral (54%), followed by other outpatient services (39%). In addition, 3 clients remained in treatment under the program's Continuing Care Group Services.

During the fiscal year, 31% of clients in the Traditional Treatment program reported having previously received treatment for gambling-related issues, indicating that reoccurrence into formal treatment is not uncommon. Given that the average cost of successful treatment was $5,008 (median $3,789), repeated treatment episodes represent a meaningful cost to the system.

It is generally considered best practice to provide referrals to additional supportive services following the completion of addiction treatment. For clients who successfully complete treatment, referrals to peer-led or community-based support services may be particularly beneficial in supporting sustained recovery.

* Some clients may have received multiple referral types. 2. Analysis of FY2024-25 clients receiving treatment.
** Outlying and other suspect data have been removed. Figures should be interpreted with caution.

1

2

RESIDENTIAL & DEPARTMENT OF CORRECTIONS TREATMENT SERVICES

RESIDENTIAL TREATMENT.

Overview

In FY2024-25, OHA PGS served 58 clients in residential treatment. During the year, 48 clients were admitted, 51 were discharged, and a total of 2,712 treatment encounters were delivered. Nearly all clients (98%) were referred from outpatient treatment programs, with the remaining 2% referred from unspecified sources. The average wait time was 10 workdays, although 17% of clients were admitted on the day of initial contact.

Demographics

Fifty-six percent of residential clients identified as male, while 44% identified as female; however, this difference was not statistically significant. Similarly, although the average age of male clients was higher than that of female clients, the difference was not statistically significant. Approximately 6% of residential clients reported being veterans. Nearly half of clients were divorced, representing twice the rate observed among Traditional Outpatient Treatment clients. Finally, two out of three clients reported a high school education or less, and the average reported income ($22,389) was 42% lower than that reported by clients in the Traditional Outpatient Treatment Program.

Gambling Activities

The most commonly cited problematic gambling activity was electronic gaming (90% of clients), occurring at a rate approximately 13 times higher than the next most frequently reported activity, table games and cards. Approximately 7% of clients reported engaging in two or more problematic gambling activities.

Well-being

Similar to what was observed among Traditional Outpatient Treatment clients, there was a high degree of dissatisfaction across the ten well-being domains reported by treatment providers. However, the average rate of dissatisfaction across these well-being measures was substantially higher for residential clients (61%) than for Regular Treatment clients (34%).*

- There is one residential treatment facility located in Marion County that is designed exclusively for gambling disorder treatment.
- The co-ed treatment facility provides peer support, counseling, and nutritious meals. The location has 8 beds is in an unlocked home-like environment with support for visitations.

* The difference is statistically significant at the 5% level.

Problem gambling-related issues and previous treatment episodes

Clients in residential treatment reported patterns of gambling-related problems similar to those observed in other treatment settings. Nearly all clients (98%) reported financial issues, followed by relationship and employment or school-related issues. More than 90% of clients reported experiencing multiple gambling-related problems, and approximately one-third reported experiencing four to five distinct issues.

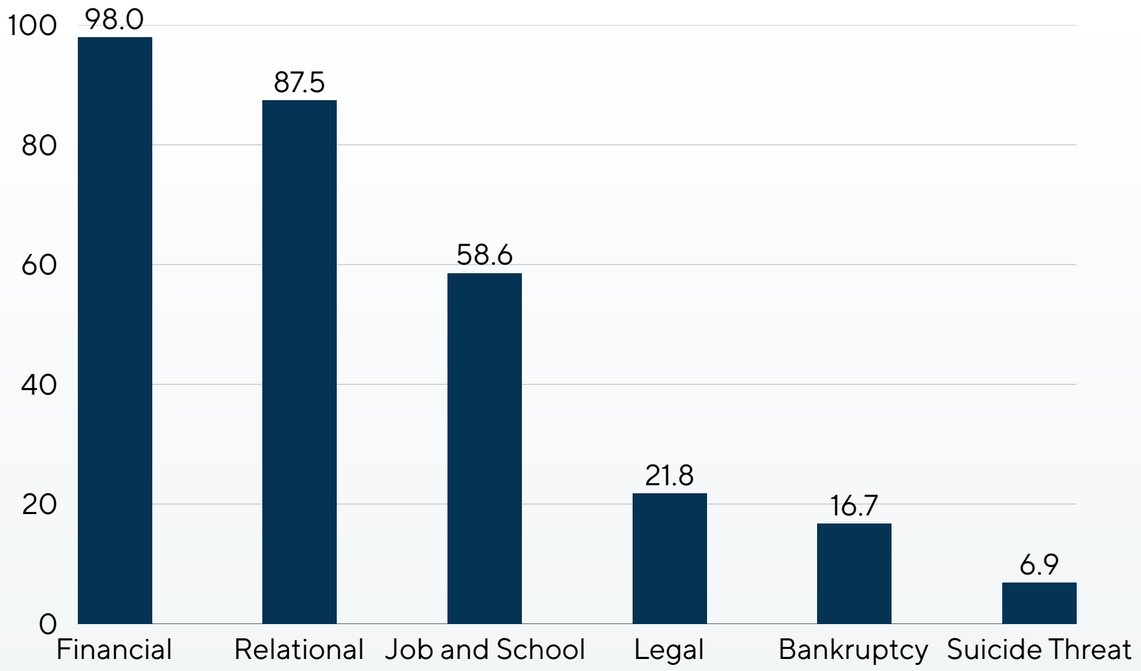
Eighty-four percent of residential clients had previously received treatment for gambling disorder, while 48% had been treated for substance use disorder and 44% for a mental health condition. In addition, 57% of clients had previously received treatment for two to three of these conditions.

Gambling Disorder Severity

Not surprisingly, residential clients exhibited the highest rate of Gambling Disorder Severity, much higher than that observed for Traditional Outpatient Treatment Clients (76% vs 35%).*

Gambling Treatment Discharge Types

In FY2024-25, 57% of clients completed the residential treatment program successfully, which is higher than Traditional Outpatient Treatment clients.* One of the primary reasons for this high success rate is that the average residential client engages in 53 encounters.



Gambling Dischange Type Label	%
Treatment Completed	56.9
Stopped Coming, Against Staff Advice	15.7
Non-Compliance with Rules and Regulations	15.7
Further Treatment Not Appropriate at this Program	7.8
Client Refused Services	3.9

* The difference is statistically significant at the 5% level.

OREGON DEPARTMENT OF CORRECTIONS

Overview

Oregon Department of Corrections (ODOC), in partnership with OHA PGS, supports the Gambling Reduction and Recovery for Incarcerated Populations (GRIP) Program, available at Coffee Creek Correctional Facility and Columbia River Correctional Institution. GRIP is a psychoeducational group consisting of 12 sessions specifically designed for incarcerated adults who meet the criteria for a gambling disorder.

In FY2024-25, the GRIP program served 70 clients, representing a decrease of 28 clients compared with the previous fiscal year. During the year, the program admitted 69 clients and discharged 70, and provided a total of 643 client encounters within the ODOC system. All encounters were delivered in a group setting.

Demographics

Males accounted for 73% of clients, compared with 27% who identified as female.* The average client age was 39 years, with no statistically significant differences between males and females. Approximately 2% of clients reported being veterans. The most common marital status was unmarried (55%), followed by divorced (28%). Only 12% of clients were married, and 5% were separated. Fewer than one in four clients reported educational attainment beyond a high school diploma.

Gambling Activities

Similar to both Regular Treatment and residential clients, ODOC clients' primary problematic gambling activity was electronic gaming, with 93% reporting this activity.

Well-being, Issues with Substances, and Problems Related to Gambling Activities

Information on ODOC clients' satisfaction across well-being measures, substance-related issues, and gambling-related problems were not available.

* The difference is statistically significant at the 5% level.

Gambling Disorder Severity

In FY2024-25, 23% of ODOC clients had Mild Gambling Disorder severity, 27% Moderate, and 37% Severity severity. The Severe gambling disorder severity level was about the same as for Traditional Outpatient Treatment clients (39%), but lower than those for residential clients (76%).

Problem Gambling Disorder Serverity	%
Subclinical	12.9
Mild	22.9
Moderate	27.1
Severe	37.1

Gambling Treatment Discharge Types

ODOC clients had the highest treatment completion rate (77%), with only 4% discontinuing treatment either by stopping attendance against staff advice or refusing services. When clients who did not complete the program due to moving out of the catchment area or conflicting schedules are excluded, the treatment completion rate increases to 95%.

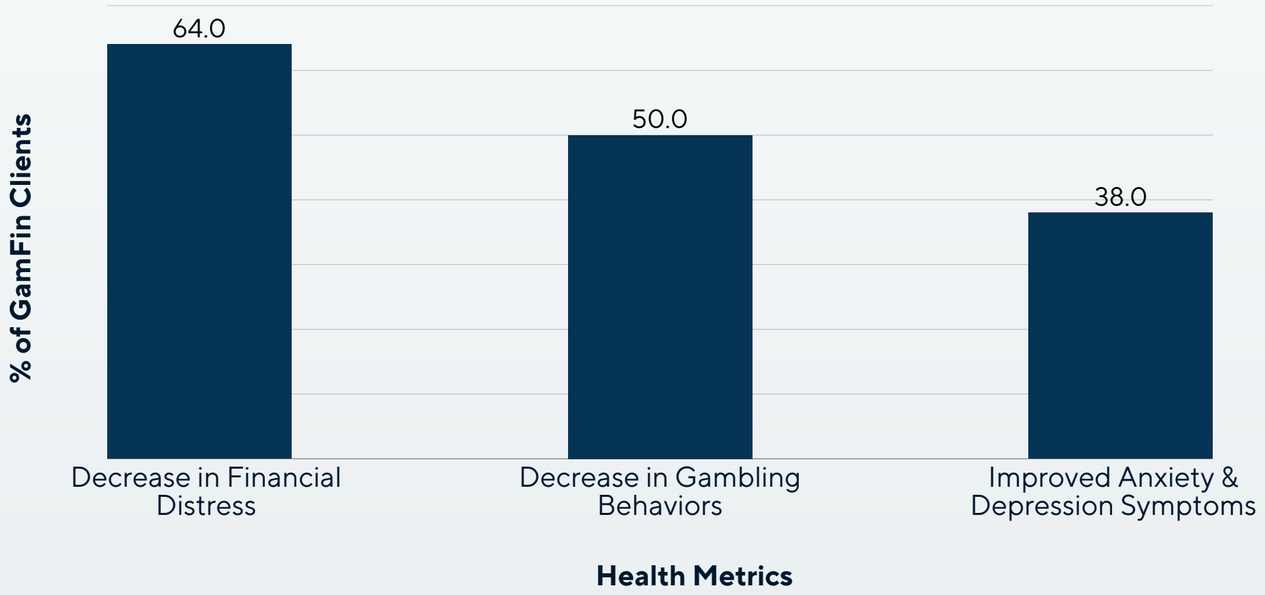
* The difference is statistically significant at the 5% level.

Gambling Discharge Type Label	%
Treatment Completed	77.1
Moved from Catchment Area	17.1
Stopped Coming, Against Staff Advice	2.9
Client Refused Services	1.4
Conflicting Hours	1.4

GAMFIN AND EVIVE SUPPORT

GAMFIN

In FY2023-24, OHA PGS partnered with GamFin to provide support for clients experiencing gambling-related financial distress. Oregonians can access OHA PGS-supported GamFin services through a gambling treatment referral, gambling helpline referral, or through self-referral. A typical GamFin client receives two to three services and then is well on their way, with the opportunity to return for refreshers if needed. Across FY2023-24 and FY2024-25,* GamFin delivered 152 sessions to 51 clients. Outcome reporting indicated improvements across several measures, including financial distress (IFDFW), gambling behaviors (PGSI), and symptoms of anxiety and depression (PHQ-4).



* Separate data for FY2024-25 is not available.

GamFin

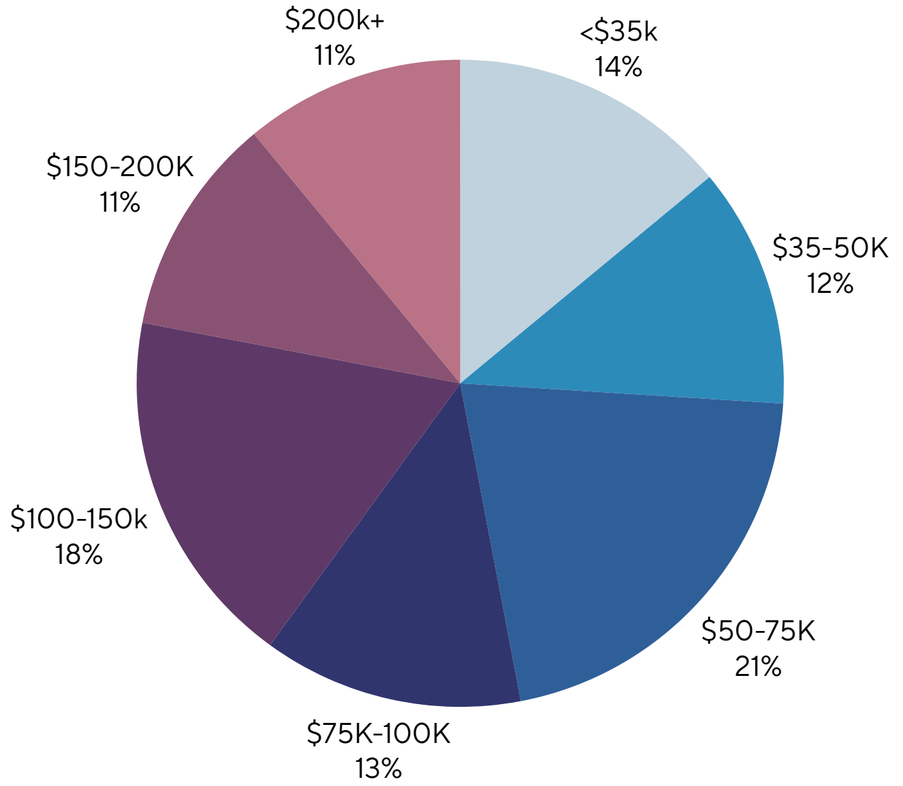
GamFin is an organization that provides financial counseling and support for individuals and families experiencing gambling-related financial distress. It connects people affected by problem gambling with expert financial counselors who help with budgeting, debt management, credit rebuilding, and overall financial recovery, often in a confidential and judgment-free setting. GamFin also offers group sessions, training, and resources for clinicians and treatment providers to better integrate financial counseling into gambling disorder treatment.

OHA PGS CLIENT PROFILES WHO UTILIZED GAMFIN

Slightly over half of Oregonians who used GamFin were male (52%). Asians were substantially overrepresented among GamFin users, accounting for 16% of participants despite representing 6.8% of the overall Oregon population. Black or African Americans were also overrepresented (11% versus 2.5%), as were individuals identifying as Hispanic or Latino/x , whose participation exceeded their share of the Oregon population by approximately 36%.

The most common age group using the service was 35-44, representing 28% of users. Individuals aged 65–74 accounted for 23% of service users, nearly twice their proportion in the Oregon population.

Income Categories



GAMFIN SESSION DISCUSSION THEMES

Three major themes that occur during discussions include:

- Mastering the skills of managing dysfunctional family dynamics is essential to long-term recovery.
- Inconsistent income, a feature of the growing gig economy, is exacerbating problem gambling with the introduction of additional uncertainty (feast or famine mentality).
- Trusted accountability partners play an oversized role in the recovery process.

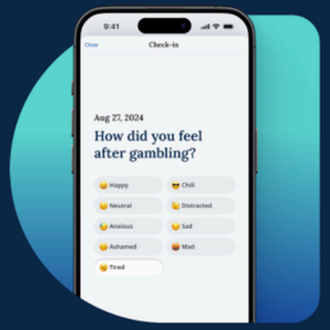
EVIVE DIGITAL SUPPORT TOOL

Evive is a free, evidence-based digital support app designed to help people understand and change their relationship with gambling. It offers personalized tools and guidance for individuals at any stage, whether they want to gamble more safely, cut back, or stop gambling entirely. Users choose the pathway that matches their goals and receive daily check-ins, progress tracking, educational content, urge management tools, and access to community support, available 24/7 on a smartphone or other device. The app is confidential and available in Oregon and many other states, and it can be used on its own or alongside other resources such as formal treatment services.

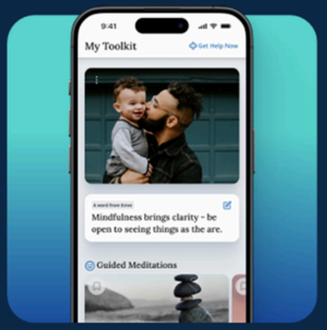
24/7 Access to Support

- Crisis numbers
- Local treatment centers
- Educational materials
- Meditation exercises

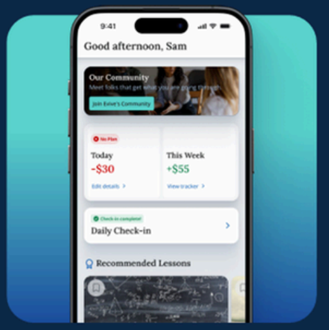
evive



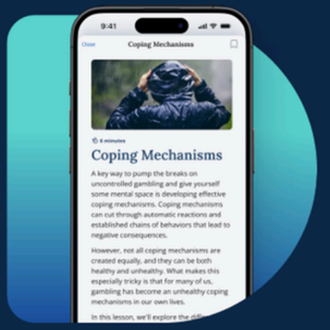
Behavior Change



Personalized Resources



Community Support

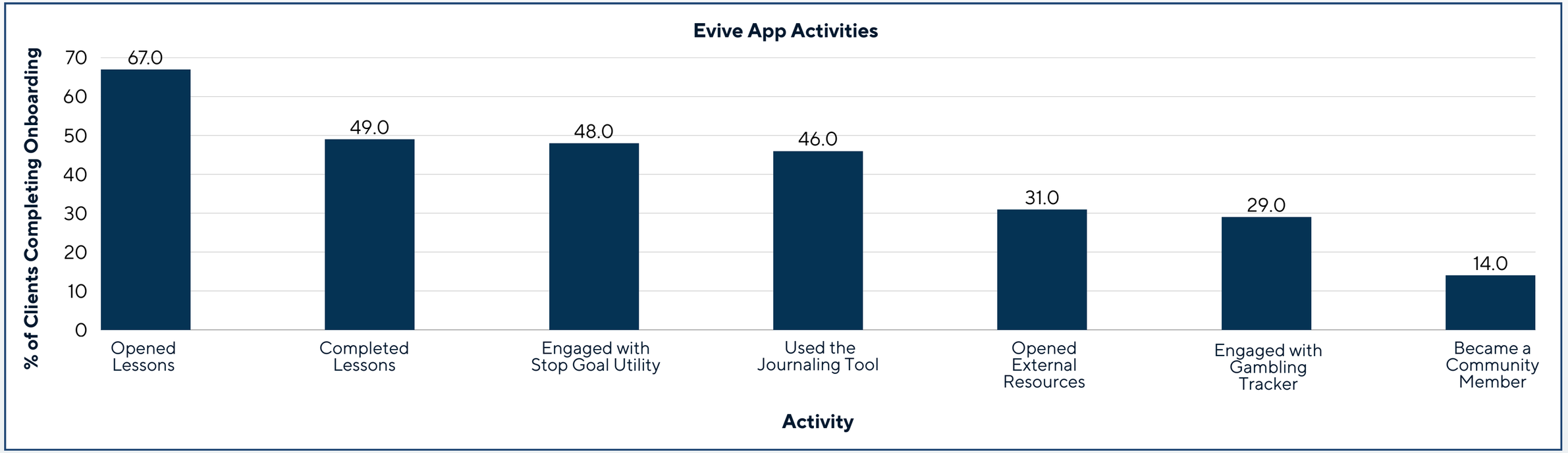


Education

EVIVE DIGITAL SUPPORT TOOL ONBOARDING AND ACTIVITY TYPES

During FY2024-25, OHA PGS began supporting the Evive digital health support tool for clients enrolled in its treatment program, as well as more broadly for Oregon residents who may be experiencing gambling-related issues. During the year, 211 users downloaded the app, and 178 (86%) successfully completed onboarding. Over half of users (55%) reported quitting gambling as their goal, while 27% aimed to reduce their gambling and 18% sought to better manage their gambling activities.

Within Evive, users can engage in a range of activities designed to support their gambling-related goals, such as tracking their gambling expenditures and time, engaging in educational content, journaling, or joining the Evive support community to read or post messages. During the FY2024-25 reporting period, approximately two-thirds of users opened at least one educational lesson, and about half completed at least one lesson and used the journaling tool. Fewer users, to date, have used Evive to access external resources, engaged with the Gambling Tracker, or joined the user community.



EVIVE CLIENT PROFILE AND USAGE

The average age of Evive users was 47, nearly identical to the average age of 48 among clients treated in the OHA PGS treatment system in FY2024–25. Users engaged with the app for an average of 17.5 sessions, compared to a median of 3 sessions, suggesting that while many users engage briefly, a subset of users is deeply engaged with the platform.

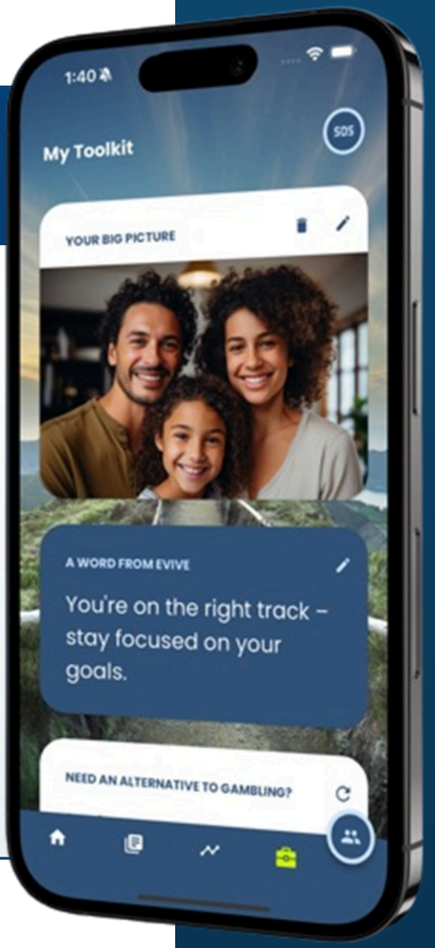
Among users who utilized the Evive Gambling Tracker to report total gambling dollars won or lost, the average reported loss was $688 (median loss of $40), with the largest reported loss totaling $7,330. Similarly, among users who tracked days gambled, the average number of days reported was one, with a maximum of 22 days during FY2024–25.

Stability in Goal Setting

Overall, 97% of Evive users had the same gambling-related goal at the end of the reporting period as the goal they selected during onboarding. Because users can change goals multiple times, this does not necessarily imply that goals remained unchanged throughout use. That said, no users ended the reporting period with a goal other than quitting after initially selecting quitting. Three percent of users ended the period with a goal of quitting after initially choosing to manage their gambling activities. Among users whose onboarding goal was to reduce gambling, 8% ended the period with a goal of quitting, while 2% ended with a goal of managing their gambling activities.

User Survey Data Suggests Evive Works!

Sixty percent of users reported meeting their goal to stop or control their gambling within 7 to 29 days of downloading the app. Importantly, survey data also show that success increases with continued use. After six months, more than 75% of users agreed or strongly agreed with the statement: “I am meeting my goal to stop or control my gambling.”



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 (N = 63) 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 severe financial loss or instability, which was reported by over half of the participants (51%). Loss of control, or realizing that the problem was escalating and feeling unable to stop, was reported by nearly a fourth of participants (22.2%). Some (14%) described that the toll gambling had taken on their relationships motivated them to seek help, such as having caused a separation, hiding gambling from their loved ones, or receiving pressure from family to seek help. 8% reported serious emotional distress, such as depression, shame, and suicidal ideation, that pushed them to change their gambling behavior. Finally, a few participants (3%) reported that it was a professional referral, such as from a medical provider or hotline, that helped them seek gambling-specific treatment.

"I got to a point where I was financially just spread thin, to a point where I would borrow money from other people to pay my bills. When I got paid, I had to pay the other people back before I could even pay my bills."

"Me estaba desesperando... Perdí dinero; lo perdí todo... Ya no quería existir... Perdí mi trabajo... Estoy muy agradecida por esta ayuda."

"I wanted to understand what's happening to me. I'm a functioning gambler. I want to understand why I can't just walk away when I'm up."

Reasons Participants Reported Seeking Help for Problem Gambling

1. Financial Crisis & Debt
2. Loss of Control
3. Relationship Strain & Impacts on Family
4. Emotional Distress & Mental Health Impact
5. Professional Referral

Importantly, when asked if there was anything that could have helped them seek help sooner, over half of the participants expressed that they needed to come to the conclusion on their own, and that there was nothing external that could have helped them sooner. However, many expressed that they were unaware of the services, and increased awareness of gambling treatment would have encouraged them to seek help sooner.

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 or worked with them to create goals for between sessions. Across surveys, homework was assigned over two-thirds of the time, and between-session goals were created over three-fourths of the time.

Peer Support

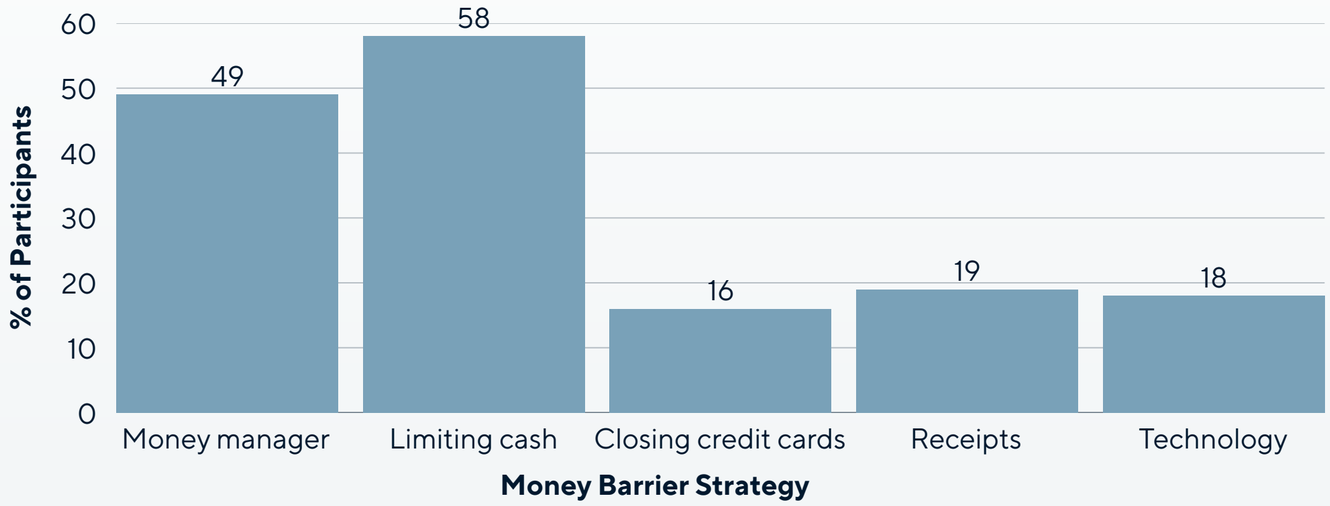
Peer support services are available to clients at select service agencies, as well as external organizations like Voices of Problem Gambling Recovery and Grupo Latino. Notably, participants utilizing peer support services are not reporting many encounters. For example, on average, participants report interacting with a peer only once in the previous month across timepoints. By the time of the first survey, only 23% of follow-up participants were simultaneously receiving peer support services. Engaged participants rated the helpfulness of their peer support as 2.9, where zero means 'not at all helpful' and five means 'very helpful', although this period was characterized by confusion about utilizing peer support services. Satisfaction ratings increased with each time point, reaching 3.9 by the 180-day survey. Overall, **participating in peer support services is statistically significantly related to a greater likelihood of self-reported goal achievement in recovery** ($p < .001$).

Community-Based Support

Of note, a number of participants describe feeling a sense of community support from attending psychoeducation classes, most commonly including Gamblers Anonymous, as well as Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery, SMART Recovery, Recovery Dharma, Charlie Health, and general recovery groups. Participants also cited psychoeducational recovery classes offered by treatment clinics. Generally, participants reported attending an average of two group meetings per month. By the 30-day survey, only 23% of participants were simultaneously engaged in community support, rating their satisfaction with it at 4.3 out of five. By the 90-day survey, 42% reported community support involvement, rating it 4.25 out of five. Engagement decreased over time, with 35% at the 180-day survey and 27% at the 365-day survey, but ratings remained high, at 4.2 and 4.3, respectively. Importantly, **participating in community recovery support groups is significantly related to a greater likelihood of self-reported achievement of goals for recovery** ($p < .001$).

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. Limiting the amount of cash one carries was the most common barrier reported, and having someone else manage their money was rated as the most helpful.



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'). Overall, having someone else manage one's finances was rated 4.5, closing credit cards was rated as 4.4, using technology (e.g., recovery apps, site blockers) was rated 4.0, and providing receipts on purchases received a 3.9 rating.

Participants shared additional strategies to safeguard their money, including:

- Puts money into Visa gift cards
- Accountability in transparent budgeting or sharing of location
- Self-exclusion from casinos, individual apps, and ATM withdrawals
- Not carrying debit cards
- Giving someone else any cash earnings, who sends it back digitally
- True Link card
- No access to online accounts

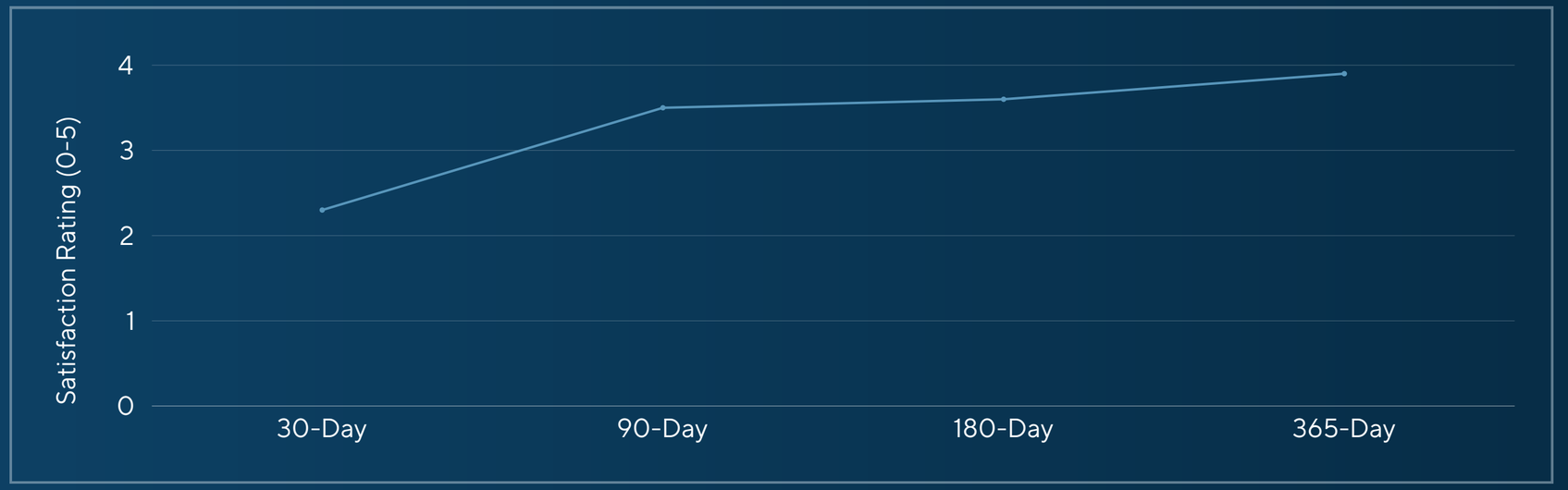
Goals for Recovery

Recovery goals vary from person to person and may naturally change over time. The majority of participants reported a goal of abstaining from either gambling or video gaming. Importantly, **participant-reported goals (i.e., abstain or limit) were not a statistically significant predictor of perceived treatment outcomes at any time point**. At the start of engaging with treatment services, 74% described their goal for gambling recovery to be abstinence, while 26% wanted to set limits for themselves, such as only spending a predetermined amount for a specific frequency or limiting the types of games played. By the 90-day survey, 83% were aiming to abstain, by the 180-day survey, it fell back to 74%, increasing to 83% again after 365 days. The level of perceived success participants felt they had in meeting their identified goal (i.e., abstaining or limiting gambling or gaming) changed over time, beginning at 77% after 30 days, staying steady at 75% after 90 days, increasing to 91% after 180 days, and falling slightly to 82% after one year.

On average, half of the participants identified additional recovery goals, largely for alcohol and tobacco use, as well as cannabis, other substances (e.g., opioids, amphetamines), eating, spending, and sexual behaviors. **Identifying other recovery goals, in addition to gambling or video gaming, was a statistically significant predictor of perceived treatment outcomes** ($p = .004$). The participants who identified additional goals for their recovery were also more likely to be engaged in peer support services ($p < .001$) as well as community recovery support ($p = .001$), but not co-occurring treatment.

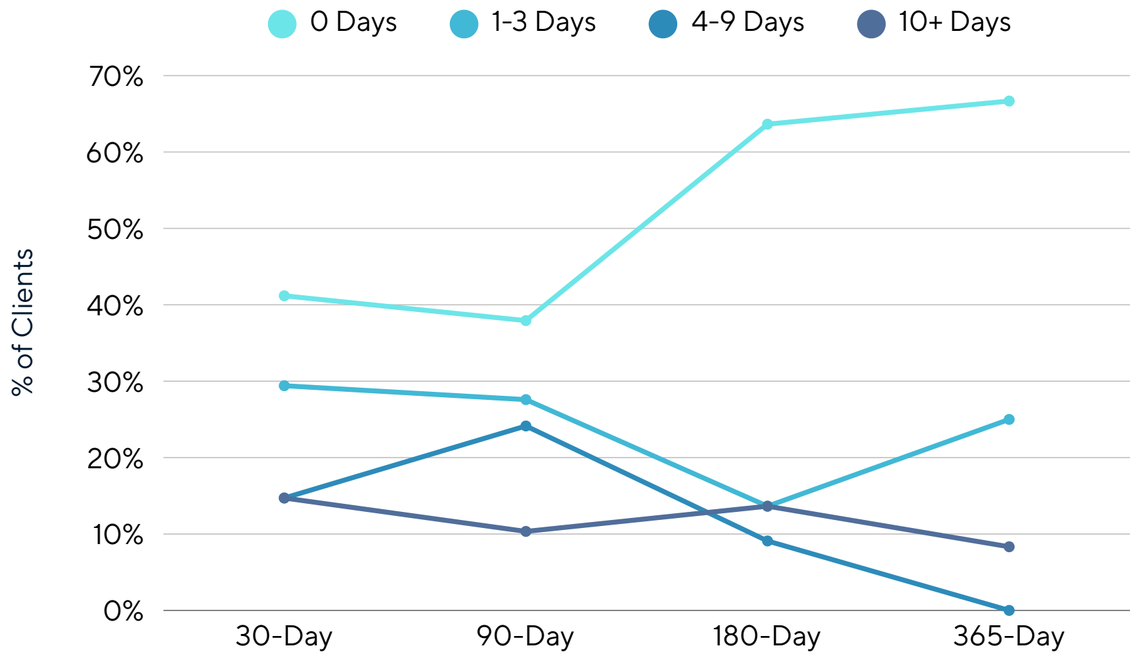
Quality of Life

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. Over time spent in treatment, quality of life ratings increased. **At 30 days, a higher rating of quality of life overall and each domain was a statistically significant predictor of positive self-perceived treatment outcomes** ($p < .001$).



Gambling Behavior

Actual reported gambling behavior varied at each time point. Across the board, most participants reported not gambling in any of the previous 30 days from their interview. Of those who reported any number of gambling days during the previous 30 days, the frequency varied substantially, ranging from one to every day. The proportion of participants who reported no days gambled in the past month, however, increased substantially over time in treatment.



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. Internal motivation, readiness for change
2. Counseling, treatment, and other structured support
3. Accountability and social support
4. Money barriers/financial safety strategies
5. Improved self-awareness and emotional growth
6. Prioritizing meaningful activities and values, distraction
7. Gambling consequences, shame
8. Spirituality and recovery mindset

SOURCES OF SUPPORT

Co-occurring Disorder Treatment

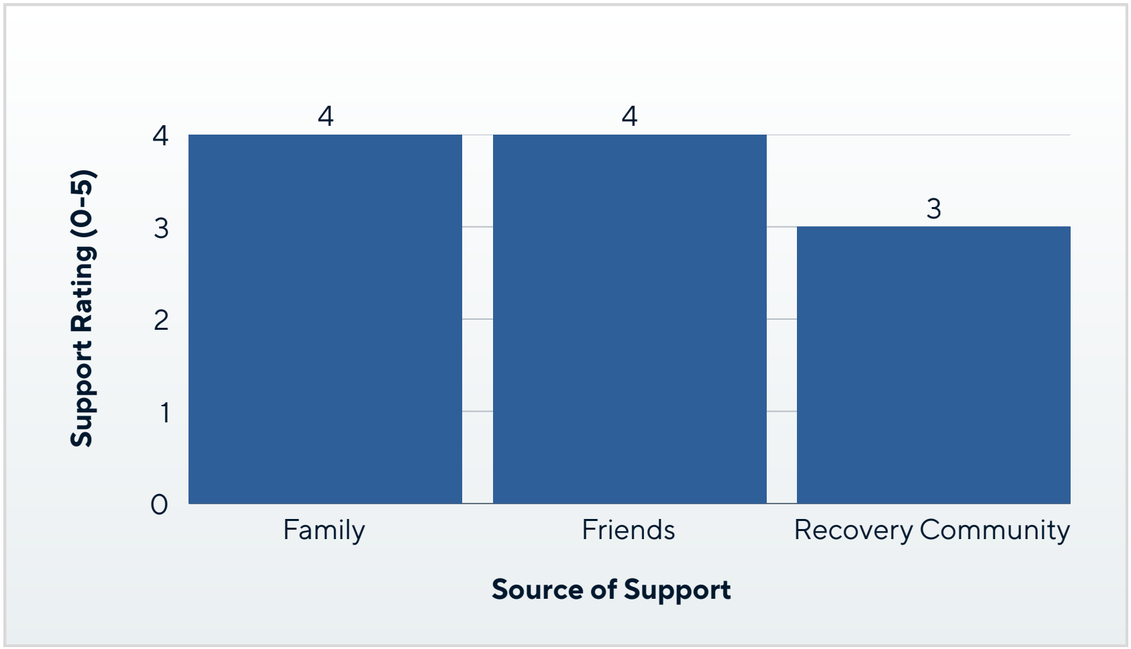
56% of participants in the study reported receiving additional treatment for co-occurring mental health or addiction concerns. 52% of participants in the study reported taking a prescription medication for their recovery or mental health at some point during the year. **Those engaged in additional treatment** (p = .002) **and those with a psychiatric prescription** (p = .001) **were statistically more likely to have a positive self-perception of their treatment outcome.**

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 ratings tended to increase over time; having greater support from family, friends, and a community of others in recovery may help clients stay engaged for longer, or, as clients stay engaged and make positive changes in their lives, perceived support from others may increase.

At the time of completing the 30-day survey, **participants were more likely to report positive perceptions of treatment outcomes when they also reported greater levels of suppor**t from family (p < .001), friends (p < .001), and other people in recovery (p < .001). At any point during treatment, participants who reported **having a family member attend treatment with them were more likely to report positive self-perceived treatment outcomes** overall (p < .001).



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. 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. Therapeutic alliance was assessed at each time point using four questions and a rating scale of zero to five. Participants were asked about their therapist match, the relevance of sessions, feeling understood, and overall fit. When summed together, an average therapeutic alliance score was derived. Across timepoints, therapeutic alliance remained generally high, from 4.6 out of five at 30 and 90 days, 4.7 at 180 days, and 4.9 at 365 days. Additionally, a **higher-rated therapeutic alliance statistically significantly predicted positive self-reported treatment outcomes** ($p < .001$).

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 4.6, with little variation across time.

Additionally, when asked if they would refer a friend or family member who was hypothetically looking for help with problem gambling or video gaming to the services they were receiving, over 95% of the participants stated they would.

95% 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. Across all time points, the sample includes 95 responses; noteably this includes a number of the same participants across multiple time points. Overall, how treatment is delivered matters as much as the content of treatment. Most frequently (in 72% of cases), clients shared that the relationship with their counselor made the biggest difference in their treatment progression. Specifically cited were feeling safe, heard, and supported, having a strong therapeutic alliance with their counselor, and being met with compassion after a relapse

"This counselor cares about me... he didn't give up on me."

"Becoming aware of why I'm gambling... it's not just me not having willpower."

Mentioned almost half of the time (48%) was the acquisition of knowledge pertaining to problem gambling and addiction. Learning the "why" about addictive behaviors, reviewing the addiction cycle, understanding the role of neurochemistry in addiction, and being able to reframe addiction as an illness helped remove some of the shame. 41% described the value of accountability with regular check-ins and having someone to follow up with on their goals. The flexibility and accessibility of services available within the treatment system were cited by 36% of respondents, and whole-person care that also addressed co-occurring mental health concerns and life stressors outside of gambling or gaming was noted by 34% of participants.

Specific skills and strategies for reducing gambling or gaming behaviors, or reducing related harms, such as financial safety strategies, setting goals, and developing coping skills, were mentioned by 32% of participants. Group recovery support, including classes and community groups, as well as connecting with others who shared lived experience, was endorsed by 29% of participants; these reduced isolation, validated, and normalized the recovery experience. Internal motivation and readiness to change also mattered, mentioned 22% of the time, with participants describing needing to get to a place of being ready to commit to change. A small number of respondents (18%) brought up the organizational quality of programs, mentioning clear communication and follow-through. Even fewer (4%) cited outside medication management as a helpful part of their recovery.

"The classes and hearing other people's input... I'm not the only one."

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. Largely, themes of what was least helpful for clients were related to administrative challenges. For example, the most frequently cited were service accessibility and scheduling barriers, mentioned by 32% of participants. Long wait times to begin treatment, session cancellations, understaffing, or lack of geographically accessible services were mentioned as frustrations for about a third of participants. 17% specifed inconstency in care continuity, describing counselor changes, lack of follow-up, or challenges with transferring care between organizations.

Group service formats came with their challenges, as they sometimes felt chaotic and uncomfortable, were too broad and hard to relate to, or were more specific and too small; this was mentioned 28% of the time. Across treatment more broadly, some (23%) reported that reading assignments, workbooks, or class curriculum felt repetitive or not engaging enough. 19%, however, expressed frustration in the broader sociopolitical system, noting the challenges to public health in the widespread promotion of gambling as a legal activity, with limited treatment services available. Similarly, 13% reported that there are constant gambling cues in their community, which they felt undermined their recovery efforts.

Some expressed a lack of broader support, including access to legal and financial relief. In contrast to many who felt their counselor alliance was strong, 18% found their counselor match to be unideal, and switching counselors to be a stressor. 15% wanted more peer support options, including more specific group availability and peer services broadly.

At a personal level, 12% felt that treatment moved too slowly and expressed anxiety about wanting to see faster changes. 11% had external stressors that they felt impacted their treatment progress, such as unsupportive family members or legal stressors, which exacerbated urges to gamble. 10% noted their own low level of readiness or engagement in the treatment process as being unhelpful to their recovery. Only 8% of participants felt that treatment, overall, was unhelpful; notably, these participants tended to express wanting more clear and active guidance than they had received.

Additionally, 21% of respondents, when asked what had been least helpful in their treatment so far, stated that nothing stood out as particularly unhelpful, and that things had been only positive thus far.

RESIDENTIAL TREATMENT

Participants described seeking residential services for similar reasons that outpatient clients described seeking help. Most commonly, for example, participants described reaching a crisis point where gambling had become unmanageable, whether that be financially, emotionally, or legally. Several cited critical moments of financial loss or legal consequences that forced them to confront their gambling behavior. Some described referrals from counselors, community recovery groups, or the court system, and others noted that they had tried to manage their gambling on their own and realized that they needed more help to maintain recovery. Some viewed residential treatment as an opportunity for structure and dedicated focus on healing, away from life stressors. Overall, the decision to seek residential treatment was motivated by a mix of desperation, external encouragement, and renewed commitment to recovery, with participants emphasizing the need for a more immersive and supportive environment than outpatient care could offer. On average, participants waited 10 days to get into residential services, with some reporting same- or next-day enrollment when they called.

26% of participants shared that they have additional recovery goals, such as being in recovery for methamphetamines, alcohol, marijuana, or being clean and sober. 100% of participants felt that they were meeting their recovery goals after they completed residential treatment. On average, the urge to gamble over the past week was rated as 1.5 out of five. Overall, the program received high ratings (4.7/5), and 93% of participants would refer a loved one who needed help with gambling.

Participants described the most helpful aspects of residential treatment as the combination of safety, structure, supportive relationships, and opportunities for learning and self-discovery. Being physically removed from gambling triggers and immersed in a structured, compassionate environment enabled them to focus on recovery. Psychoeducation deepened understanding of addiction, while peer and counselor relationships provided empathy and accountability. Engaging in creative and physical activities promoted holistic healing. Collectively, these elements fostered personal growth, connection, and renewed hope for lasting recovery.

SUMMARY

SUMMARY

Oregon's publicly funded gambling treatment services are making a difference. During FY2024-25, the OHA Problem Gambling Services system delivered a total of 17,634 counseling and peer mentor sessions to approximately 833 individuals, including serving 58 persons with high needs in a specialized gambling treatment residential program. In addition, 211 Oregonians engaged with the Evive digital health app and 42 individuals received free financial consultations through GamFin. These services were primarily funded through an Oregon law that directs 1% of Oregon Lottery proceeds to OHA Problem Gambling Services, enabling Oregonians who experience gambling related harm to receive high quality and comprehensive care at no out-of-pocket costs to them.

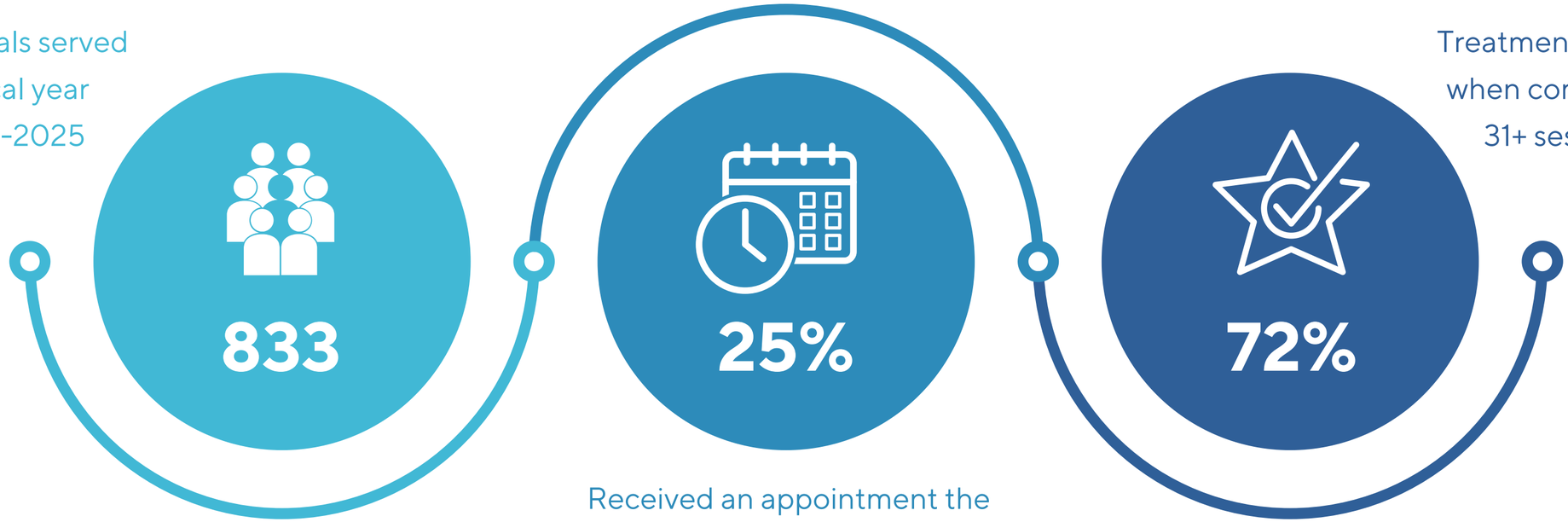
OHA Problem Gambling Services help persons in need initiate, maintain, or reengage in problem gambling recovery. The majority of participants reported decreased urges, fewer days gambled, and increased quality of life as time engaged in services went on. Importantly, services extend beyond outpatient care; residential services and simultaneous support from peer support mentors and community-based recovery groups appear to have beneficial outcomes for those who utilize the services. Recovery is not a linear process, and help-seeking occurs at different paces.

Findings detailed in this report provide valuable insights into the population that obtains gambling treatment services. Evaluation efforts of the OHA Problem Gambling Treatment System continue to include a client follow-up component, involving 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'm feeling grateful about [treatment]. I'm feeling good about myself [for] taking the step. I've been seeing the posters and signs for a while now and felt like I should call. I finally decided to call; they were impactful."

FINDING SUCCESS IN OREGON GAMBLING TREATMENT SERVICES

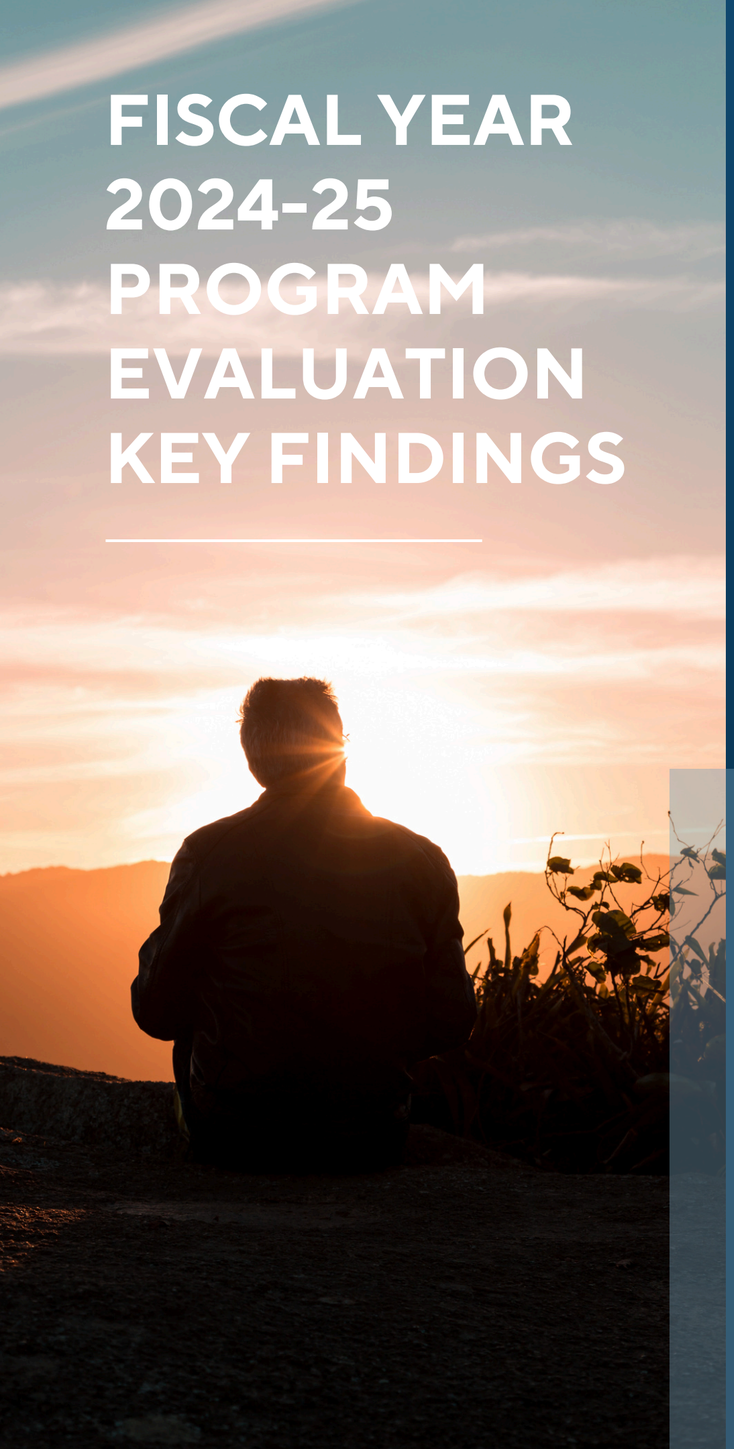
Individuals served in fiscal year 2024-2025



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

Treatment success when completing 31+ sessions

FISCAL YEAR 2024-25 PROGRAM EVALUATION KEY FINDINGS



- Oregon Health Authority problem gambling treatment services include a range of supports. A problem gambling helpline, a digital health app (Evive), and a minimal intervention program (GEAR), are the lowest levels of care. The next step up is comprised of a network of outpatient treatment programs (which includes culturally-specific programs and programs within correctional facilities). The highest level of care is a residential gambling treatment program. Peer support services are also offered and can be an additional source of support during an individual's recovery process, at any level of care.

- The helpline received 564 calls from individuals seeking support for their own gambling behaviors or from concerned others. Of these calls, 72% resulted in referrals to treatment and 7% involved a warm transfer to crisis counseling services.

- Oregon's gambling treatment system provided treatment to 833 individuals. Additionally, 211 Oregonians found support through the Evive digital health support app and GamFin services provided free financial consultations for approximately 42 Oregonians.

- 91% of clients received services for their own gambling behaviors, 8% were individuals affected by another persons gambling (concerned others), and less than 1% received services related to social gaming.

- Treatment was available quickly, with 25% 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 42% over the past 18 months.

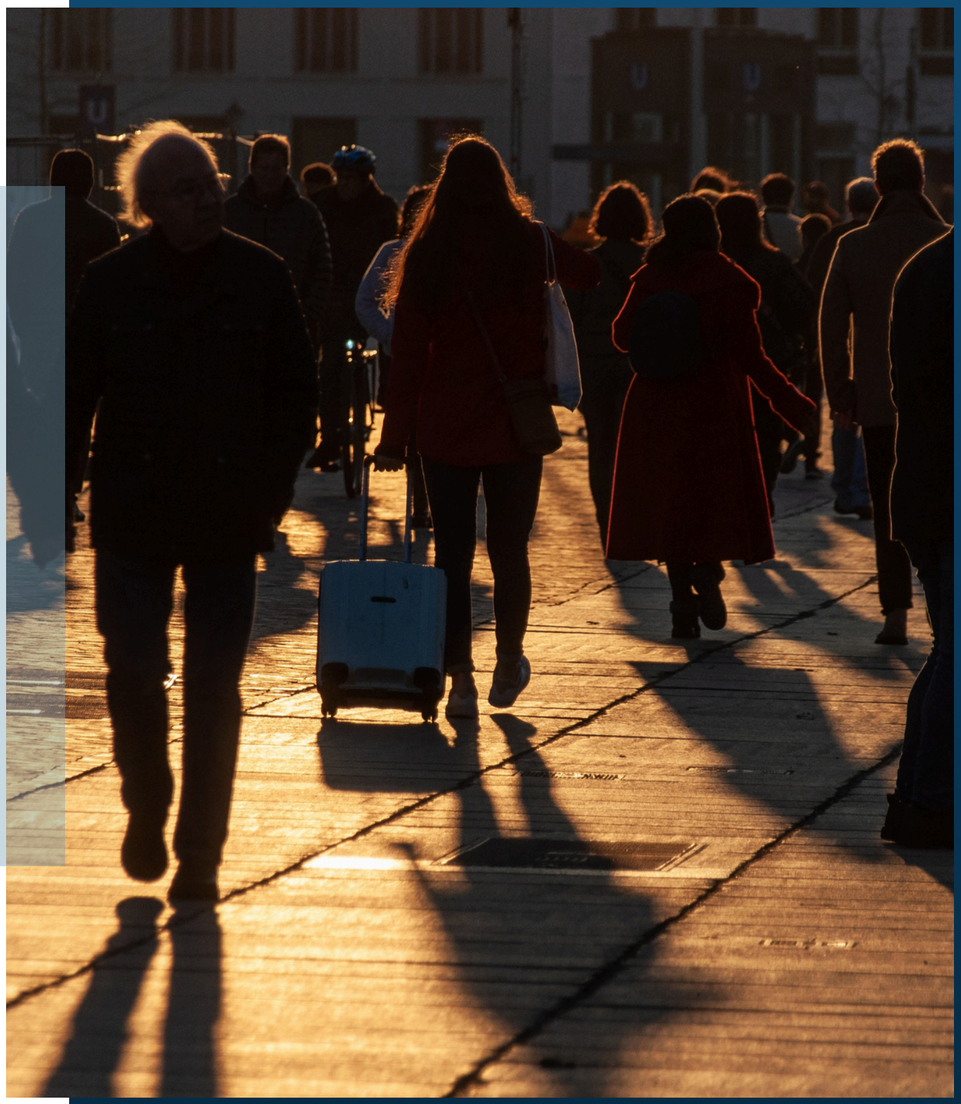
- Successful treatment was defined by the absence of harmful gambling, completion of treatment goals, and development of a wellness plan. The adjusted successful treatment completion rate was 40%. Clients who completed 7+ treatment encounters are nearly five times more likely to successfully complete treatment, compared to those who completed 7 or fewer (51% vs 11%)

- 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.

- 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 49. Females seeking treatment tended to be older than males. Slightly over half of the clients had completed more than a high school degree.
- 6% of clients were connected to the military. 38% of clients were married, 30% never married, and one-third previously married but currently not (e.g., separated, divorced, widowed).
- 80% of clients reported one or more dependents relying on them financially. Nearly two-thirds reported being employed full-time or part-time. About 61% of the clients earned less than $30,000 annually including 11% reporting no income.
- 8% of clients were loved ones of a person with a gambling disorder seeking concerned others supportive counseling, and 91% were individuals addressing their own gambling concerns and less than 1% received services related to social gaming.
- Of clients who sought treatment for gambling, electronic gaming was by far the most frequently reported primary gambling activity (82%). Wagering on sports-related events has grown to 9.6%. Males were 8 times more likely to report sporting events as their primary activities compared to females (14.4% versus 2.1%, respectively). Video lottery retailers were the most common primary gambling venue (66%).
- A large proportion of people entering gambling treatment had a complicated clinical profile: 43% of clients had 2 or more co-occurring conditions, 39% presented with a severe level of gambling disorder, and 33% 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.
- Penetration: Relatively few individuals with gambling issues are accessing OHA PGS problem gambling treatment services.

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 associated with the rapid growth of sports betting and non-traditional forms of gambling, such as prediction markets.
- Increase in problem gambling on account of technological advances.
- Without robust problem gambling prevention efforts to keep pace with the popularity and cultural acceptance of gambling, a greater number of Oregon will likely experience gambling related problems.
- Low community readiness to address problem gambling.

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.