



**State Of Oregon
Oregon Health Authority
Addiction and Mental Health Division
Problem Gambling Services**

***GAMBLING PROGRAMS EVALUATION
UPDATE - 2014***

July 1, 2013 - June 30, 2014



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

EXECUTIVE SUMMARY

This is the annual report of the statewide problem gambling services for Fiscal Year 2013-2014 (FY 13-14 – July 1, 2013 through June 30, 2014). Program gambling services have been funded statewide through proceeds from Oregon Lottery since 1995 and are currently coordinated through the Problem Gambling Services (PGS) that is part of the Addictions and Mental Health Division (AMH) of the Oregon Health Authority (OHA). There were a total of 45 service points throughout the state including a residential; short-term respite; and, a home-based minimal intervention program.

 Utilization projections for gamblers enrolling in treatment were set at approximately 2,100 for the year.

- 1,119 gamblers were enrolled, down 7.8% from last year and 46.7% below the utilization projections; 146 family clients enrolled, down 18.0%
- 50 individuals were enrolled in the residential program, down 32.4% while six received services from the respite program.
- 31 participants were enrolled in the minimal intervention program down 8.8%.

 Treatment Access:

- 24.7% of the gambler clients reported obtaining the treating agency's contact information from the Helpline, down from 28.8%. All other sources were down except from web/internet which was up very slightly.
- 823 calls for assistance or information were reported by the Helpline, down 22.1%; 145 web chats were reported, down 14.2% from last year.

 Treatment Availability:

- Treatment remained readily available across the state with the average time between initial call and first available appointment of 3.8 calendar days, essentially the same as last year.
- Residential care reported a lag time of 13 calendar days, down from 22 days previously reported.

 Treatment Output:

- The average length of enrollment in outpatient treatment for gamblers was 144.6 days, up from 138.5 days; females remained in treatment significant longer (173.4 days) than males (118.5 days).
- Successful treatment completions rate was 49.9%, up from 44.3%; females were significantly more likely to be successful (55.0%) than males (44.8%).

- Average number of service hours per client for all outpatient gamblers was 23.2, up from 20.9 hours. For program completers that average was 46.7 hours, up from 40.4 service hours.
- Average case cost for program completers was \$2,581 up again from \$2,379.



Demographic Characteristics:

- For the first time in eight years male (53.6%) enrollments outnumber female enrollments (46.4%).
- The average age was 46.9 years, same as previously reported, and females continued to be significantly more likely to be older (49.2 years).
- Race/Ethnicity remained stable with 82.1% of the gambler clients reported as White, 6.6% Hispanic, 3.3% Black, 2.8% Asian, and 2.2% Native American.
- Married clients dropped again this year from 32.3% to 28.1%, 27.5% were never married, and 26.1% divorced.
- Full-time employment was reported for 35.8%, with males being significantly more likely to be working full-time; 19.0% were unemployed and looking for work and 11.1% were unemployed and not looking.
- Average household income was \$31,068, with no statistical difference between males and females or that reported last year.
- Average gambling related debt was \$23,919, down again slightly from last year. The ratio of debt to income was 89%.
- Machine-based gambling was the primary game of choice for 88.7% (video poker 52.8%, video line games 20.2%, slots/mechanical reel 15.7%), followed distantly by cards at 5.6%.
- The primary gambling venue continued to be video lottery retailers (71.4%), followed distantly by casinos (13.6%).



Treatment Outcomes:

- Statistically significant improvements were document across a spectrum of key quality of life indicators at six and twelve month follow-up.
- At six-month follow-up 64.1% of the sample reported no gambling and 60.5% of the 12-month sample reported abstinence. For those who left treatment early, 43.3% reported abstinence at six-month follow-up.



Client Satisfaction:

- 97.3% of the completers at six-month follow-up and 93.9% of those at 12-month follow-up indicated strong endorsement regarding recommending the program to others. Even 81.4% of those who dropped out of treatment early indicated willingness to recommend the program.

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1. INTRODUCTION

This is an annual report of the Oregon Problem Gambling Services activities for Fiscal Year 2013 – 2014 (FY 13-14) that included the period July 1, 2013 through June 30, 2014. The purpose of this report is twofold: to document the critical system performance elements of a large dataset addressing critical trends to provide a historical and comparative record; and, provide empirical data which program managers and policy makers can use to make decisions regarding the efficacy and efficiency of the effort.

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

2. BACKGROUND AND HISTORY

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

Several pilot problem gambling treatment programs were initiated throughout the state from 1992 through the spring and early summer of 1995. On July 1, 1995, the statewide treatment effort was consolidated through a management contract by the Department of Administrative Services (DAS) with the Association of Community Mental Health Programs

(AOCMHP). In 2001, following 1999 legislative action, management of the statewide treatment and prevention effort was consolidated in-house by the State Office of Addiction and Mental Health (AMH)¹ under the direction of the Problem Gambling Services Manager.

During the current year there were 40 county – based programs funded to provide treatment services with five statewide programs including a statewide residential program in Marion County; a statewide respite program in Josephine County; a statewide, home-based minimal intervention program based in Lane County; a statewide prison project in Coffee Creek Corrections Facility (Clackamas County); and, a Native American program in Multnomah County. The number of treatment programs has varied over the years due mostly to the regionalization and de-regionalization of treatment efforts in rural counties.

Beginning in the summer of 2001, several special project contracts were initiated with provider organizations throughout the state by AMH to enhance local outreach and prevention. Funding for prevention was formalized under a separate line item and is currently blended with substance abuse prevention efforts at the state level. Beginning in July 2009, treatment providers were provided the financial support to conduct outreach and case finding efforts in the local communities and in July 2012 flexible funding was allowed for services outside the standard billing codes.

Gambling Opportunities

Oregon, like most states, has dealt with illegal and gray gambling² since statehood was achieved. In 1933 the State passed legislation that allowed for pari-mutuel wagering on

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

horses and dogs. From the mid-1950's through 1991, various modifications and new rules were adopted covering pari-mutuel wagering and in 1987 off-track betting was legalized. Since legalization, pari-mutuel wagering has been governed by the Oregon Racing Commission, now primarily focused on off-track wagering.

Social gaming was legalized by the Oregon Legislative Assembly in 1973. This statute allowed for counties and cities to, by ordinance, authorize social gaming in private business, private clubs, or a place of public accommodation. Social gaming requires there to be no house player, house bank, nor house odds and there is no house income for the operation of the social game – usually poker and blackjack. At the time of this report, ten of the 36 counties and 34 cities had adopted such ordinances.

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

In 1984, the Oregon State Lottery was created by a vote of the people through the initiative process and passed by a margin of two to one. The Lottery is governed by a five-member governor-appointed Commission that is approved by the State Senate. The Lottery's statutory mandate is to "produce the maximum amount of net revenues to benefit the public purpose ... commensurate with the public good."³ A minimum of 84% of the Lottery's annual net revenue must be returned to the public in the form of prizes and benefits to the public purpose. The Lottery offers instant tickets (Scratch-Its® were first available in 1985), Megabucks® (1985), Multi-State Lotteries – (Lotto America® from 1989 to 1992 and

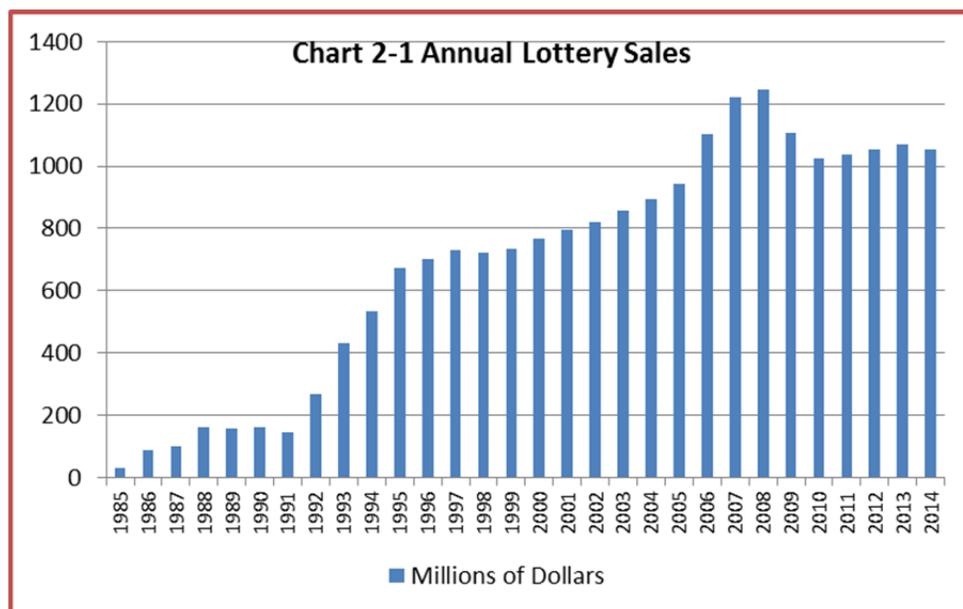
² Illegal gambling that is unofficially allowed to continue such as slot machines at private clubs.

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

Powerball® from 1992), Sports Action® (1989) the first and only state lottery game based on the outcome of professional sporting events (discontinued by 2005 legislative action), Keno® (1991), video poker (1992), Pick 4 ® (2000), and Win for Life® (2001). Video Poker machines were converted in 2007 to allow line games to be played at all Lottery Retailer locations having the VLTs.

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

At the end of Fiscal Year 2013, there were approximately 3,380 Traditional game retailers in the state (some selling Video Lottery also) and 2,293 Video Lottery retailers (some also selling Traditional lottery products also). The total number of Video Lottery terminals was 12,023 at the end of FY 2013. The annual sales for FY 13-14 were \$1.05 billion. As can be seen in Table 2-1, there was a considerable jump in the sales during FY 06-07 to approximately \$1.09 Billion that exceeded expectations and the ensuing drop, along with the economy, in 2008 and 2009.



During the previous reporting period, several Bills were introduced that could have affected the Lottery. House Bill (HB) 2163 was introduced with the intent of requiring the Lottery to employ an individual to advise the Director and Lottery Commission on mental health and addictions issues associated with the Lottery activities. This bill also required the Lottery Commission to adopt policies to minimize and mitigate harms associated with lottery games. In response to this proposed legislation, the Lottery requested a Department of Justice (DOJ) opinion regarding the constitutionality of fulfilling the requirements of the Bill.

The DOJ opinion⁴ found that the Lottery could not constitutionally provide funds to support the activities as delineated in HB 2163. As a result, the Lottery ceased funding critical television, radio, and print ads that had historically been associated with over 30% of the enrollments in outpatient treatment. In the current reporting period, a second bill, HB 4028A, was eventually enacted that provided the Lottery with the ability to resume funding for the critical media service of advertising the availability and access to treatment with the Lottery resuming advertising in late Spring.

A third critical legislative action (HB 2355) provided legislative support to stabilize available funding to PGS by establishing a protocol where funding would essentially not be decreased under the baseline funding established as of July 1, 2011.

The first Indian Gaming Center (IGC) in the State was established in 1993 under the auspices of the Federal Indian Gaming Regulatory Act of 1988. This act allowed tribes to offer any and all forms of gaming that were otherwise legal in the state. There are currently eight IGCs in the state and with the combination of charitable, social, and Lottery games

⁴ DOJ opinion of March 18, 2013.

regulated in Oregon, these IGCs were able to offer all gaming customarily associated with “Las Vegas” style casinos.

Program Funding

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

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

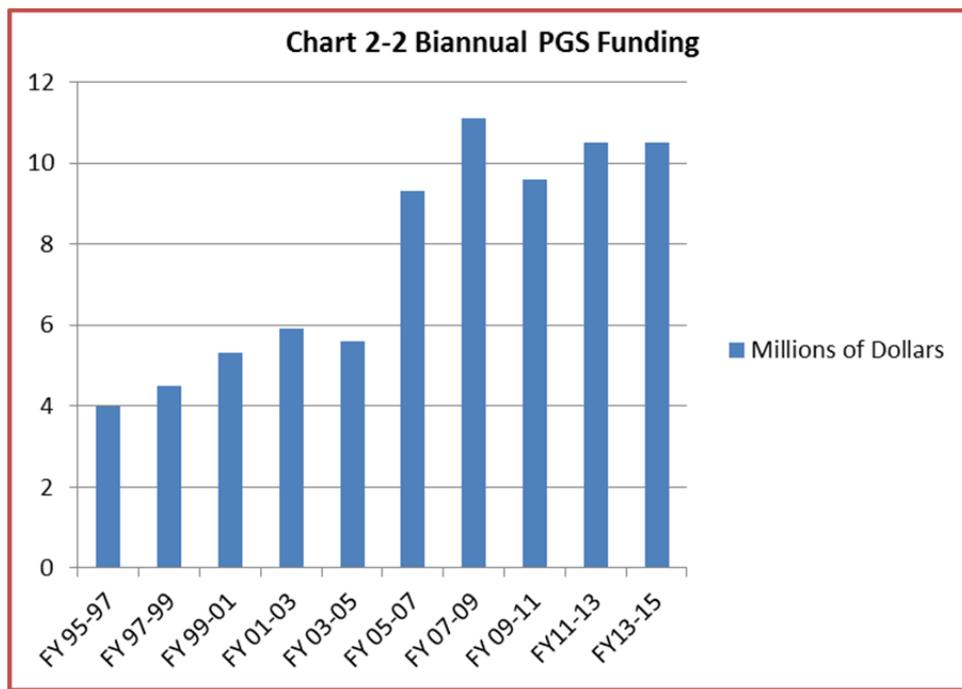
The introduction of Senate Bill (SB) 118, eventually led to the enactment of legislation in 2001 that again tied the funding of problem gambling services to the Lottery proceeds. Oregon Revised Statute (ORS) 409.435 created the Problem Gambling Treatment

Fund and ORS 461.549 set aside one percent of the net lottery proceeds annually. These funds were to be transferred from the Administrative Services Economic Development Fund to the problem gambling fund. This transfer was to occur on a quarterly basis and unused funds were to accrue interest. Enactment of this bill also moved administration of the Problem Gambling Services from the Department of Administrative Services to the Department of Human Services (now Oregon Health Authority).

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

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

Chart 2-2 is a presentation of the actual program funding levels that do not reflect the set-aside. Funding for the current biennium (FY 13-15) is somewhat of an estimate as not all of the transfers in to the OHA have yet occurred.



Estimating Treatment Needs

In 1997, the Oregon Gambling Addiction Treatment Foundation (OGATF)⁵ commissioned an adult prevalence study of problem and pathological gambling in the State. The study, completed in August 1997, estimated the lifetime problem gambling prevalence at 3.1 percent and the probable pathological lifetime gambling at 1.8 percent. The study

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

estimated the current year problem gambling rate at 1.9% and the current year probable pathological gambling prevalence at 1.4%, for a combined current year disordered gambling prevalence of 3.3%. Based on this study estimates indicated the number of admissions of gamblers to the programs each year should be between 600 and 1,400 individuals. (Volberg, 1997)⁶

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

The most recent adult prevalence study found the combined prevalence had increased insignificantly to 2.7% (1.7% problem gamblers and 1.0% probable pathological gamblers) (Moore, 2006). Applying the most recent current year estimates of combined prevalence for problem and probable pathological gambling to the most recent estimate of the adult

⁶ Copies of all studies sponsored by OGATF can be downloaded from www.oregoncpg.com.

population in Oregon, the projected enrollments in all programs during the report period was estimated to be approximately 2,100 to 2,400⁷ gambler clients.

In 1998 OGATF commissioned a study to estimate the prevalence of disordered gambling among adolescents (13 years to 17 years old). That study estimated 5.0% of adolescents were Level 2 (in-transition) gamblers and 1.4% were problem gamblers (Carlson, M. and Moore, T., 1998).^{8,9} The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals. Nonetheless, a subsequent anecdotal investigation¹⁰ by OGATF found that, in practical terms, the development of adolescent-specific treatment programs would most likely not be cost effective. It continues to be very rare for treatment providers in the state to see adolescents seeking treatment, further confirming the Foundation's recommendation.

During 2008, a replication adolescent prevalence study was commissioned by the Problem Gambling Services and found that 1.3% were problem gamblers and another 4.6% were at risk. (Volberg, R., Hedberg, E., Moore, T., 2008)¹¹

In 2000, OGATF commissioned a study to estimate the prevalence of disordered gambling among Oregon adults aged 62 years or more and found that 58% of this population

⁷ In the past, the number of adults seeking treatment was estimated to be 3% of those in potential need. In the spring of 2006 the assumption was increased to 5% (penetration rate) and then subsequently readjusted back to the 3% in 2008 which is the figure utilized for this report.

⁸ Based on the literature for adolescents, the terminology regarding the definition of disordered gambling is slightly different than for adults. "In-transition" is indicative of problems associated with disordered gambling but has not been found predictive of progression to pathological gambling.

⁹ Previous reports have cited these as 11.2% and 4.1% which are calculated by the "broad" method. The 5.0% and 1.4% are the prevalence rates as calculated by the narrow method and reported by the authors and are included herein for comparison with the study referenced below.

¹⁰ This was evidenced through consultations with Dr. Rina Gupta, McGill University, Canada who was working with the only identified adolescent specific gambling treatment program in North America.

¹¹ This study used a slightly altered protocol that purposefully omitted charitable gambling (raffles, etc.) from the mix of games. This may have reduced the total number of adolescents reporting any gambling, but most likely had very little effect on the prevalence of problem and at risk gamblers.

reported past year gambling, and an estimated 1.2% were problem gamblers with an additional 0.3% probable pathological gamblers (Moore, T., 2001b).

Gambling Treatment System Design

Background

Formal programs for the treatment of disordered gambling in Oregon were first established with public funding as pilot projects in 1993, although at least one program was operational prior to the availability of those funds.¹² Agencies applying for state funding¹³ were required to be a state-recognized alcohol and drug (A&D) treatment provider or a community mental health (MH) provider to streamline the approval and implementation process. Nearly all programs were developed within an overarching framework of their sponsoring agency's philosophical approach. Programs that emerged from within an A&D agency tended to adhere to an abstinence-based social treatment model (self-help oriented along the lines of Alcoholics Anonymous (AA) and Gamblers Anonymous {GA}), while those that were developed by MH agencies tended to be oriented towards harm reduction (controlled gambling) and a psychodynamic approach to therapy.¹⁴ Several agencies developed programs unique to the treatment of disordered gambling, but much had to be quickly learned in the face of little to no available experience in Oregon. Over the past 20 years the programs have evolved and the vast majority continues to rely heavily on a cognitive-behavioral approach.

¹² Project Stop was one of the earliest "programs" in the state to offer a dedicated treatment track for individuals with gambling problems and their families.

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

¹⁴ This is arguably a generalization.

As education, training, and counselor certification efforts, led and implemented by the informal gambling treatment providers' association,¹⁵ blossomed within the state, most programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.¹⁶

In FY 01-02, a major change in funding occurred when all providers began transitioning from a grant-based payment structure to a fee-for-service basis for payment. Initially, the rate for group counseling sessions was \$27.04 per hour and the rate for individual counseling was \$81.08. On October 1, 2003, these rates were increased to \$27.52 and \$82.52 respectively and are currently \$29.68 and \$89.00. Current funding strategies allow for a myriad of treatment and outreach reimbursement categories and, paralleling the efforts of the State's compliance with the Affordable Care Act, allow a good deal of flexibility. Substantial funding was also made available for prevention as noted above.

There is no charge to Oregon residents who enroll in the programs.

Description of Current Treatment Services

Oregon's Problem Gambling Services are guided by a public health paradigm and approach that take into consideration biological, behavioral, economic, cultural, and policy determinants influencing gambling and health. It incorporates prevention, harm reduction and multiple levels of treatment by placing emphasis on quality of life issues for gamblers, their families, and communities. By appreciating the multiple dimensions of gambling, Oregon's

¹⁵ In 1995 when AOCMHP assumed contractual responsibility for oversight and coordination of the gambling treatment, the Executive Director, Michael McCracken, assembled an advisory group, open to all provider agencies. This group had met monthly for several years and has provided a great deal of insight and guidance to the formation of treatment, treatment program standards, and counselor certification. Within the past several years the programs have become stabilized and this group no longer meets regularly.

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

Problem Gambling Services have been developed to incorporate strategies that minimize gambling's negative impacts while recognizing the reality of gambling's availability, cultural acceptance, and economic appeal.

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

Philosophically the treatment system design follows a stepped-care approach beginning with a home-based, telephonically supported minimal intervention program that is available for individuals who, for a variety of reasons, prefer not to attend brick and mortar facilities.¹⁷ Originally designed as an intervention for those with less severity, the effort has proven to be utilized by many with severity similar to those entering traditional outpatient programs. Traditional outpatient programs comprise the bulk of the treatment effort with non-English services available in some areas. There is one short-stay respite program located

¹⁷ During the FY10-11 report period this service was cut due to budget constraints but was re-introduced in FY11-12.

in Southern Oregon with treatment durations typically five or less days and a social model residential program located in the central part of the state (west of the Cascade Mountain Range). Length of stays at this facility typically ranges from 30 to 40 days. Transportation to and from both the respite and residential programs can be paid by problem gambling funds.

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

Prevention Efforts

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

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

By definition, problem gambling prevention programs are directed at avoiding or reducing the negative emotional, physical, social, legal, financial, and spiritual consequences

of disordered gambling for the gambler and the gambler's family. Oregon's prevention efforts are guided by the Center for Substance Abuse Prevention's (CSAP) 6 core prevention strategies. Problem Gambling Services delivers prevention and outreach services by three separate, yet related administrative bodies:

The Oregon Health Authority, Addictions and Mental Health Division, Problem Gambling Services unit develops and maintains policies, promotes collaborative relationships between various stakeholder groups, provides technical assistance, and provides local governments with funds to develop and implement regionally specific prevention plans. . . , Problem Gambling Prevention Services is integrated at the state level with the substance abuse prevention efforts which allows for facilitation of problem gambling being included in overall prevention efforts.

County/Local Governments develop and implement regionally specific prevention plans that are based on CSAP's prevention models and include measurable goals and objectives.

The Oregon Lottery develops and delivers public awareness and education programs designed to provide clear and consistent messages regarding healthy and unhealthy gambling behavior. The lottery campaigns use a variety of media, including TV, radio, social media and print to help increase awareness of problem gambling and to encourage Oregonians to utilize the Problem Gambling Helpline if needed. The Lottery developed and operated a "Play Responsibly" campaign several years ago and typically invests up to approximately 10% of their overall marketing budget in problem gambling awareness campaigns. . These award winning ads remind people that lottery games are for fun and entertainment and should be played as such, to inform the public and lottery retailers about problem gambling and

treatment availability.¹⁸ In the past, analysis of the available data by the author has demonstrated a significant increase in the frequency of helpline calls when the Oregon Lottery's ads for treatment were run.

3. TREATMENT PROGRAM UTILIZATION

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

The plateau in the number of gamblers enrolling in treatment in FY 00-01 was hypothesized to have been influenced by two primary factors. In the spring of 1999, a successful legislative effort¹⁹ was launched to increase treatment program funding and attach the level of funding to a minimum percent of the lottery proceeds in the state. That effort included actions intended to stabilize the programs by moving the management and coordination function from the temporary contractual situation, established in July of 1995 with the AOCMHP,²⁰ to a state agency. The unintended consequences of the passage of legislative action was an 18-month period of contractual uncertainty including short term funding cycles, continual discussions of varying funding levels, and general loss of statewide coordination of outreach and treatment efforts. Effects of this uncertainty permeated throughout most provider agencies²¹ until the state placed the services under the AMH and created/filled a Problem Gambling Services Manager position.

¹⁸ These programs have received national recognition from the National Council on Problem Gambling and the North American Association of State and Provincial Lotteries.

¹⁹ Senate Bill 118

²⁰ AOCMHP is a membership organization, comprised mainly of county mental health directors within the state with focus on activist and lobbying activities to support the advancement of mental health care in the state.

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

The second intervening variable that contributed to a flat enrollment rate in FY 00-01 was the fact that the Oregon Lottery, tasked by the legislature to conduct the “Play Responsibly” campaign that included effective paid advertising (print, radio, and television) promoting free treatment, was in the process of a major research and design effort for a new media campaign and consequently, the purchase of media appeared to decrease during the year. A new campaign was aggressively deployed in the fall of 2001 and subsequently enrollment began to increase again with a 36.2% increase over FY 00-01.

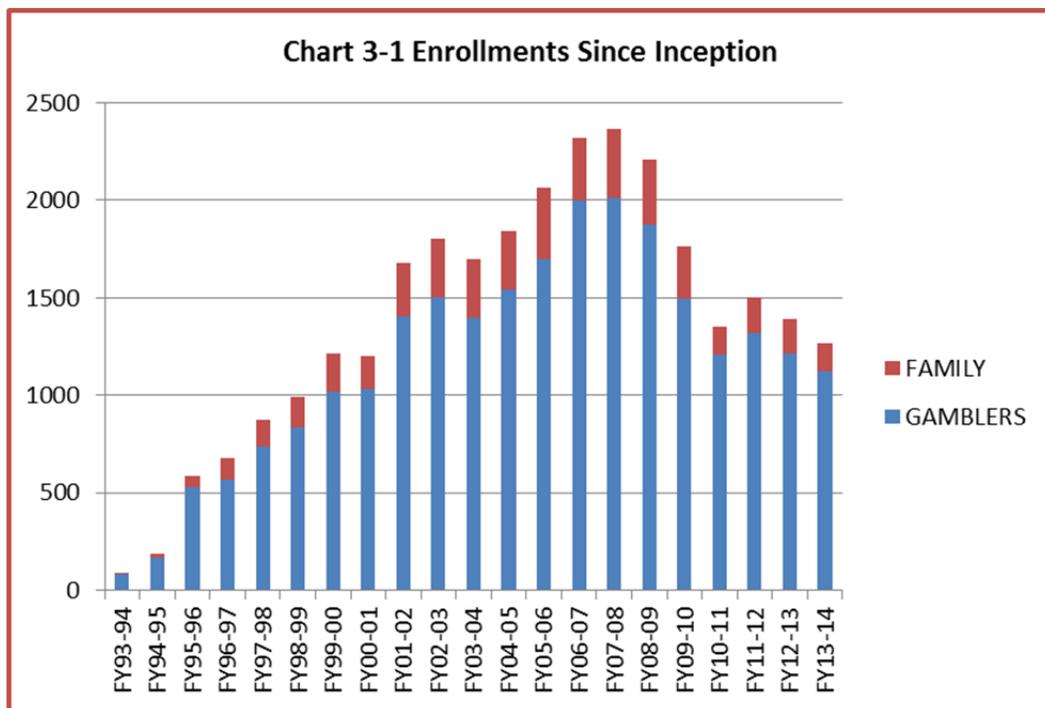
This phenomenal growth in FY 01-02 was speculated to have been influenced by five factors. The first two factors were the reversals of the two that contributed to the flat growth rate in FY 00-01 discussed in the preceding paragraph (set budgets and clear leadership). The third factor was the implementation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

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

and had caused programs to simply lose momentum from the loss and pending loss of infrastructure.

Over the next three years, enrollments increased by an average of 12.6% each year. In FY 07-08 the economy began another rapid descent and enrollments dropped nearly 42% from FY 07-08 through FY 10-11. The following year enrollments came back 9.3% (essentially back to FY 01-02 levels) and then dropped 8.1% the following year and another 7.8% for the current reporting year.

For FY 13-14 total gambler enrollments was 1,119 and family 146 for a total of 1,265 enrollments. (Chart 3-1)



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

were reported in FY 00-01 with three or fewer sessions and those reported in FY 01-02 revealed a statistically significant²² difference. The artifact of a change in the funding source that required a client be “enrolled” before the provider was able to receive fee-for-service credit may have accounted for an increase in 100 to 150 enrollments. Another potential artifact of the more precise reporting²³ was the finding that the annual recidivism rate of gamblers for FY 01-02 was 6.1%, up from 2.4% reported during the previous fiscal year.

Approximately 27.1% of the outpatient gamblers enrolling during the period had at least one prior enrollment at the same outpatient program. This compares to a rate of 27.5% reported last year. For those with more than one enrollment, the average remained at 2.8 episodes of care. Approximately 3.4% (n=37) had five or more enrollments compared to 28 individuals last year. This data excludes enrollments in the specialty respite, residential, and minimal intervention programs.

As noted above, during the current year there were 30 agencies funded to provide treatment services with 45 separate programs including a statewide residential program in Marion County; a statewide respite program in Josephine County; a statewide, home-based minimal intervention program based in Lane County; and, a prison program in Clackamas County. The reader will note that some programs reported no enrollments during the period. This is due to efforts in the more rural counties to provide minimal funding (\$15,000), since approximately 2009, in an effort to provide outreach and minimal services base and maintain system infrastructure. (Table 3-1)

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

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

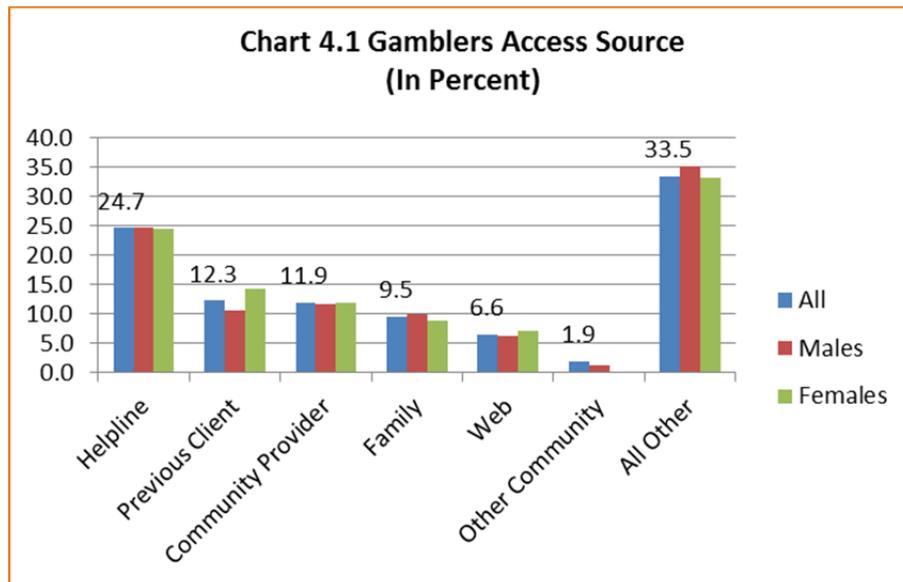
4. TREATMENT SYSTEM PERFORMANCE

Access

Table 3-1 Treatment Enrollments FRY 13-14			
Funded Programs			
County- Agency/Program	Gamblers	Family	Total
BAKER - NEW DIRECTIONS NORTHWEST	0	0	0
CLACKAMAS - CASCADIA	72	10	82
CLATSOP COUNTY	2	0	2
COLUMBIA COUNTY	9	0	9
COOS - ADAPT	22	2	24
CROOK	1	0	1
CURRY COUNTY HUMAN SERVICES	4	0	4
DESCHUTES - BESTCARE	24	4	28
DOUGLAS - ADAPT	20	2	22
GILLIAM - CC SOLUTIONS	0	0	0
GRANT - CC SOLUTIONS	2	0	2
HOOD RIVER - MID COLUMBIA CENTER FOR LIVING	4	0	4
JACKSON - ADDICTIONS RECOVERY CENTER	60	7	67
JACKSON - ON TRACK	45	3	48
JEFFERSON - BESTCARE	9	0	9
JOSEPHINE COUNTY	19	2	21
KLAMATH - BESTCARE	6	0	6
LAKE	1	0	1
LANE - CENTRO LATINO AMERICANO	1	0	1
LANE - EMERGENCE	88	16	104
LINCOLN COUNTY	7	0	7
LINN COUNTY	42	5	47
MALHEUR / LIFEWAYS	10	0	10
MARION -BRIDGEWAY OUTPATIENT SERVICES	90	6	96
MORROW - CC SOLUTIONS	0	0	0
MULTNOMAH - INACT, INC.	41	11	52
MULTNOMAH - LEWIS AND CLARK COLLEGE	34	15	49
MULTNOMAH - OHSU INTERNATIONAL	7	0	7
MULTNOMAH OREGON HEALTH SCIENCES UNIVERSITY	25	1	26
POLK COUNTY	15	1	16
PORTLAND - CASCADIA	109	19	128
SHERMAN - MID COLUMBIA CENTER FOR LIVING	0	0	0
TILLAMOOK FAMILY COUNSELING	9	0	9
UMATILLA COUNTY MENTAL HEALTH	9	0	9

UNION - GRANDE RONDE	4	0	4
WALLOWA - GRANDE RONDE	1	0	1
WASCO - MID COLUMBIA CENTER FOR LIVING	4	0	4
WASHINGTON – LIFE WORKS NORTHWEST	103	18	121
WHEELER - CC SOLUTIONS	0	0	0
YAMHILL COUNTY	34	4	38
STATEWIDE - BRIDGEWAY RESIDENTIAL SERVICES	50	0	50
STATEWIDE - COFFEE CREEK CORRECTIONS	92	14	106
STATEWIDE - GEAR	31	6	37
STATEWIDE - JOSEPHINE COUNTY RESPITE	6	0	6
STATEWIDE - NATIVE AMERICAN REHABILITATION ASSN	7	0	7
Total	1119	146	1265

Approximately 24.7% (down significantly²⁴ from 28.8% last year and 34.4% the previous year) reported obtaining the treating agency contact information from the Helpline. The number of clients indicating they had received the contact information from the web was up significantly²⁵ from 4.0% last year to 6.6% this year. Also up significantly²⁶ from 9.1% to 12.3% this year was the number of clients indicating they had received the treatment contact information from a previous client.

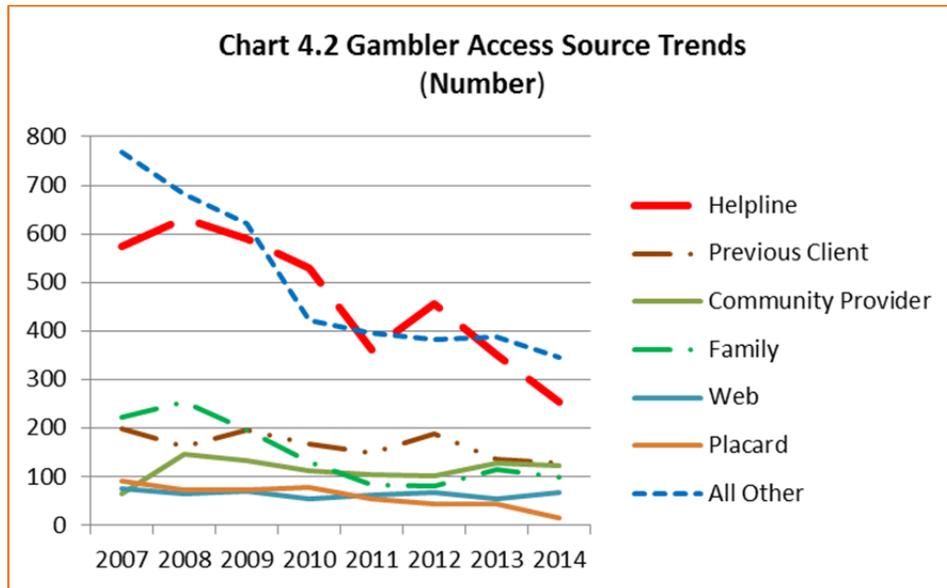


²⁴ p < .05

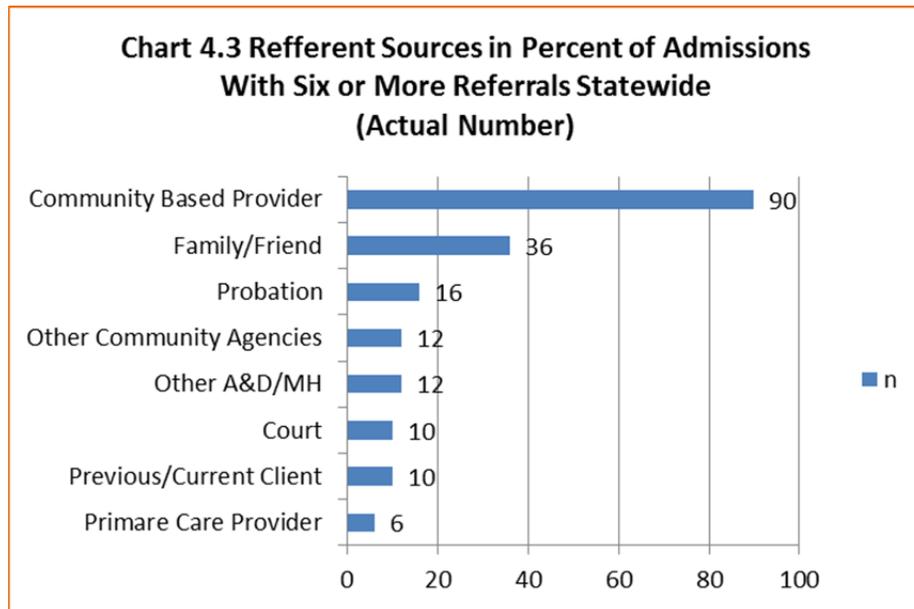
²⁵ p < .01

²⁶ p < .01

Community providers (addictions and mental health providers) remained relatively constant at 11.9% while placards on video lottery terminals dropped from 3.0% last year to 1.5% this year. There was little difference between the genders in respect to where the treatment agency phone number was accessed. (Chart 4.1)



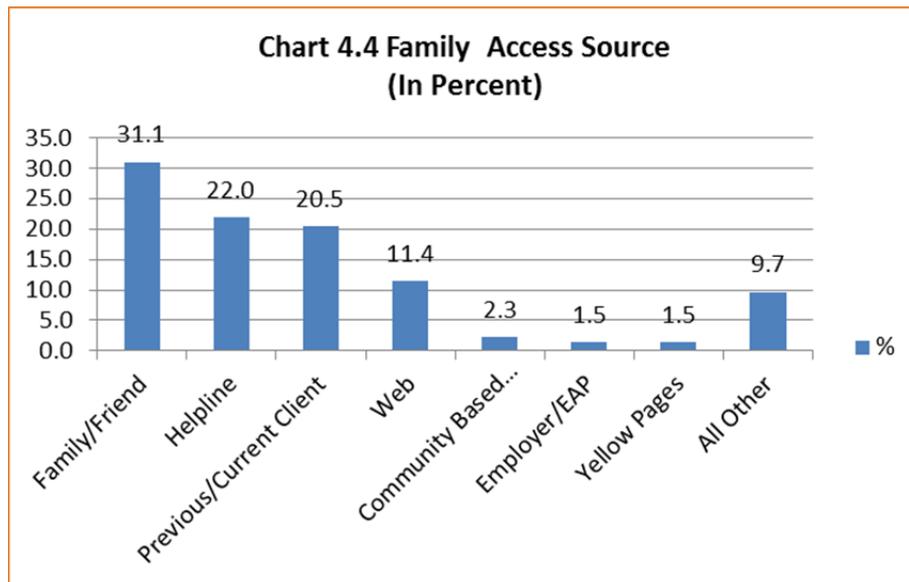
Once again this year, the report contains a chart delineating the actual number of clients reporting the source for the treating agency. As discussed above, access to the system through the helpline saw a downward trend in FY 12-13 and again this year – as did access from “all other” sources. (Chart 4.2)



Approximately 22.8% (down from 25.5% last year) of the gamblers enrolling during the period reported receiving a deliberate referral²⁷ to one of the treatment programs. As can be seen in Chart 4.3, the largest portion (38.3%) were from a community based addictions or mental health provider followed distantly (15.3%) by a family member or friend. (Chart 4.3)

As expected, the largest referral source (31.1%) for family member access was a family or friend which would be expected as many agencies send out invitations to family members with the consent of the gambler client. This was followed by calls to the helpline (22.0%) and previous/current client (20.5%). (Chart 4.4)

²⁷ This is defined as another person or institution taking deliberate action to get the client to the treating agency.



Treatment providers are contractually required to have appointment availability in the

	n	Mean	sd
Calendar Days	943	3.8	5.0

outpatient programs within five work days. The average number of calendar days system wide between the call date and the first available appointment was only 3.8 days. This lag time exceeds requirements and is statistically equal to the lag time for the previous year.

(Table 4.1)

As expected, including client delays for convenience, the lag increased to 6.2 days from initial call to first seen.

During the report period the residential program experienced a significantly²⁸ shorter period between first call and first available appointment than last year (13.2 days compared with 22.0 days reported last year).

²⁸ p < .01

Females were significantly²⁹ more likely to have a longer lag time for outpatient (4.9 calendar days) than males (4.0 days) from first call to first available and a similarly significant longer lag from call to first seen (6.8 versus 5.7 days for males) statewide. Interestingly, the lag time for rural clients was significantly³⁰ less (3.3 days versus 4.1 days in the metropolitan areas) and there was no significant difference in the lag time between first call and first available for males and females in the rural areas. Nonetheless, there was a significantly³¹ longer wait for females in the metropolitan area (4.7 days versus 3.7 days). It is hypothesized that females were more likely to request a same-sex counselor than males in the metropolitan areas somewhat restricting their access.

The lag between the initial call by family clients and the first available appointment was 3.2 days again down for the previous year from 4.6 days.

Length of Time Enrolled

During the winter of 2010, and in the face of large budget cuts, an in-depth analysis of case costs and length of stay was conducted. This analysis revealed that well over 30% of the enrolled clients had been in treatment for long periods of time – some for several years. Following lengthy dialogue between PGS and stakeholders, a decision was made to place a 12-month cap on outpatient lengths of stay with the provision that providers could request a waiver, based on clinical needs, from PGS to extend the length of stay. This cap was implemented on November 1, 2010. Providers who determined that a client needed to remain engaged in treatment longer than the 12 month period could request a waiver from PGS. Of

²⁹ p < .05

³⁰ P < .05

³¹ p < .05

those discharged from outpatient treatment, 7.9% were with waivers to the annual cap, up insignificantly from 5.8% last year.

Of interest was a subsequent analysis that looked at 2,992 outpatient gambler discharges since January 1, 2012. Of those 186 had waivers and of those with waivers, 136 (73.1%) completed successfully. There were 2,806 gambler discharges without waivers. Of those, 910 (32.4%) completed successfully. The likelihood of those with waivers remaining engaged in treatment and successfully completing was significantly³² greater.

The average length of time gamblers were enrolled in outpatient treatment was 144.6 days up somewhat from the 138.5 days previously reported. Females were again significantly³³ more likely to remain enrolled longer than males. (Table 4.2)

	n	mean	sd
All Gamblers	952	144.6	169.4
Males	501	118.5	147.0
Females	451	173.4	187.1

Those clients who remained in the programs until they had met the criteria for successful program completion (1. completed 75% of their treatment plan; 2. problem free for the last 30 days; and, 3. had a continuing wellness [aftercare] plan) remained enrolled significantly³⁴ longer than non-completers (256.3 days) and up from 243.8 days previously reported. As expected, those who left under conditions other than successful remained, on average, only 81.9 days, down slightly from last year (83.0 days).

³² p < .01

³³ p < .01

³⁴ p < .01

The adjusted³⁵ successful completion rate for gamblers was 49.9% overall, up from 44.3% previously reported. Females continued to significantly³⁶ be more likely reported as successful program completers (55.0%) than males (44.8%). (Table 4.3)

Status	All	Males	Females
Adjusted Successful Completion Rate*	49.9	44.8	55.0
Stopped Attending ASA*	35.1	37.7	32.2
Successful Completion*	35.9	31.1	41.2
Refused Service	5.0	5.2	4.9
Moved from Catchment Area	4.8	6.2	3.3
Evaluation Only	4.6	5.8	3.3
Further Treatment Not Appropriate	3.0	2.8	3.3
Physical/Mental Illness	2.7	2.2	3.3
Conflicting Hours	2.4	2.4	2.4
Incarcerated	1.6	2.2	0.9
Program Closure - Non Cap	1.5	1.2	1.8
Non-Compliance With Rules*	1.1	0.6	1.6
No Transportation	0.9	0.8	1.1
Other	1.2	1.8	0.7
*Used for Calculating the Adjusted Rate			

Following treatment, approximately 33.4% (down from 38.8%) were reported as being referred to Gamblers Anonymous (GA). (This is down from 54.5% reported three years ago.) As discussed in previous reports, the informal relationship between treatment programs and GA has continued to disintegrate with informal referrals from GA members dropping.

³⁵ The method of calculating the successful completion rate removes the neutral reasons from the equation (see Table 4-3 for each of these categories).

³⁶ $p < .01$

Only 13.1% were reported as being referred to traditional aftercare/continuing care and 35.8% were reported as having no continuing care referrals most likely due to departure prior to the integration of a treatment/wellness plan.

Family clients remained in treatment an average of 184.2 days, up from 128.3 days previously reported. Those who successfully completed their treatment plans remained significantly³⁷ longer in treatment at 284.1 days (up sharply from 205.9 days). The adjusted successful program completion rate for family clients was 45.9%, down from 58.5% previously reported.

Level of Effort for Outpatient Services

The average number of service hours for all gambler cases was 23.2, up slightly from 22.0 hours previously reported. For those who successfully completed treatment, the average number of service hours received increased to 46.7 from 44.0 hours. For family clients the average number of service hours per case was 17.8 up from 13.5 and for successful family program completers it was 28.6 up from 21.6 hours. (Table 4.4)

	n	mean	sd
All Gamblers	878	23.2	33.5
Successful Discharges	291	46.7	43.6
All Family	136	17.8	20.1
Successful Discharges	70	28.6	21.7

Over the past few years, as enrollments have gone down, length of enrollments have gone up. Year to year changes have not been statistically significant, but when comparing current expenditures with two or more years past some increases have become statistically significant.

³⁷ p < .01

The average cost per case overall for gamblers was \$1,352.7, up from \$1,249.3.

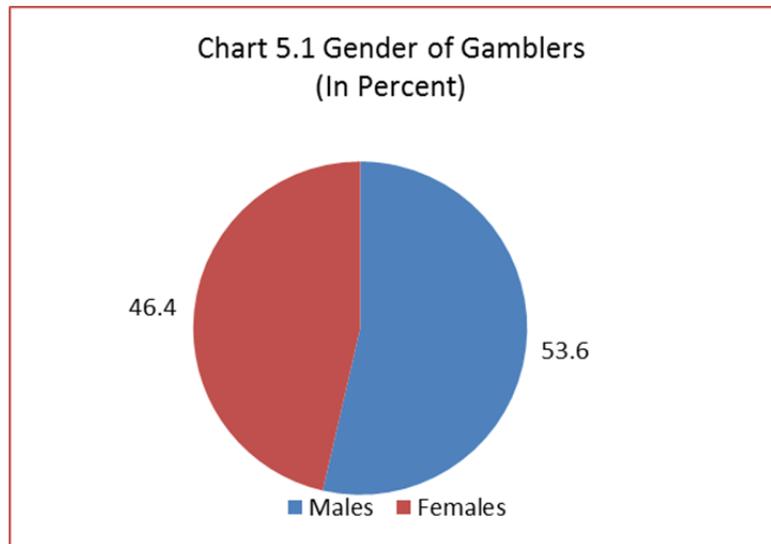
For program completers, the average cost per case was \$2,581.0, up from \$2,379.2 Family member case cost also increased from \$948.3 to \$1,282.6 this year, and for successful

family completers \$2,027.1, up from \$1,525.3 reported last year. Again these case costs are based on recorded billable hours per case closed during the period. (Table 4.5)

	n	mean	sd
All Gamblers	878	1,352.7	1,762.0
Successful Discharges	291	2,581.0	2,227.0
All Family	136	1,282.6	1,274.9
Successful Discharges	70	2,027.1	1,322.4

5. GAMBLING CLIENT DEMOGRAPHICS

Approximately 53.6% of the individuals seeking treatment within the state-funded outpatient programs were males. This was the first time in eight years where the distribution of males exceeded females and the difference was statistically significant.³⁸ (Chart 5.1)



The average age of gamblers was 46.9 years, the same as last year. Males continued to be significantly³⁹ younger than females at 44.9 versus 49.2 years. There were 110

³⁸ p < .01

³⁹ p < .01

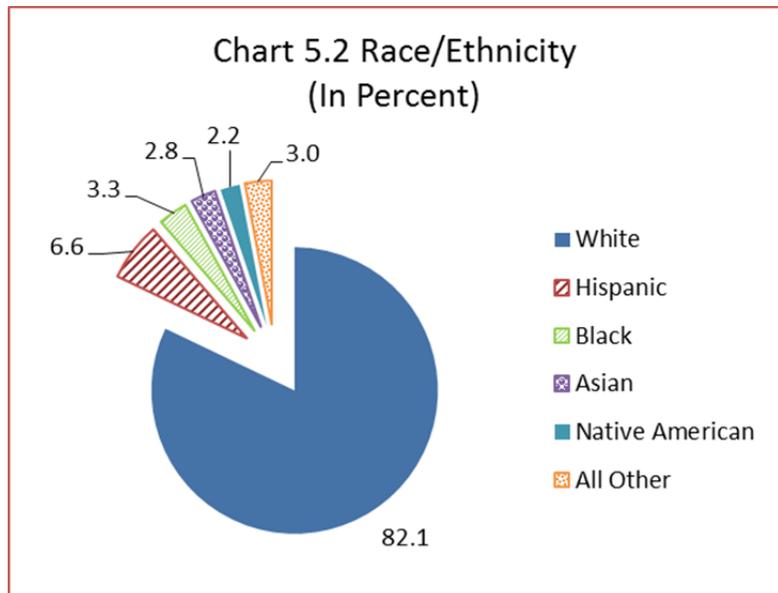
individuals with reported ages of 65 and older (no significant change from last year). (Table 5.1)

	n	mean	sd
All	1027	46.9	13.3
Males	552	44.9	13.2
Females	475	49.2	13.1

The distribution of clients based on race/ethnicity was very similar to that reported last

year after the shift from White to other categories. This year 82.1% were reported White with 80.2% reporting last year.

Hispanics accounted for 6.6% of those enrolling followed by 3.3% Black, 2.8% Asian and 2.2% Native American. (Chart 5.2)



As has been consistently

noted in these reports, research suggested that the prevalence of problem and pathological gambling among non-white populations was much higher than within the white category.⁴⁰

PGS has continued support for voluntary advisory committees (Latino and Asian) looking at how best to provide services to minority populations as well as providing culturally specific treatment to these populations along with Native American and Black/African American programs.

The average number of years of education for clients was 13.1 years, up very slightly from 13.0 previously reported. Females once again reported a small, but statistically

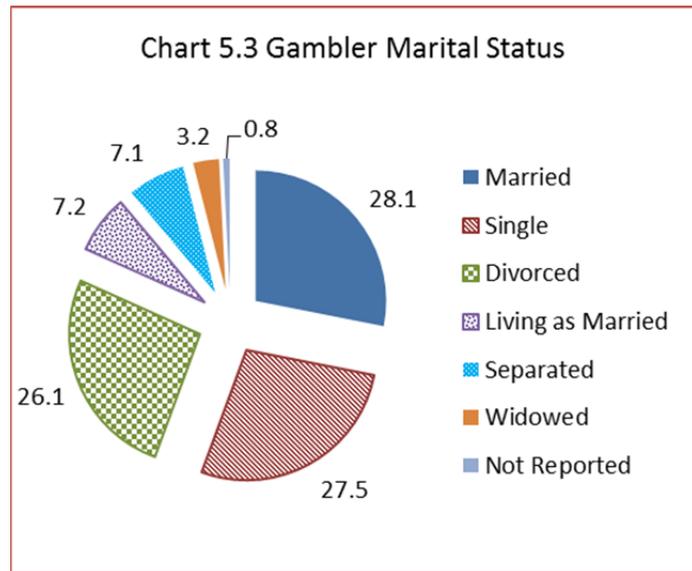
⁴⁰ See Moore, T., Jadlos, T., Carlson, M. (2000). Findings and recommendations for the strategic plan: identification, prevention and treatment of disordered gambling in Multnomah County.

significantly⁴¹ increase over males in the number of years of education completed. (Table 5.2)

	n	Mean	sd
All	1006	13.1	2.3
Males	542	12.9	2.2
Females	464	13.3	2.4

Approximately 28.1%, down from 32.3%, of the gambler clients were reported as married; 27.5% were single/never married, up from 25.7%, and 26.1% divorced, up from 24.7%.

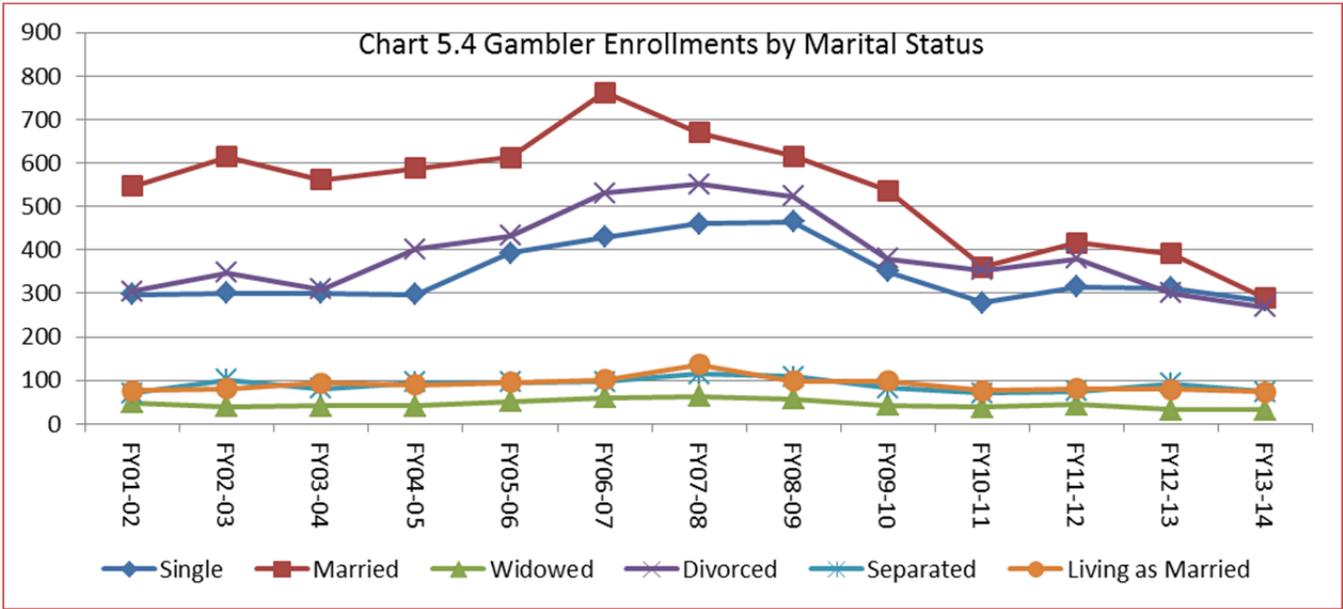
Another 7.2% were reported living as married and 7.1% separated. The decrease in the distribution of married clients was once again an important finding this year. (Chart 5.3)



Three years ago it was reported that the ratio of married clients had

decreased significantly from previous years. Last year, the number of married client remained depressed, but tended to trend closely with other categories, as enrollments decreased overall. Disturbingly, this year another drop in married clients enrolling was recorded. As can be seen in the preceding and accompanying chart, the distribution of married clients is about the same as single/never married and divorced. This change is profound. (Chart 5.4)

⁴¹ p < .01



Approximately 35.8% of gamblers were reported as working full-time, essentially the same as last year, and 7.7% reported working part-time, down from 9.0%. Female full-time employment status was significantly ⁴²

Status	All	Males	Females
Full-Time	35.8	40.9	29.8
Part-Time	7.7	6.3	9.2
Irregular	3.6	4.2	2.9
Unemployed Looking	17.9	19.0	16.6
Unemployed - Not Looking	12.4	11.1	14.0
Retired	10.3	8.7	12.2
Disabled	11.0	8.7	13.6

below males this year as well as below the 34.9% reported last year. Males continue to be more likely to have full-time employment than females.⁴³ The distribution of individuals reporting other employment situations fluctuated from last year, but none significantly. (Table 5.3)

⁴² p < .05

⁴³ p < .01

The average household annual income was reported at \$31,086, down slightly from \$31,602, previously reported. There was a significant

⁴⁴difference between males and females household income, as previously reported. Source of income

was most frequently reported as wages (49.9%, down from 52.5%), public assistance 12.4% (up from 9.8%), and pension 9.5% (down slightly from 9.9%). Approximately 13.2%, up from 12.6%, were reported as having zero income and the median annual household income was reported at \$21,600, down from \$25,200 reported last year. (Table 5.4)

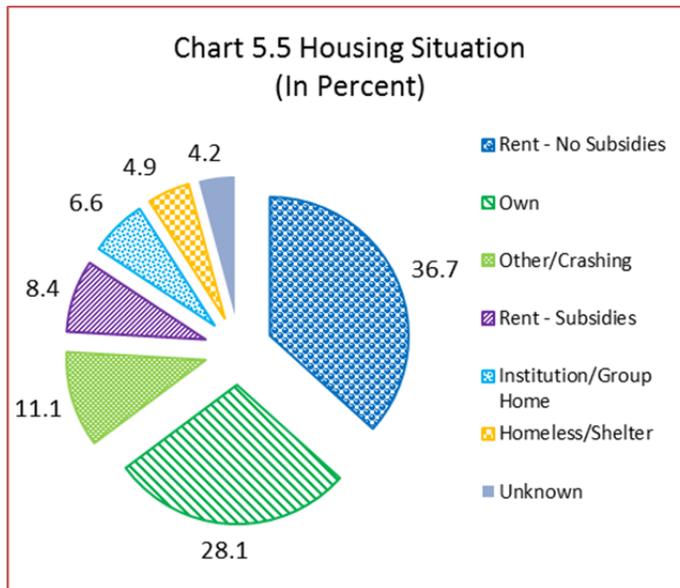
	n	mean	sd
All	932	31,086	32,678
Males	513	31,437	33,725
Females	419	30,657	31,343

Approximately 26.2% of the clients reported having no health insurance, down 32.6% reported last year; while 21.7% reported being enrolled in Medicaid/Oregon Health Plan, up from 13.4%. Clients with Medicare coverage remained essentially the same at 11.3% as did those with Veterans benefits at 4.9%. Those reporting private insurance remained essentially the same at 33.7%. Males were once again more likely to report having no insurance than females (31.3% versus 22.9%). (Table 5.5)

Private	33.7
Medicaid/OHP	21.7
Medicare	11.3
VA	4.9
Other Public	2.2
None	26.2

Approximately 36.7% reported renting their housing with no subsidies. This was down slightly for 39.3%. Living in a home owned by the client or family fell from 39.3% to 28.1% while subsidized rental increased from 6.7% to 11.1%. Homeless or “crashing” was reported at 16% up from 14.7%. Females were more likely to report living in an owned home than males (30.6% versus 25.9%). (Chart 5.5)

⁴⁴ p > .05



6. GAMBLING CHARACTERISTICS

The single most frequently noted game of choice has been video poker since the inception of the treatment programs. During the pilot treatment programs (1993 -1995), it was initially indicated as the primary game of choice by over 80% of the clients in treatment. As the IGCs came on line in 2005 and the Lottery introduced line games to the existing VLTs in 2007, the distribution shifted from video poker to line (slot) games, and over the years the distribution of video poker as the primary choice has fluctuated from a low of 52.8% this year, down very slightly from 53.0%, to a high of 76.3% in FY 96-97. In the last few years, video poker has continued to be identified less frequently as preference moved to other machine- based games such as line games.

Game	All	Males	Females
Video Poker	52.8	56.3	48.6
Video Line Games	20.2	18.5	22.2
Slot/Mechanical Reel	15.7	10.5	21.8

In recent years there has been a tendency to lump video poker, electronic line games, and old-fashioned mechanical reel games into one category. Although slot and video line games can reasonably be lumped into one category, there is still the perception that video poker takes some skill. As has been consistently reported, males were significantly⁴⁵ more likely to report video poker (compared with all other gambling activities) as the primary game of choice than females and conversely females are more likely⁴⁶ to report slot/line games as their primary choice. (Table 6.1)

Card gambling was reported as the fourth most frequently cited game of choice (5.6%) with males continuing to be significantly⁴⁷ more likely to report this choice (8.0%) than females (2.9%). Scratch-Its⁴⁸ were reported by 1.5% of the gamblers as their primary gambling activity followed by Keno and Bingo (0.8% each). All other games were reported by less than one percent each. There was some slight shifting in the distributions from year to year. (Table 6.2)

	All	Males	Females
Machines	88.7	85.3	92.6
Cards	5.6	8.0	2.9
Scratch	1.5	1.3	1.7
Keno	0.8	1.4	0.0
Bingo	0.8	1.1	0.4
Animals	0.4	0.5	0.2
Sports	0.3	0.5	0.0
Other	1.9	1.9	2.2

The location for the primary gambling activity was lottery retailers with the VLTs, 71.4% - down slightly from 73.4%, followed by IGC/casinos (13.6%, same as last year). Restaurant/bars without VLTs accounted for 6.2%, up from 5.3%, followed by

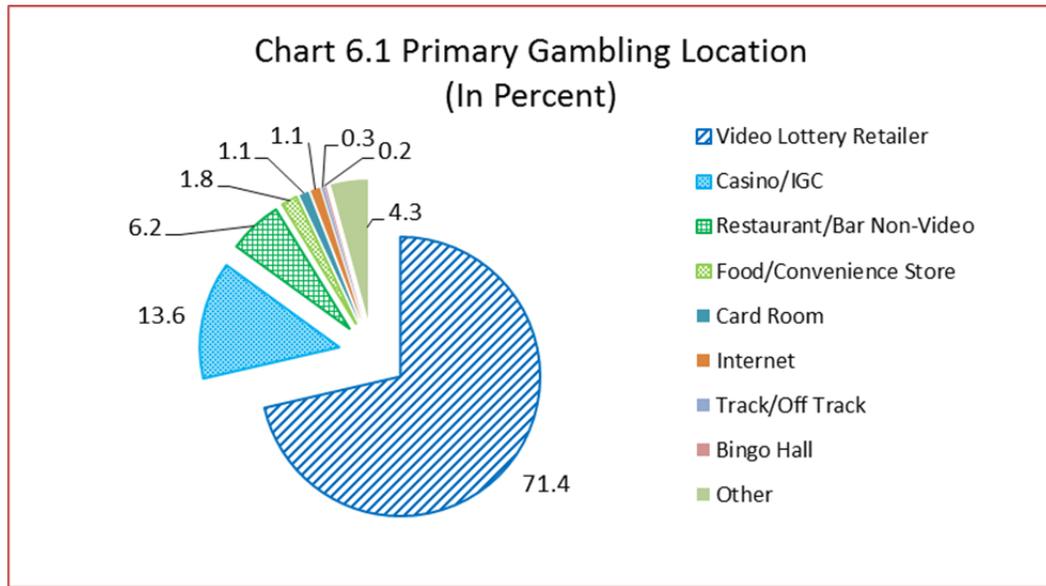
⁴⁵ p < .01

⁴⁶ p < .01

⁴⁷ p < .01

⁴⁸ Scratch-Its, and Megabucks are registered service marks of the Oregon Lottery ® and Powerball is a registered mark.

food/convenience stores (1.8%). Those reporting internet gambling remained at approximately 1.1%. (Chart 6.1)



In previous reports it has been noted that there was a tendency for a larger distribution of clients to report gambling in a casino when there was a casino in their county. This tendency continued, but it should be noted that IGCs in Oregon are primarily in rural areas where convenience plays a strong role in gambling venue selection.

The average age of first gambling experience remained stable at 24.6 years. Males continued to report a significantly ⁴⁹ earlier age of their first gambling experience (21.9 years) than females (27.8 years). (Table 6.3)

	n	mean	sd
All	1000	24.6	12.5
Males	539	21.9	10.8
Females	461	27.8	13.6

⁴⁹ p < .01

Males were also significantly⁵⁰ more likely to report a younger age of onset of problems (33.3 years) than females (40.6 years). Overall, the average age of the first gambling experience and onset of problem gambling remained statistically unchanged since last year. (Table 6.4)

	n	mean	sd
All	998	36.5	13.5
Males	538	33.0	12.7
Females	460	40.6	13.2

Approximately 82.6% of the clients were reported as primary pathological gamblers and 8.7% problem gamblers at the time of enrollment. Approximately 5.7% received a primary diagnostic impression of substance-related disorders and secondary gambling disorders.⁵¹

7. CONSEQUENCES AND RELATED CONDITIONS AT ENROLLMENT

The most visible consequence of disordered gambling was the devastated financial impact on the gambler and the gambler’s family. Nonetheless, this year, only 58.8% of the clients enrolling were reported as having a debt related to gambling. This is down from 68.4% previously reported.

The average gambling related debt reported by clients, who reported any gambling related debt, was \$23,919.5, down slightly from \$24,916.0 previously reported. Although females reported a greater debt than males, this difference was not significant. (Table 7.1)

	All	mean	sd
All	658	23,919.5	49,758.8
Males	349	21,758.2	42,732.4
Females	309	26,360.7	56,557.2

The ratio of debt to income was approximately 89%, down from 100%. This ratio has decreased over the past three years. The number of gambler clients with reported gambling

⁵⁰ p < .01

⁵¹ The DSM IV criteria were in use at the time of this report and are planned by AMH to remain through the following year.

related debts of \$100,000 or more was 53, up from 46 previously reported. Of these, 12 reported debts of greater than \$250,000, up from nine previously reported.

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

However, recently the APA published a revision (DSM 5) that moved gambling from the category of impulse control disorders, not elsewhere classified, to the category of substance-related and addictive disorders. Subsequently such terms as pathological and problem gambling were replaced with

“gambling disorder.” Additionally, other terminology adjustments included changing “is preoccupied with gambling” to “is often preoccupied...;” “gambles as a way to escape from problems” to “gambles when feeling distressed;” and clarifies, “chasing one’s losses” as the “frequent, not short-term, chase of losses.” Finally, “committing illegal acts” was omitted and included in the clarification for

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

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

“lying.” The DSM 5 also specifies that the criteria must be met in the past 12 months, not included in the DSM IV, but included in the state’s PGS protocol since its inception. Using the DSM IV criteria, problem gamblers are those with endorsement of three or four of the ten

criteria (see sidebar) and those individuals endorsing five or more are considered pathological gamblers.

The new classification categories include mild disorder (4 to 5 criteria met); moderate disorder (6 to 7 criteria met); and, severe disorder (8 to 9 criteria met). Eliminating the “committed illegal acts” criteria appears to have a small effect on the number of individuals being diagnosable with disordered gambling and down grading the severity to a lower category by about six percent. This change by the APA will have a potential impact on insurance billing across the country (it should not affect treatment eligibility in Oregon) and could have an impact on treatment planning.

Nonetheless, as footnoted above, AMH continued to use the DSM IV classification criteria as the system is gearing up for transition to electronic medical records when all updated DSM criteria will be implemented.

The average number of DSM IV criteria endorsed by the clients was 7.6. There were no significant difference between this and last

year as well as no significant difference between males and females. (Table 7.2)

As can be seen in the accompanying table, seven of the criteria were endorsed by approximately 80 percent or more. Jeopardizing relationships and relying on others for money were grouped below the core group, and committing illegal acts was only endorsed by 29.7% of the clients. (Table 7.3)

	n	mean	sd
All	1002	7.6	2.0
Males	541	7.6	2.0
Females	461	7.7	2.0

**Table 7.3
DSM IV Endorsed Criteria by Gender
(In Percent)**

	All	Males	Females
Preoccupation	92.0	92.1	92.0
Escaping	90.5	87.8	93.7
Unsuccessful attempts to stop	89.8	89.6	90.0
Returning to get even	87.4	88.7	85.9
Lying	83.9	82.6	85.5
Increasing size of bets	82.7	81.7	83.9
Restlessness	79.2	77.3	81.6
Jeopardized relationship/job	65.4	68.0	62.3
Relies on others for money	61.2	61.2	61.2
Committed illegal acts	29.7	29.4	30.2

Approximately 23.7% of gambler clients, as reported on the record abstracting form by counselors, had suicidal thoughts during the past six months. Another 1.9% reported making threats of suicide, 1.9% reported

having a plan, and 2.9% reported actually taking action to complete the suicide. Combing these numbers, approximately 30.4% of enrollees reported some involvement with suicidal ideation. These findings were again very similar to those reported in from the previous year. (Table 7.4)

**Table 7.4 Suicide
(In percent)**

	All	Males	Females
Thoughts	23.7	21.7	26.2
Threat	1.9	1.9	1.9
Plan	1.9	1.7	2.1
Action	2.9	3.1	2.6

Nonetheless, the findings were confirmed by the clients’ responses to the pen and paper enrollment survey where approximately 16.4% reported having suicidal thoughts “sometimes”, “often” (5.6%) or “always” (1.9%) during the past six months. Nearly 55.2% reported “never” having such thoughts and 20.8% reported “rarely.” Responses to the questions regarding attempting suicide were higher (“rarely” 5.2%, “sometimes” 2.2%, “often” 0.8%, and always 0.8%) than those reported to the counselor, although care should be exercised in interpreting Likert-type scaled questions.

Males were significantly⁵² more likely to report having job problems associated with

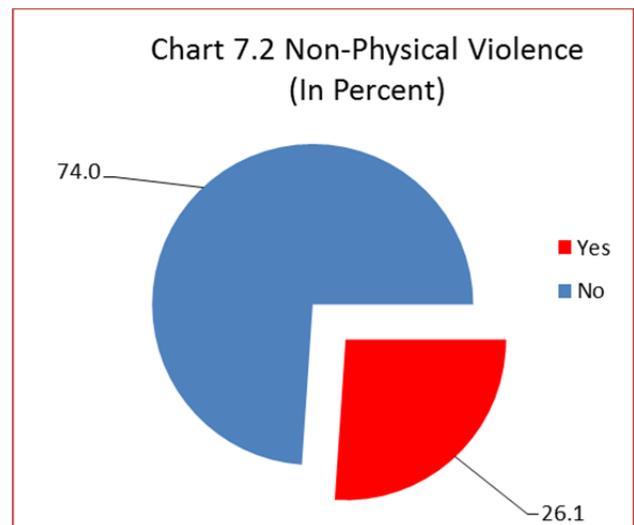
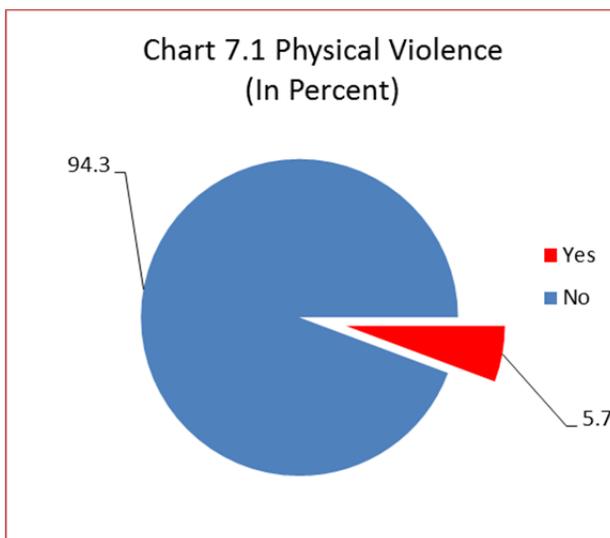
⁵² p < .01

their gambling (24.1% compared to 17.0%). They were also significantly⁵³ more like to report relationship and legal problems than females. (Table 7.5)

	All	Males	Females
Job	20.8	24.1	17.0
Bankruptcy	8.5	7.4	9.6
Relationships	53.6	57.6	49.1
Legal	13.2	14.1	12.2

This year was the fourth year for tracking client self-report of abuse. These were added to the data set as a means to track the possible link between problem gambling and family violence. These questions were contained on the self-completed survey and included experiencing any violence in a relationship during the past six months, experiencing any verbal, emotional, or psychological abuse, and feeling controlled, trapped, or manipulated by a significant other in the past six months.

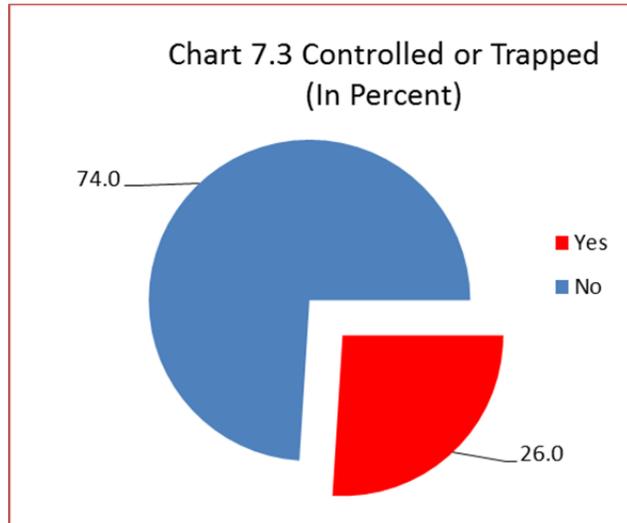
Approximately 5.7% of those enrolling reported experiencing physical violence in the



past six months. Twenty-six percent reported non-physical violence and a similar distribution reported feeling controlled or trapped. These findings are quite similar to those previously reported. (Charts 7.1, 7.2, and 7.3).

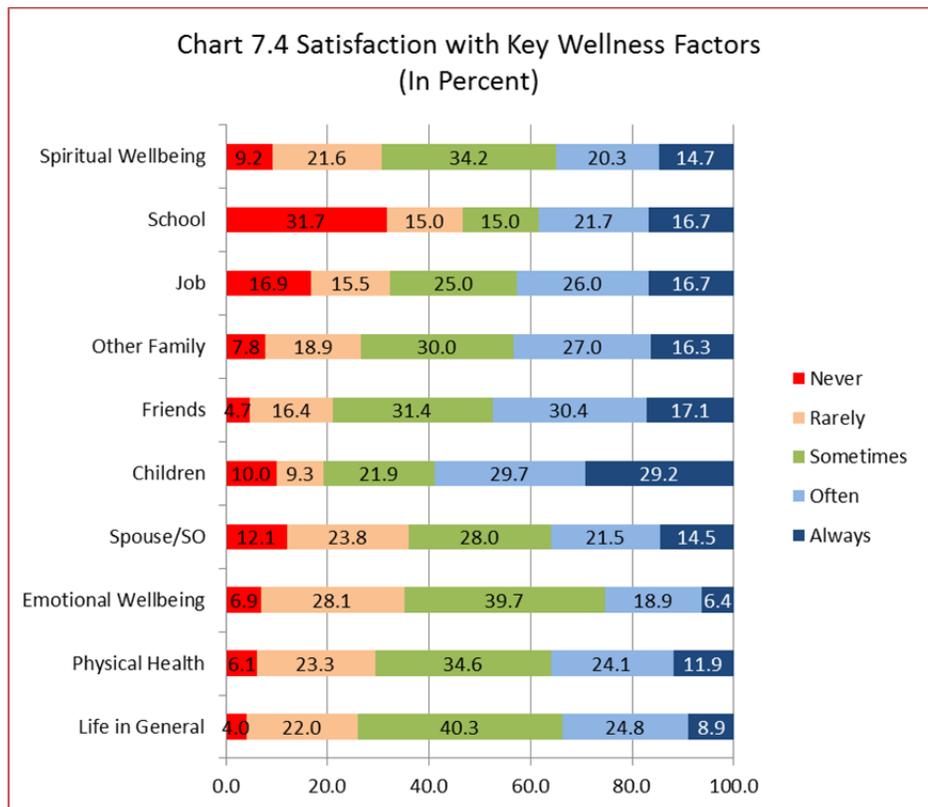
⁵³ p < .01

Interestingly, when these questions were introduced the clinicians on the review committee felt that it was inappropriate to ask such questions directly for the record abstracting form during the enrollment process. As a compromise, a decision was made to include a question on the discharge record



abstracting form regarding the notation of the clients discussing abuse during treatment and whether that abuse was reported outside the agency. Only 1.4% (n =14) of the clients were recorded as discussing abuse and of these cases, only three were recorded as being reported to a cognizant authority.

Based on self-reported responses to the survey within the domain of general life satisfaction, clients continued to indicate the highest level of



satisfaction among the key wellness factors were their children (29.2% “always” and 29.7% “often”) and friends (17.1% “always” and 30.4% “often”). As can be seen on the accompanying chart, clients were generally neither highly satisfied nor dissatisfied with the other key wellness factors. These indicators from the self-report survey have remained

relatively constant over the years. Chart

7.4)

About 50.5%

reported using

tobacco always and

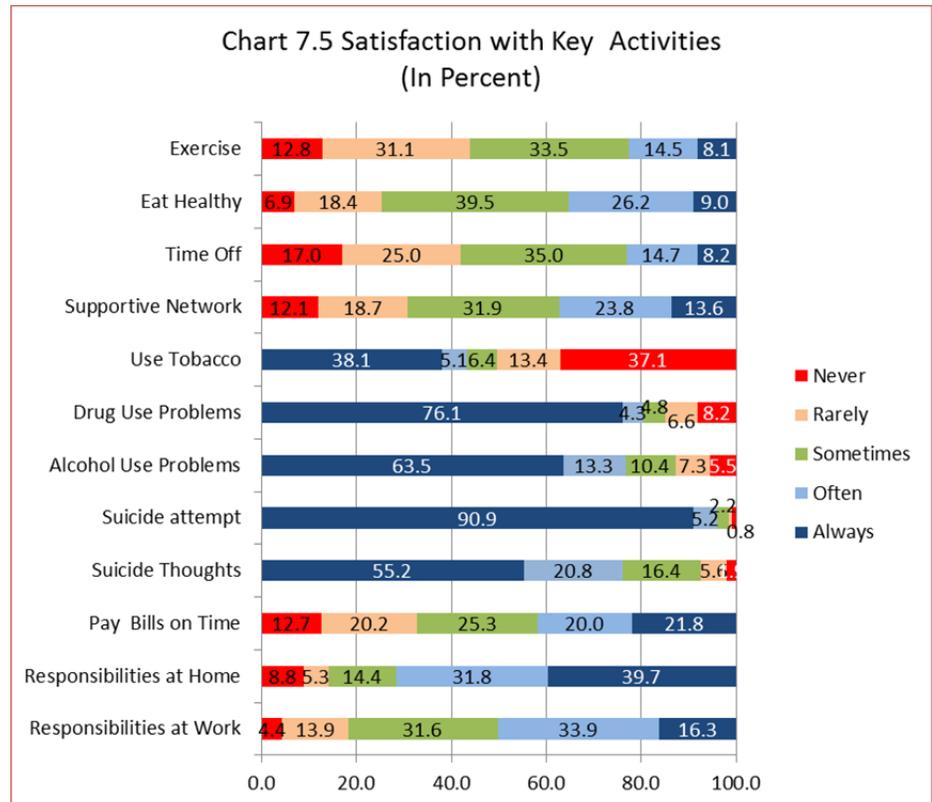
often while 14.8%,

up from 11.9% last

year, reported drug

use problems

“always” or “often.”



Similarly, 13.8% (up from 10.3%) reported alcohol use problems. As can be seen in the accompanying chart, client responses were dispersed across the continuum for the other wellness indicators. (Chart 7.5)

Approximately 35.7% (down from 38.6%) of those enrolling reported an average of 2.8 previous treatment episodes for A&D while approximately 8.5% (same as last year) were reported as being concurrently enrolled in A&D treatment at the time of enrollment in the gambling program. (Table 7.6)

Table 7.6			
Prior A&D Treatment Episodes			
	n	mean	sd
All	399	2.8	2.8
Males	245	2.8	2.7
Females	154	2.7	3.0

Table 7.7			
Prior Mental Health Treatment			
	n	mean	sd
All	381	2.6	2.9
Males	175	2.4	2.6
Females	206	2.7	3.1

Similarly, approximately 34.0% (down from 39.9%) of gambling clients reported, on average, 2.6 prior MH treatment episodes. Approximately 18.1% (down from 19.0%) were reported as concurrently enrolled in mental health programs with their gambling treatment.

(Table 7.7)

8. TREATMENT OUTCOMES

Follow-up for gambling clients included surveying at six and twelve months post discharge for those who successfully completed the treatment program. For those who left treatment prior to formal completion, follow-up was accomplished at six months post termination. Follow-up was only undertaken for clients who had provided informed consent to participate in the program evaluation and for whom adequate locator information was provided by the treating agency.

The longitudinal outcomes for gamblers continued to be very positive, especially for the most critical indicators of program success. At 6-months post discharge, those gamblers who successfully completed treatment reported an abstinence rate of 64.1%, down slightly from last year, while another 16.7% reported gambling much less than before starting treatment. Importantly, non-program completers at 6-month post discharge reported an abstinence rate of 43.3%, up from 33.8%, while another 22.4% reported gambling much less than before treatment. At 12-month follow-up the abstinence rate was 60.5% down from last year. Another 21.1% reported gambling much less than before treatment. For those who

gambled, the choice of game was essentially the same as that reported at admission. (Table 8.1)

	None	Much Less	Less	Same	More	Much More
12-Month Completers	60.5	21.1	11.8	5.3	1.3	0.0
6-Month Completer	64.1	16.7	11.5	5.1	1.3	1.3
6-Month Non-Completers	43.3	22.4	11.9	19.4	0.0	3.0

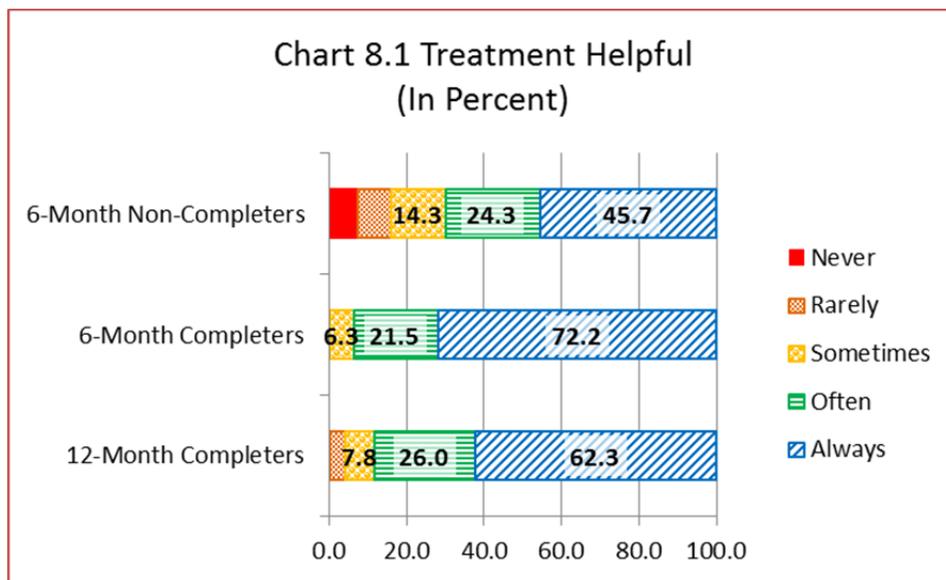
Of those program completers who reported a gambling debt at enrollment, at 12-month follow-up, approximately 58.6% reported reducing their gambling debt an average of about 88.1%. A small percentage (6.9%) reported no change in their gambling related debt and 5.0% reported an increase in gambling related debt.

When comparing baseline scores on the self-report survey to follow-up scores at six and twelve month follow-up, successful completers demonstrated similar significant improvements⁵⁴ in many key critical indicators as previously reported. This year, non-completers saw fewer significant changes in the key indicators than previously reported, but there was no apparent pattern to the differences. In the accompanying table the arrows are used to depict the direction of the change in respect to expectations. That is, a positive change is indicated with an up arrow (↑) and a negative, or unexpected, change with a down arrow (↓). (Table 8.2)

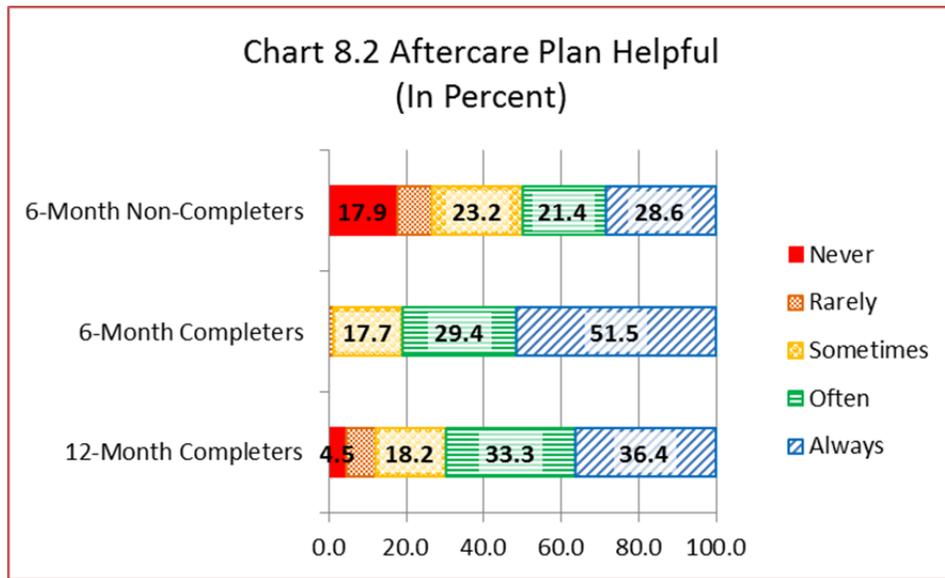
⁵⁴ ANOVA p < .05 to p < .01

Table 8.2 ANOVA Pre/Post Survey			
	Six-Month		Twelve Month
	Completers	Non- Completers	Completers
Satisfaction With			
Life in General	↑ p < .01	↑ p < .01	↑ p < .01
Physical Health	↔ ns	↔ ns	↑ p < .05
Emotional Wellbeing	↑ p < .01	↑ p < .05	↑ p < .01
Relationship with Spouse/SO	↔ ns	↔ ns	↔ ns
Relationship with Children	↔ ns	↔ ns	↔ ns
Relationship with Friends	↑ p < .01	↔ ns	↔ ns
Relationship with other Family	↑ p < .01	↔ ns	↔ ns
Job	↔ ns	↔ ns	↔ ns
School	↔ ns	↔ ns	↔ ns
Spiritual Wellbeing	↑ p < .01	↔ ns	↑ p < .01
Activities			
Accomplish Responsibility at Home	↑ p < .01	↔ ns	↑ p < .05
Accomplish Responsibility at Work	↔ ns	↔ ns	↔ ns
Pay Bills	↑ p < .05	↔ ns	↑ p < .05
Thoughts of Suicide	↔ ns	↔ ns	↔ ns
Attempt to Commit Suicide	↔ ns	↔ ns	↔ ns
Drink Alcohol	↔ ns	↔ ns	↔ ns
Problems with Alcohol	↔ ns	↔ ns	↔ ns
Use Illegal Drugs	↔ ns	↔ ns	↔ ns
Problems with Illegal Drugs	↔ ns	↔ ns	↔ ns
Use Tobacco	↔ ns	↔ ns	↔ ns
Commit Illegal acts to get Money	↔ ns	↔ ns	↔ ns
Maintain Supportive Friend/Family	↑ p < .01	↔ ns	↑ p < .01
Take off Time to Rest/Relax	↑ p < .01	↔ ns	↑ p < .01
Eat Health Foods	↑ p < .01	↔ ns	↑ p < .05
Exercise	↑ p < .01	↔ ns	↔ ns
Attend GA/Community Support	↑ p < .01	↔ ns	↔ ns
DSM Criteria			
Thinking about gambling	↑ p < .01	↑ p < .01	↑ p < .01
Gambling with more money	↑ p < .01	↑ p < .01	↑ p < .01
Unsuccessful attempts to stop	↑ p < .01	↑ p < .01	↑ p < .01
Restless when attempting to control	↑ p < .01	↔ ns	↑ p < .01
Gambled to escape	↑ p < .01	↑ p < .05	↑ p < .01
Chasing	↑ p < .01	↑ p < .01	↑ p < .01
Lying to hide gambling	↑ p < .01	↑ p < .01	↑ p < .01
Illegal ways to get money	↔ ns	↔ ns	↔ ns
Risk/lost significant relationship/opportunities	↑ p < .01	↔ ns	↑ p < .01
Borrowed from others	↑ p < .01	↑ p < .05	↑ p < .05

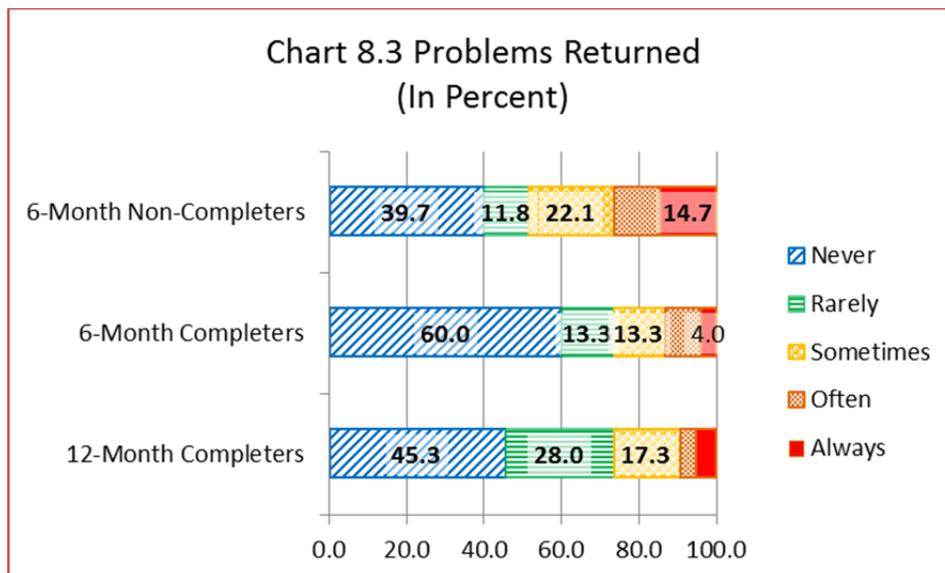
At 12-month follow-up, 88.3% (62.3% “always” and 26.0% “often”) of the sample indicated they were satisfied with the helpfulness of the treatment they had received. This was down from 93.3%. Those successful program completers in the six-month sample were more positive about the helpfulness of treatment with 93.7% indicating “always” or “often.” This was up slightly from 91.1% previously reported. As would be expected, six-month non-completers were less positive than either of the completer samples with approximately only 70.0% reporting the treatment as helpful, up from 64%. (Chart 8.1)



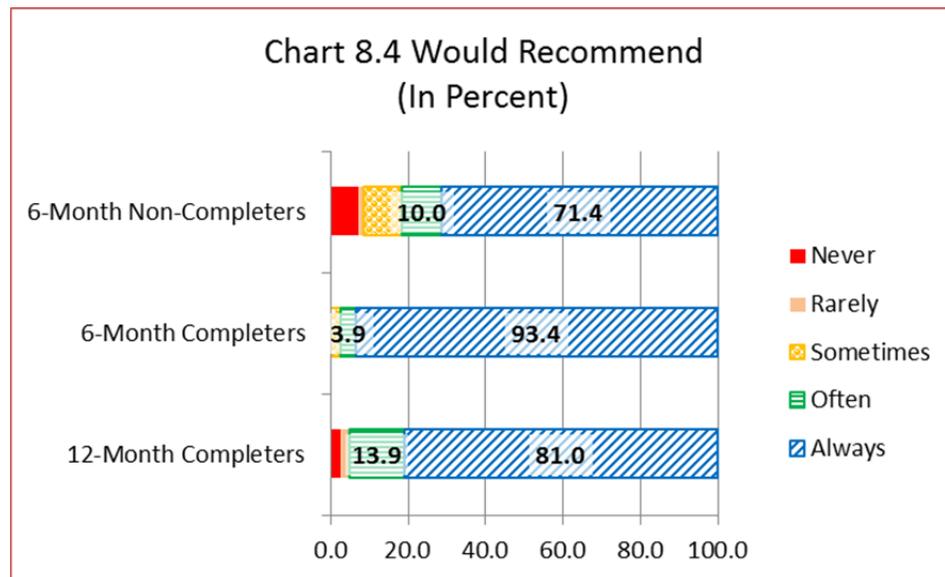
Satisfaction with their aftercare plan followed an expected pattern with somewhat lower satisfaction. Approximately 69.7% of the 12-month sample reported satisfaction with their aftercare plan, down from 83.4%. Six-month completers reported an 80.9% satisfaction, also down from 85.9%. Six-month non-completers were much less satisfied at 50.0% although this was similar (48.9%) to that previously reported and most likely due to the fact they left treatment without having the opportunity to develop such a plan. (Chart 8.2)



The relative effectiveness of treatment is reflected in the participants' responses to the question regarding the extent to which the problems that had brought them to treatment had returned/remained. Approximately 73.3%, down slightly from 76.8%, of those in the 12-month follow-up reported recurrence "never" or "rarely" followed by 73.3% , same as last year, of those in the six-month completer sample. Slightly over half of the six-month non-completer sample indicated the problems had reoccurred "never" or "rarely," same as last year. (Chart 8.3)



Normally, a minimum benchmark of 85% positive responses (“always” and “often”) is expected regarding participants’ willingness to refer the program to others. Approximately 94.9% of those in the 12-month sample endorsed their willingness to recommend the program



to others. The six-month sample was slightly more positive with 97.3%. As would be expected, non-completers were less like to indicate a willingness to recommend, but it was still considered supportive at 81.4%. These ratings were similar to last year. (Chart 8.4)

9. Family Client Demographics

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

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

This year, the number of family clients enrolled was 146, compared to 178 last year. Females were three times more likely to enroll as family clients than males and were more likely⁵⁵ to be younger than male family clients. (Table 9.1)

	n	mean	sd
All	132	47.9	15.0
Males	30	54.6	11.4
Females	102	46.0	15.4

The majority of family clients were the spouse or significant other (SO) of a gambler (76.3% up significantly⁵⁶ from 62.6% previously reported). (Table 9.2)

	All	Males	Females
Spouse/SO	76.3	84.0	73.6
Parent	11.3	16.0	9.7
Child	5.2	0.0	6.9
Sibling	3.1	0.0	4.2
Other Family	1.0	0.0	1.4
Co-Worker/Friend	2.1	0.0	2.8
Employee/Employer	0.0	0.0	0.0
Other	1.0	0.0	1.4

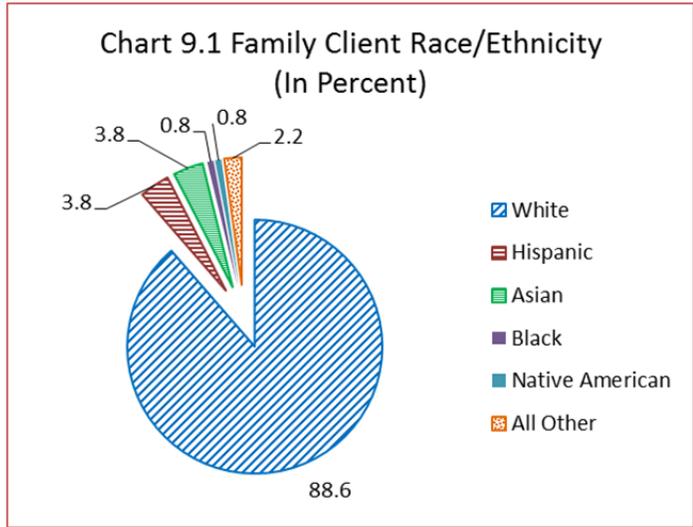
Male gamblers were significantly⁵⁷ more likely to have a female family member attending treatment than females. Discharge status for gamblers was no different this year whether a family member was also attending or not. Previous years have seen a significantly greater proportion of gamblers be successful completers than those without family members in attendance.

⁵⁵ p < .05

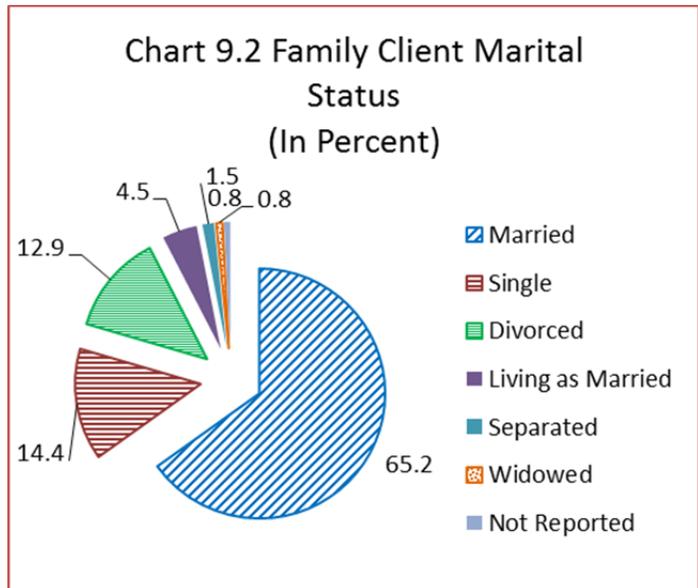
⁵⁶ p < .05

⁵⁷ p < .05

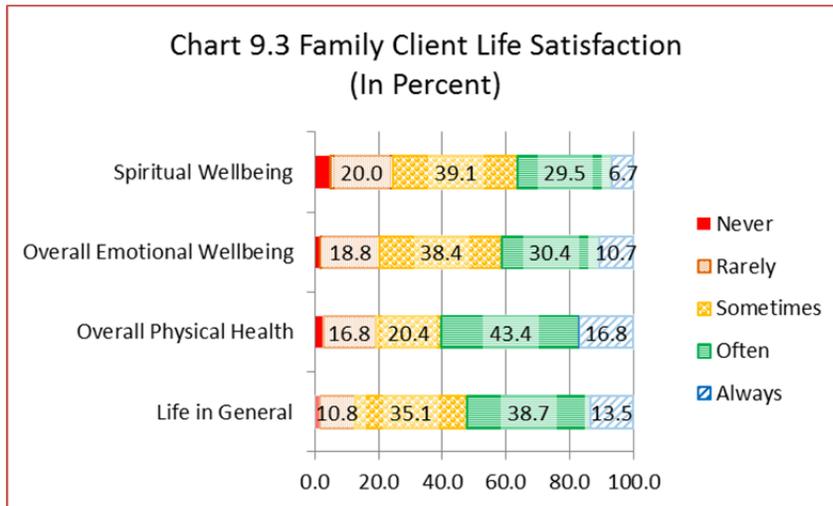
Family client race/ethnicity somewhat mirrored that of the overall gambler population as would be expected. The majority were reported as White (88.6%), followed by Hispanic 3.8%, Asian 3.8%, Black 0.8%, and Native American 0.8%. These distributions also were very similar to those reported last year. (Chart 9.1)



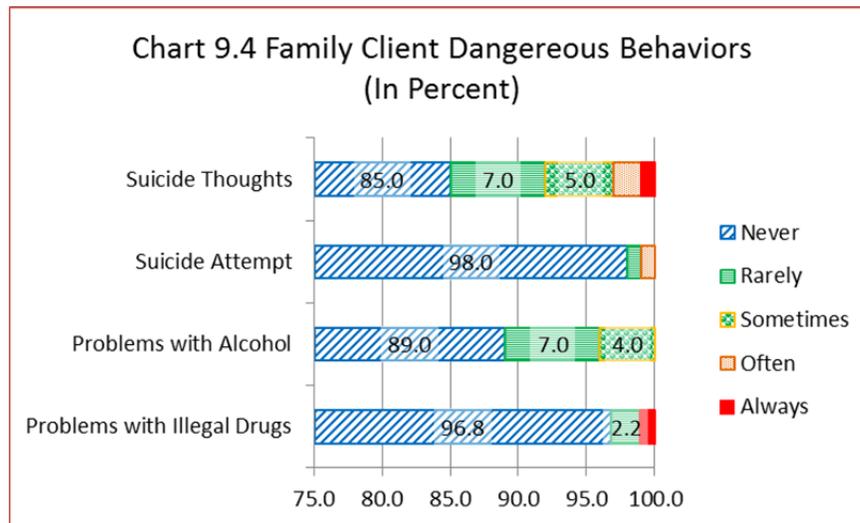
Approximately 65.2% of the family clients were married, 14.4% single, 12.9% divorced, and 4.5% reported as living as married. There were only minor fluctuations from that previously reported. (Chart 9.2)



At enrollment, family clients, in the past six months, were only moderately satisfied with their life in general and overall physical health. Satisfaction with spiritual and emotional wellbeing was low. (Chart 9.3)

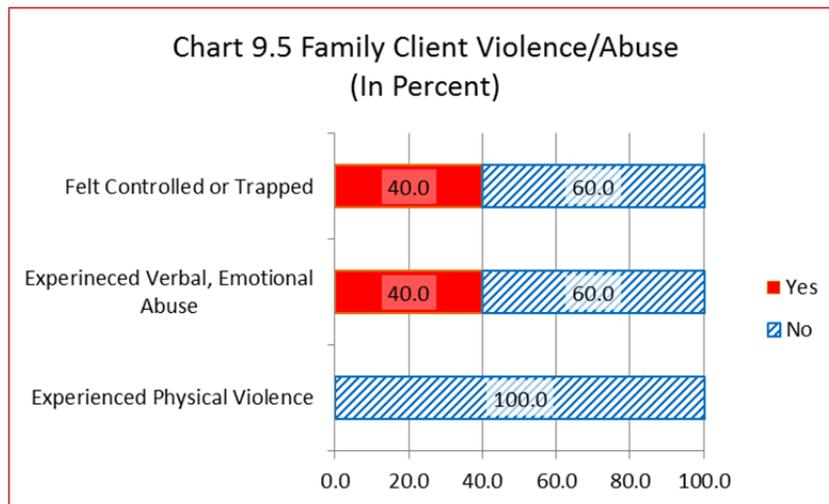


Approximately 15% of the family members reported having any thought of suicide in the past six months with 3.0% reporting “often” or “always.” Two percent reported suicide attempts while approximately 11% reported having any problems with alcohol and 3.3% with any problems with illegal drugs. (Chart 9.4)

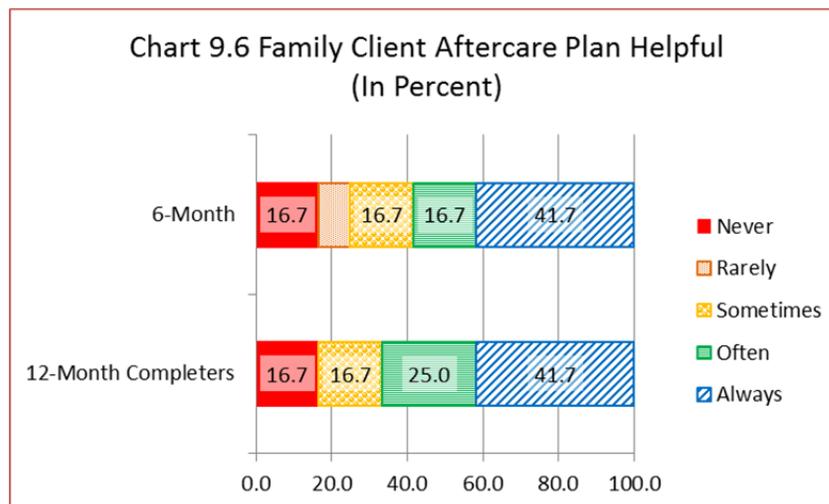


None of the family clients reported experiencing any physical violence in the previous six months while 40% reported experiencing verbal or emotional abuse and 40% reported

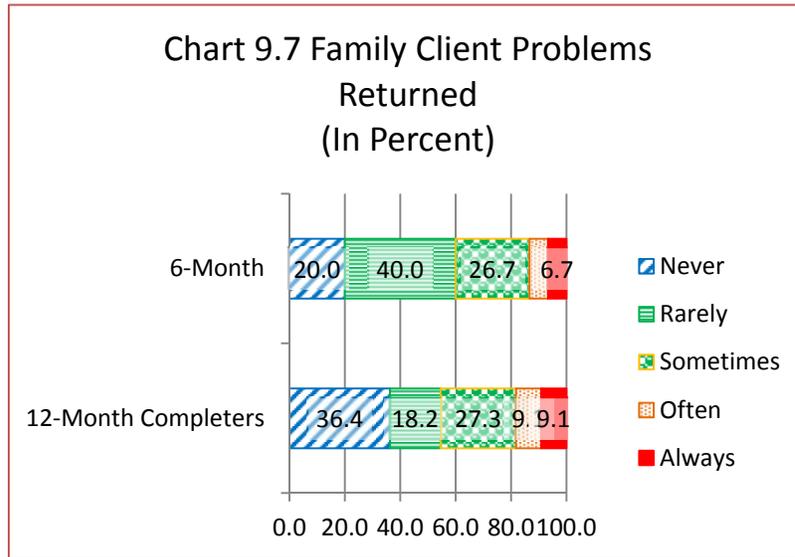
feeling controlled or trapped in their relationship. These findings are quite similar to those reported last year. (Chart 9.5)



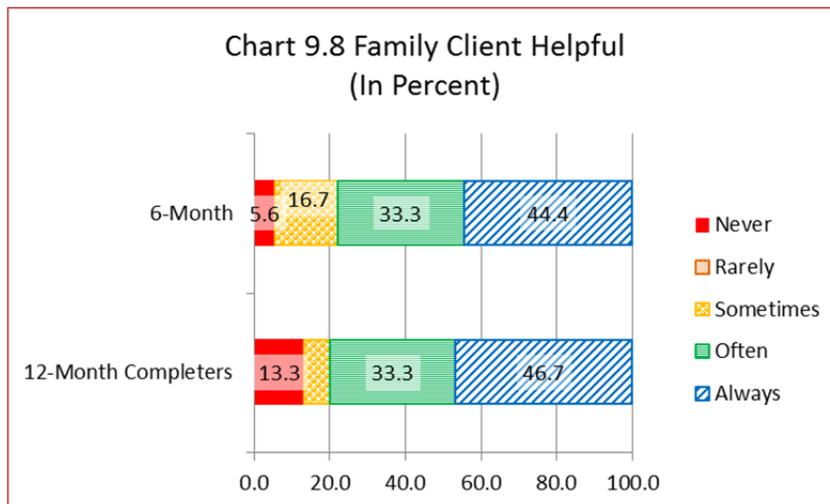
Family clients reported moderate helpfulness of their aftercare plans at both the six and twelve-month follow-up. Nonetheless, there was a somewhat large distribution (16.7%) that reported very low satisfaction. (Chart 9.6)



This year, the family clients’ self-report regarding the return of problems was similar to that reported last year with approximately 18% of the 12-month sample reporting “always” or “often.” (Chart 9.7)

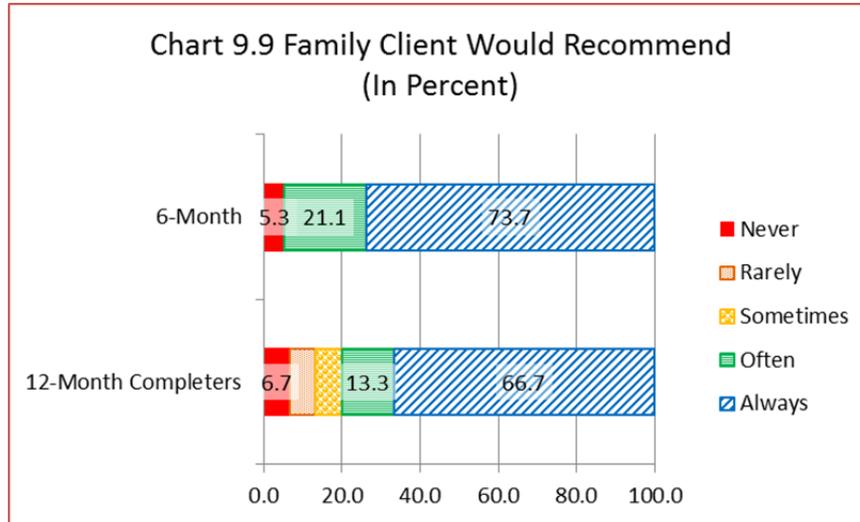


Both six-month and twelve-month family respondents were positive regarding the overall helpfulness of the program with a somewhat higher distribution of “never” and “rarely” reported this year. (Chart 9.8)



Finally, the six-month sample was quite positive regarding their willingness to recommend the program to other family members while the 12-month sample was lower than

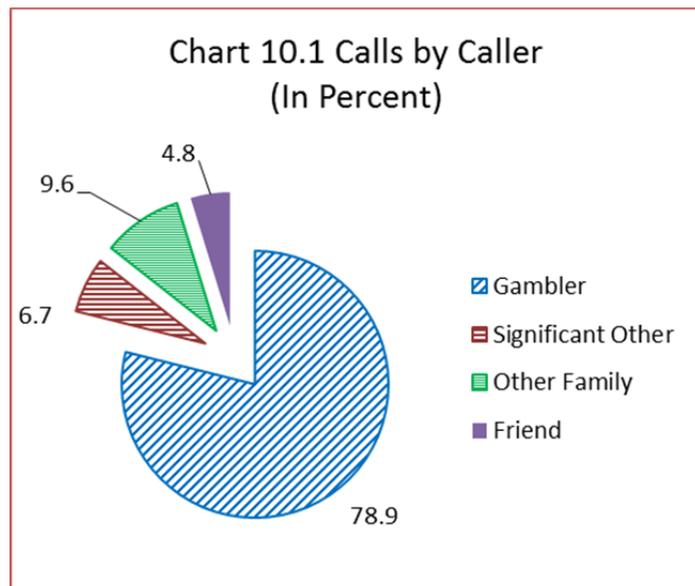
last year with only 80% endorsing a willingness “always” and “often” to recommend compared to 100% last year. (Chart 9.9)



10. HELPLINE

The Helpline was staffed by qualified gambling counselors who have hands-on experience within the problem gambling treatment setting. The Helpline was operational 24-hours per day. Approximately 52.5% of calls were during normal work hours, 28.7% after hours on week days, and 18.8% on weekends. This distribution of the time of the call was essentially the same as previously reported.

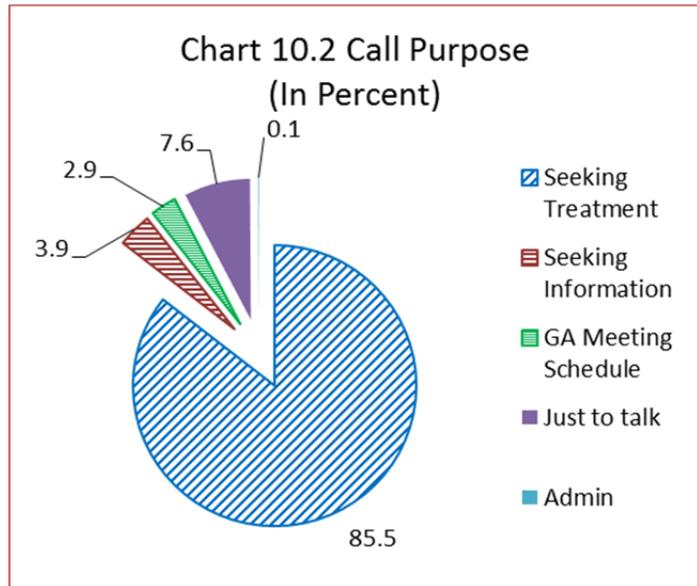
During the report period, the Helpline reported 823 total calls for assistance (down sharply by 28.3% from 1,056 reported last year). Of the total, 78.9% were from gamblers,



down from 84.7% previously reported. Spouse, or significant other, accounted for 6.7% of the calls while 9.6% were from other family members, up from 6.3% previously reported.

Calls from friends were 4.8%, up from (2.8%). (Chart 10.1)

Of the calls, 85.5%, down slightly from 87.7%, were for help finding treatment. The distribution of callers (3.9%) seeking treatment information was down from 6.5%. GA meeting schedule calls comprised 2.9% up from 1.8% and just to talk was 7.6%, up from 3.6%.



(Chart 10.2)

Of those seeking treatment or treatment information, 711, down from 925, were referred on with 186 reported as receiving a “direct referral” (three-way phone connection), down from 245 last year.

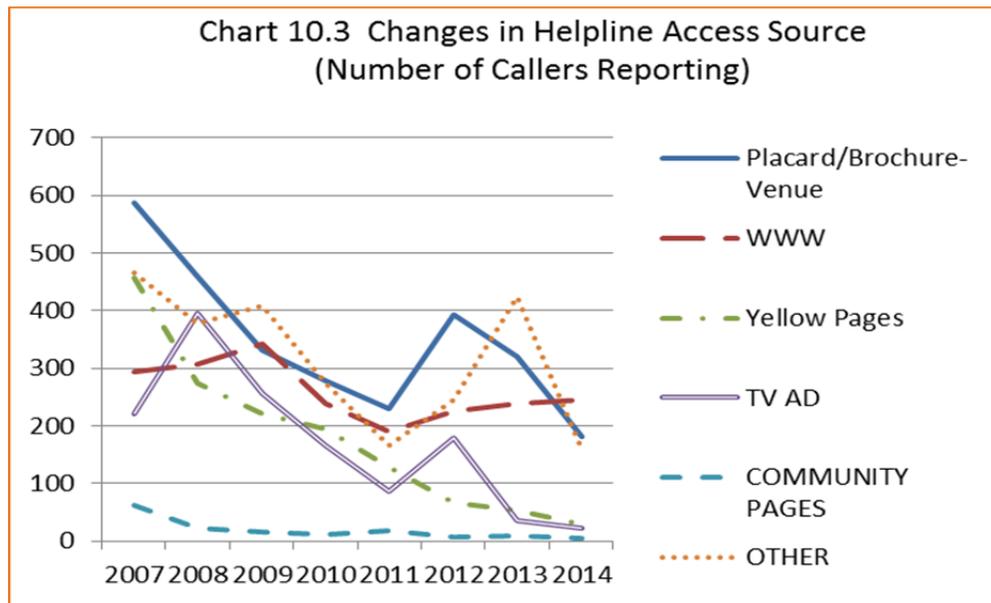
Of those calling, none were reported as having recent suicidal attempts, 12 were reported with plans for suicide, and 17 with serious suicidal thoughts. (Table 10.1)

Ideation	17
Plan/Means	12
Plan/No Means	1
Recent Attempts	0

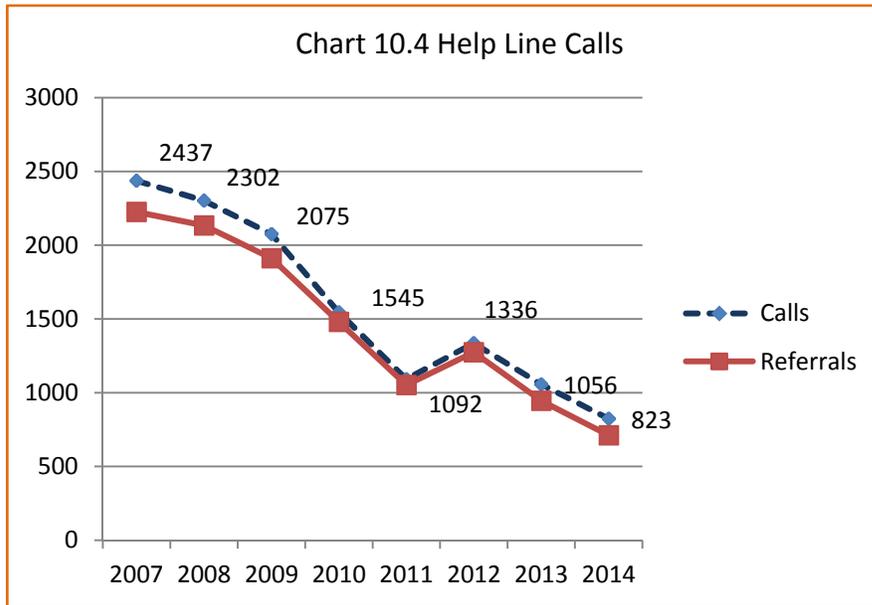
Approximately 37.0%, up from 27.7%, of the callers reported obtaining the Helpline phone number from the Web/Internet. This was followed distantly by placards on the machines (16.5%) and local brochures or posters at gambling locations. TV ads were only 3.3%, down from 4.1%. (Table 10.2)

An analysis of the access source for the Helpline telephone number over the past eight years demonstrated an overall downward trend for all sources through the previous year except for an increase in 2012 and a slight increase in accessing the helpline number from the Web/Internet. (Chart 10.3)

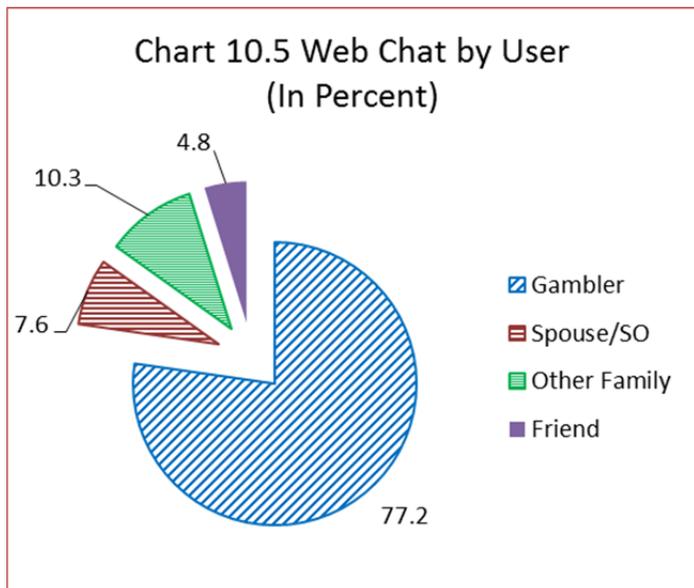
10.2 Access Source for Phone Number (In Percent)	
Web/Internet	37
Placard	16.5
Brochure/Poster Local	10.8
Yellow Pages	4.4
TV Ad	3.3
Brochure/Poster Community	2
Community Pages	0.6
Radio	0.6
Print Story	0.3
TV Program	0.2
White Pages	0.2
Print Ad	0.2
Billboard	0.2
Other	23.9



The actual number of calls to the helpline and number of referrals for the past eight years since the fall in participation in the programs began is presented in the accompanying chart. The potential reasons for the increase in 2012 are unknown. (Chart 10.4)



The number of web chat users was reported at 145, down from 169 previously reported. Of these, 77.2% were the gambler, down from 81.7%; and, 7.6% spouse/SO, down from 13.6%. The remainder were comprised of other family, 10.3%, and friend, 4.8%. (Chart 10.5)



Approximately 68.7% of the web chat users were reported as seeking treatment (down from 72.9%) and 21.8% seeking information (up from 19.3%). (Chart 10.6)

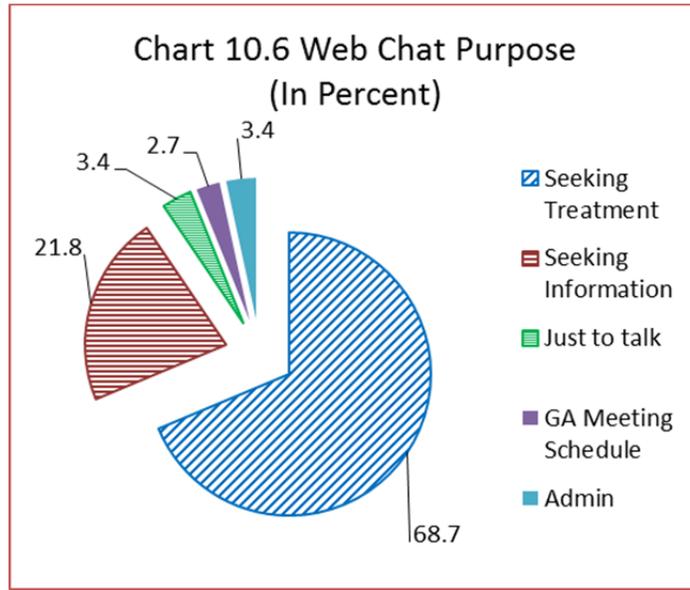
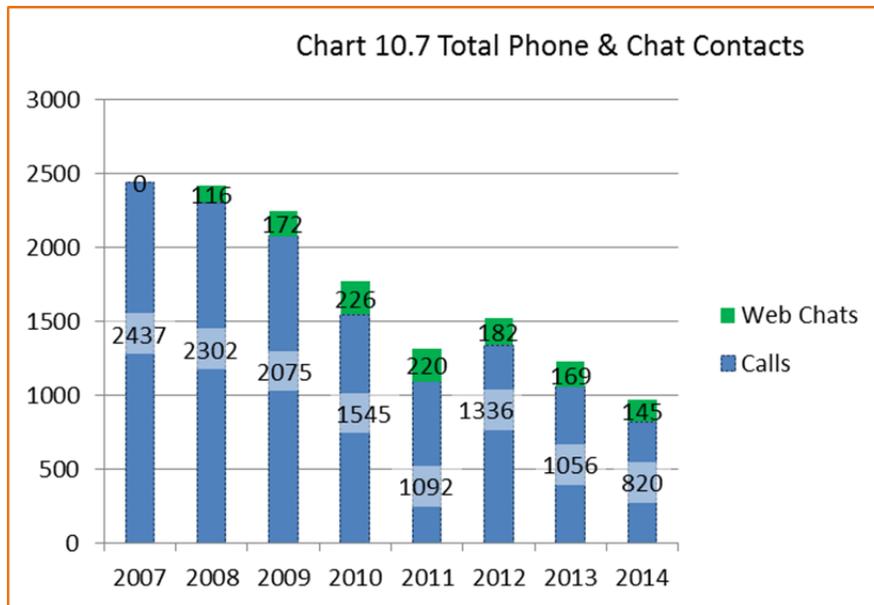


Chart 10.7 is a presentation of the actual number of helpline calls and over the past seven years for reference purpose.



11. RESIDENTIAL CARE

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

In order for individuals to be eligible for residential or respite care they needed to have a referral from a state-approved gambling treatment program and were expected to be referred back to the outpatient program following treatment. During the period, 50 individuals, down 32.4% from 74 individuals, were enrolled in residential care.

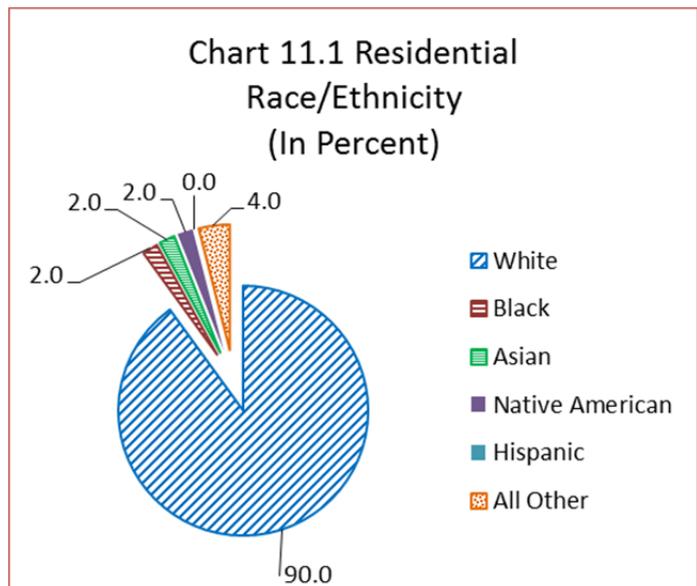
The average age of clients in the residential program was 46.0 years. This was statistically similar to the age of those enrolling in the outpatient programs and essentially the same from last year for the

	n	mean	sd
All	50	46.0	13.4
Males	23	47.1	13.1
Females	27	45.0	13.5

residential clients. There was also no significant difference between males and females in regards to age. Approximately 54% were female, slightly more than in the outpatient population but not significantly so.

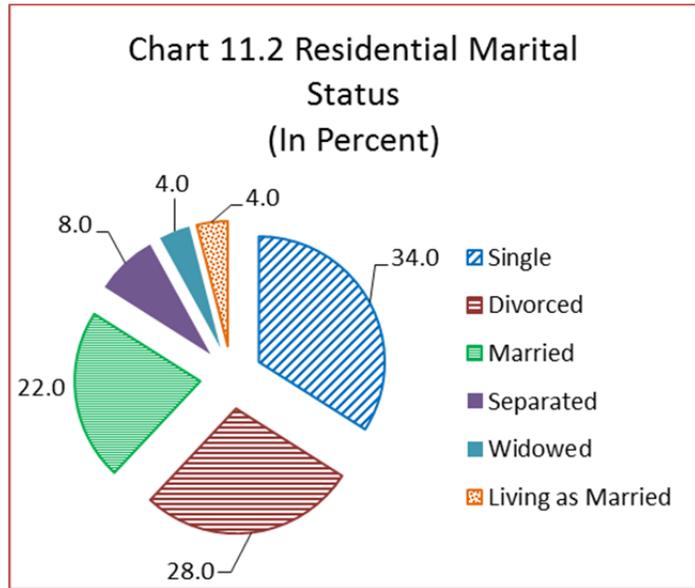
(Table 11.1)

Approximately 90.0% were reported as White, up from 82.4% and 2.0% each for Black, Asian, and Native American. No Hispanic clients were reported. The race/ethnic



distribution was statistically similar to the outpatient population and to that previously reported. (Chart 11.1)

Thirty-four percent the clients were reported as being single – never married. Divorced represented 28.0% this year and married, 22.0%. These were essentially the same as last year. (Chart 11.2)



	n	mean	sd
All	49	25,399	25,246
Males	22	22,150	25,343
Females	27	28,046	24,854

The average household income was reported as \$25,399, significantly⁵⁸ higher than the \$18,623

previously reported but statistically not dissimilar from the outpatient population. Males reported a slightly lower household income than did females. The median income was \$24,000. (Table 11.2)

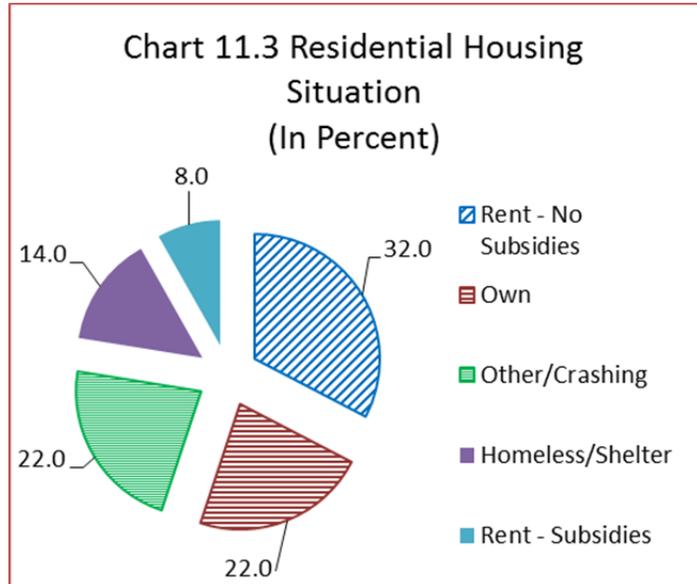
The average gambling debt, for those who reported a gambling debt (80.0%), was approximately \$26,744, down considerably from \$54,396 previously reported. The difference between males and females, as well as, outpatient clients was not statistically significant. (Table 11.3)

	n	mean	sd
All	40	26,744	42,507
Males	20	30,298	53,992
Females	20	23,190	25,948

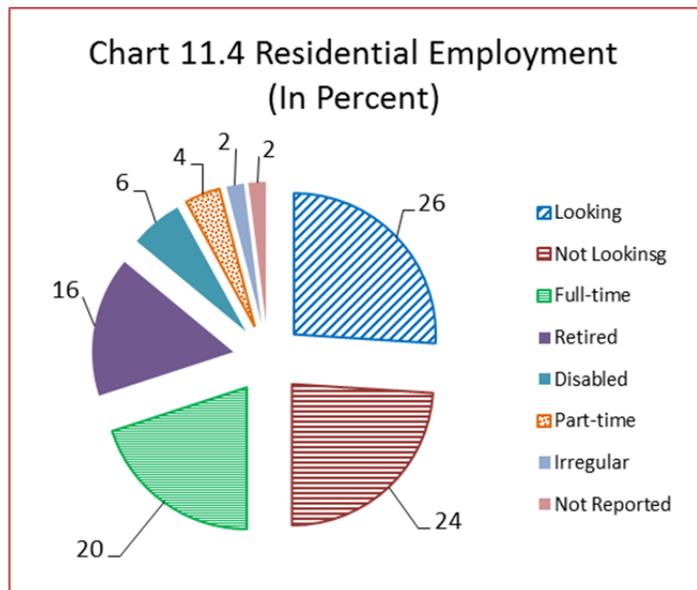
⁵⁸ p < .01

The average years of education was 13.0 with females having slightly more with 13.1 years compared to 12.8 years.

Thirty-two percent of the residential clients reported living in a market rental and another 22.0% in a home own by them. As with previous years, residential clients were more likely⁵⁹ to report being homeless (14.0%) or crashing (22.0%) than the outpatient population. (Chart 11.3)



Twenty-six percent of the residential clients were reported as unemployed and looking for employment while 24% were reported as unemployed and not looking. Only 20% were working full-time and 4% part-time. The residential clients were more likely to report being employed than the outpatient clients and more likely to report being retired. Due to



the relatively small sample size statistical testing was not available. (Chart 11.4)

⁵⁹ p < .01

The primary gambling activity of residential clients was machine-based (58% video poker, 22% slot machines, and 8% video line games). Eight percent reported cards and 2% each reported pull tabs or stocks.

Eighty percent reported primarily gambling at a lottery retailer (bar/pub), 14% at a casino, and 2% each at a food or convenience store, home, or internet.

The average age of first gambling experience was 22.5 years, up from 18.3 years, with males reporting 19.6 years old and females 24.9 years. The average age of onset of problem gambling was reported as 32.8 years with males younger (29.3 years) than females (35.7 years).

These findings are consistent with previous years and do fluctuate quite a bit.

The average number of DSM IV criteria endorsed by the clients enrolled in residential care was 8.8, down from 9.4 items. and was significantly⁶⁰ higher than the average reported for

Preoccupation	100.0
Increasing size of bets	94.0
Unsuccessful attempts to stop	96.0
Restlessness	94.0
Escaping	96.0
Returning to get even	92.0
Lying	94.0
Committed illegal acts	52.0
Jeopardized relationship/job	84.0
Relies on others for money	74.0

the general outpatient population. There was no statistical difference between the males and females. (Table 11.4)

Approximately 48.0%, down from 66.2%, of the residential clients reported having thoughts of suicide, 2.0% reported threatening suicide, none reported having a plan (down from 2.7%), and 8.0% reported making an attempt at suicide in the past six months, down from 9.5%. (Table 11.5)

	(%)
Thoughts	48.0
Threat	2.0
Plan	0.0
Action	8.0

⁶⁰ p < .01

Approximately 26.0% reported having employment problems and 34% reported relationship problems related to their gambling. Approximately 12.0% reported having legal problems and 6.0% reported filing, or planning to file, for bankruptcy. These findings were lower than previously reported, but due to the small sample size no statistical comparisons were attempted.

Lag time from initial call to first availability of a bed was 13.2 days, down from 22.0 calendar days previously reported. There was no statistically significant difference between males and females in respect to availability. (Table 11.6)

	n	mean	sd
All	50	13.2	11.2
Males	23	13.8	10.9
Females	27	12.7	11.3

The average length of stay (LOS) at residential treatment jumped significantly⁶¹ from 34.3 days to 41.6 days with no difference between males and females. (Table 11.7)

	n	mean	sd
All	51	41.6	15.8
Males	23	42.9	10.2
Females	28	40.6	19.2

The unadjusted successful completion rate was 74.5% up from 67.6% previously reported.

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

⁶¹ p < .05

12. MINIMAL INTERVENTION PROGRAM (GEAR)

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

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

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

The program was operated under a separate contract with the State by Emergence located in Springfield, Oregon. Historically, the program had not received as many referrals

as expected and those who had been referred to the program, by-and-large, had serious problems with gambling, and had been diagnosed as pathological gamblers. Due to funding shortages and lack of extensive utilization, the program was temporarily closed in FY 10-11 and refunded for a partial of FY 11-12.

The total number of gamblers reported this year was 30, down slightly from 31 reported last year. This year an additional six family clients were enrolled, the same number as previously reported.

Table 12.1A Average Age of Gambler (In Years)			
	n	mean	sd
All	30	52.8	12.6
Males	9	42.2	10.2
Females	21	57.4	10.6

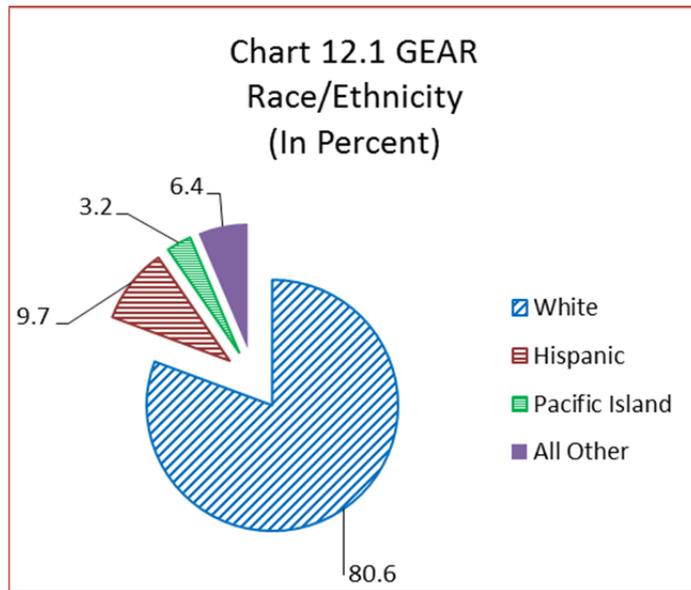
Table 12.1B Average Age of Family (In Years)			
	n	mean	sd
All	6	49.4	16.3
Males	1	60.5	0
Females	5	47.1	17

The average age of participants was 52.8 years, down slightly from 53.5 years previously reported. Females were significantly⁶² older than males and they were significantly⁶³ more likely (70.0%) than males to enroll in the GEAR program. The Average age of family clients was 49.4 years. (Tables 12.1A and 12.1B)

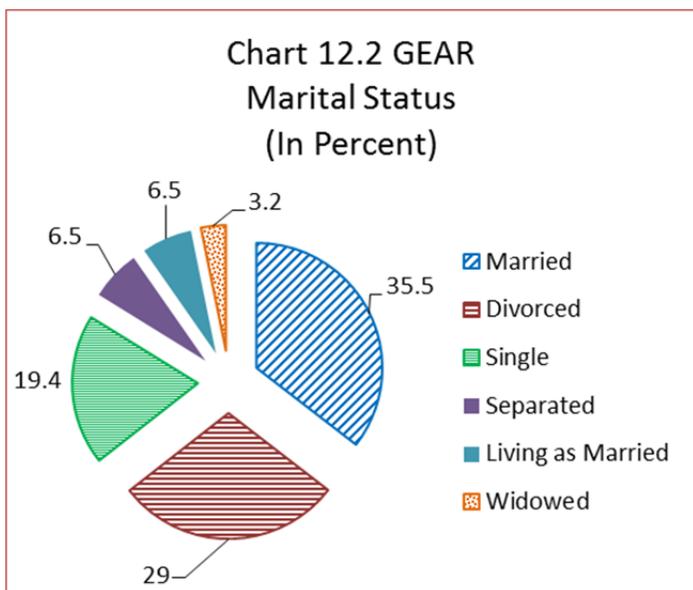
Approximately 80.6% were reported as White, 9.7% Hispanic, 3.2% Pacific Islander, and 6.4% other. (Chart 12.1)

⁶² p < .01

⁶³ p < .05



Approximately 35.5% of the GEAR clients were reported as being married, 29.0% divorced, 19.4% single, and 6.5% each separated or living as married. The distribution by marital status this year was similar to last year and also similar to the outpatient gambler population. The



sample sizes were too small to appropriately test for statistical significance. (Chart 12.2)

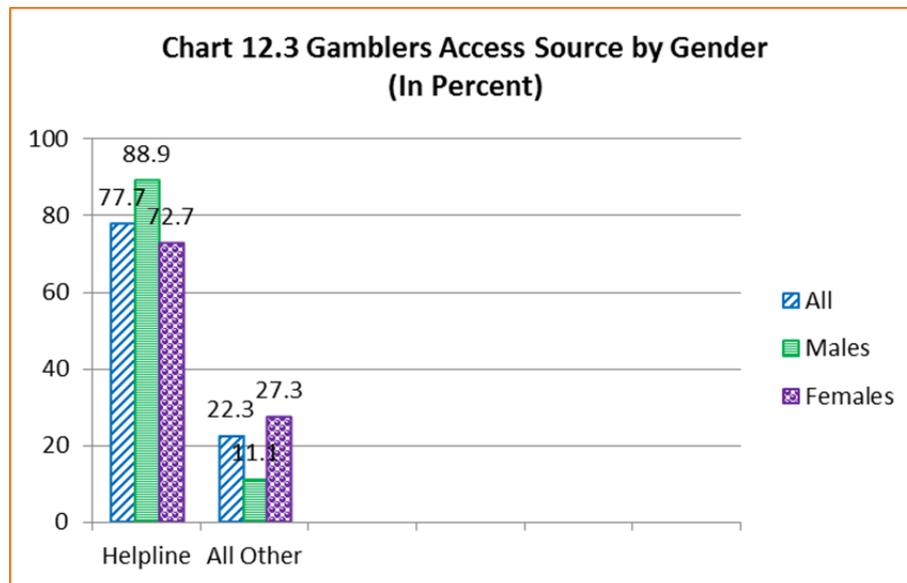
The average annual household income for the GEAR clients was \$36,125 down from \$45,590. The median income was \$36,125. There were no statistically significant differences between this and last year or the outpatient incomes. (Table 12.2)

	n	mean	sd
All	29	36,125	23,622
Males	9	33,021	14,226
Females	20	37,522	26,679

The average numbers of years of education completed was 13.6, up from 13.0 years. This year females were significantly⁶⁴ more likely to report a higher number of completed years at 14.2. (Table 12.3)

	n	Mean	sd
All	31	13.6	1.9
Males	9	12.3	1.3
Females	22	14.2	1.9

A majority of the clients (77.7%) reported accessing the GEAR program through the Helpline. All other sources were reported by only one individual each and included, past or current client, other private MH/A&D service provider, yellow page, radio/PSA, or web/internet. (Chart 12.3)



As previously reported, the primary gambling activity for both males and females were machines (video poker, slots, line games). (Table 12.4)

	All	Males	Females
Machines	96.8	89.9	100.0
Sports	3.2	11.1	0
Other	0	0.0	0

⁶⁴ p < .05

The reported lag time from initial call to first available was reported as 11.8 days, down from 16.2 days previously reported. The lag from initial call to first clinical contact was reported as 14.8 days, down from 22.6 days. These longer lag times are an anomaly in that staff mail out the packet at the same time of the initial call, but have to wait until the prospective participant mails back the release and consent forms.

Those enrolling in the GEAR program reported a significantly⁶⁵ older age at the time of their first gambling experience than outpatient clients (33.4 years versus 24.6 years).

Correspondingly, they also reported a significantly⁶⁶ older age in association with the onset of gambling

	n	mean	sd
All	31	33.4	14.9
Males	9	26.9	12.9
Females	22	36.1	14.8

problems (43.5 years versus 36.5 years) for the outpatient clients. (Table 12.5)

The average number of DSM IV criteria endorsed was 8.5, significantly⁶⁷ more than the outpatient population which was 7.6. One individual was reported as attempting suicide in the six months prior to enrollment, two were reported with ideation, and one with a threat to suicide. Two reported job problems related to gambling, two with a plan or recently filed bankruptcy, and two with legal problems associated with their gambling.

The average length of time reported being enrolled in GEAR was 167.7 days, up significantly⁶⁸ from 80.7 day previously reported. Although males remained enrolled longer than females, the difference was not significant. Of the 28 cases closed during the report year, 57.1% were reported a successful, up from 45.2% previously reported.

⁶⁵ p < .01

⁶⁶ p < .01

⁶⁷ p < .05

⁶⁸ p < .05

13. CORRECTIONAL PROGRAMS Coffee Creek

A brief educational course, initially designed in the theme of the minimal intervention program for gamblers discussed above was initially introduced into the Coffee Creek Correctional Facility (CCCF) for female participants in early 2004. As interest grew, non-gamblers began volunteering for the course and in 2012-2013 the program was restructure into two tracks. The first, a five-session, 7.5 hour, course was implemented for women who were identified as having substance abuse problems, implemented in conjunction with that and is referenced as the treatment (TX) group. The second was a seven-session, 8.75 hour course for volunteers from the general population (GP) who were gamblers, family members of gamblers, or were just curious. Due to funding cuts in FY 09-10, the program was placed on a hiatus and resumed in FY 12-13.

For this report the data was received for 74 women in the TX group and 37 in the GP group. The average age of the TX group was 31.4 years while those in the GP group were significantly⁶⁹ more likely to be older with an average age of 39.3 years. (Table 13.1)

Table 13.1 Average Age (In Years)			
	n	mean	sd
TX	74	31.4	7.2
GP	37	39.3	9.1

Interestingly, the distribution of the reasons for attending the courses was quite similar with 50.0% of the TX group and 60.9% of the GP group indicating they had, or might have, a problem with gambling. (Table 13.2)

Table 13.2 Reason For Attendance (In Years)			
	Gambler	Family	Curious
TX	50.0	27.8	22.2
GP	60.9	26.1	13.0

⁶⁹ p < .01

Slightly over 90% of both groups reported themselves as White and over 15% of both groups reported multiple categories as participants were able to select more than one category for race and/or ethnicity. The second most frequently chosen was Native American with approximately 15% so indicating.

The largest distribution of the women in both groups was never married with approximately half so reporting, followed by nearly a third being divorced. (Table 13.3)

	TX	GP
Never Married	52.7	43.2
Married	12.2	16.2
Widowed	4.1	10.8
Divorced	29.7	27.0
Separated	1.4	0

Approximately 20.3% of the TX group reported not finishing high school and 28.3% reported having a GED. Only 8.1% of the GP group reported not finishing high school with 24.3% having a GED. Slightly over half of the GP reported some college with 2.7% having a bachelor's or master's degree. Approximately 36.5% of the TX group reported having some college with 4.1% earning an associate's degree. None reported completing a bachelors or higher degree.

Again, of interest was the finding that 86.1% of the TX group and 86.5% of the GP group scored on the DSM criteria for disordered gambling. The average number of items endorsed by the TX group was 7.3 and that for the GP group was 7.9 items. Both groups were very similar in severity with the outpatient clients.

Slightly fewer than 26% of the TX group reported having a debt related to gambling with an average amount of \$43,798. Nearly 30% of the GP group reported a higher average gambling debt at

	n	mean	sd
TX	19	43,798	78,574
GP	11	62,636	61,342

\$62,636. There was no significant difference. It should be noted that there may have been a

small number of individuals who might have over-stated their gambling debt, but that was not certain. (Table 13.4)

	TX	GP
VLT	37.8	48.7
Scratch-Its	6.8	2.7
Cards	2.7	2.7
Multiple Games	43.2	32.4
No Gambling	9.5	13.5

The TX group indicated they had essentially no favorite game (43.2%) followed by video games. The GP group's preference was similar with 48.7% indicating video machines and 32.4% no preference. Approximately 9.5% in the TX group and 13.5% in

the GP group indicated they did not gamble. (Table 14.5)

In the TX group, approximately 13.5% reported having thoughts of suicide during the six months prior to incarceration, 2.7% plans, and 2.7% reported making an attempt. The GP group reported similar distributions. (Table 14.6)

	TX	GP
Thoughts	13.5	13.5
Plans	2.7	5.4
Attempts	2.7	2.7

In the TX group 4.1% reported the suicidal ideations were due to gambling and 2.7% in the GP group. The TX group reported that for 18.9% the current incarceration was due to gambling related issues and in the GP group 40.5% reported their incarceration was due to gambling related issues. For the TX women, 23.0% reported that they had concerns regarding the potential negative influence of gambling after their release and 29.7% of the GP women so reported.

Approximately 71.6% of the TX group and 62.2% of the GP group reported having children that would be in their custody upon release. The average number of children was 2.1 and 2.6 respectively.

Participants were given a 10 item questionnaire before and after the information sessions in order to assess the degree to which they retained the information they were provided and, in several cases, change their attitudes. Positive changes were seen in all knowledge and attitudinal areas, for the TX group eight items achieve statistically significant improvement as noted in the accompanying table. The GP group's changes achieved statistical significance in nine of the key areas. (Table 14.7)

Statement	TX	GP
1. Problem gambling can become an illness	ns*	ns*
2. Problem gambling is treatable	p < .01	p < .01
3. Treatment is available in Oregon	p < .01	p < .01
4. PG is widely accepted as a mental health issue	p < .01	p < .01
5. It's possible to find PG treatment in Oregon	p < .01	p < .05
6. Asking for help is OK	ns*	P < .05
7. You have to gamble ever day to be a Problem Gambler	p < .01	p < .01
8. People gamble for the same reason	p < .01	p < .01
9. Goals are important to help Problem Gamblers	p < .01	ns*
10. Gambling treatment is affordable	p < .01	p < .01
* There was high agreement with these statements on the pretest and consequently little margin for improvement.		

Included with the knowledge and attitude survey used for the ANOVA, the final survey includes six questions regarding the participants' agreement with statements regarding their perceptions of what they had gained from the program and four questions regarding their level of satisfaction with what they had gained. The response categories are framed on a Likert-type five point scale including strongly agree, agree, somewhat agree, disagree, and strongly disagree. Both group responded 100% strongly agree, or agree to all of the questions

except the question pertaining to setting personal goals to reduce or eliminate problem gambling.

Table 13.8 Additional Self-Report of Outcomes and Satisfaction Questions
I have gained insight and greater perspective about my gambling behavior.
I have gained education about problem/compulsive gambling.
I have gained some skills to help initiate recovery.
I have gained education about the importance of a recovery support system.
I am aware of the Action Cycle.
I can identify three of my triggers to gamble.
This program was helpful to you?
I would recommend this program to others?
The materials were helpful?
The presenter was effective?
I have set personal goals to reduce or eliminate problem gambling?

14. PREVENTION

Problem gambling prevention and outreach programs are directed at avoiding or reducing the emotional, physical, social, legal, and financial consequences of disordered gambling for the gambler, the gambler's family, and the community. Oregon's prevention efforts are guided by the Center for Substance Abuse Prevention's (CSAP) six core prevention strategies. As noted in previous Prevention Efforts section of this report, Oregon Problem Gambling Services delivers prevention and outreach services via three separate, yet related, administrative bodies.⁷⁰

Significant Outcomes

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

⁷⁰ Special thanks to Roxann R. Jones, Public Health and Problem Gambling Prevention Specialist, Oregon Problem Gambling Services, for providing the prevention information provided in this section.

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

State Office

The state Prevention Specialist position was vacant for the majority of the time covered during this reporting period, due to the state Problem Gambling Manager position was vacant, and slated to be hired prior to the Prevention Specialist position. During the reporting period Problem Gambling Prevention Connect calls were implemented, and sustained during vacancies. These calls facilitated by state staff provided county Prevention Coordinators with state updates and opportunities to share success and challenges experienced at the county level. Once staffing at the state was at optimal level, Problem Gambling Services embarked on six regional trainings to provide information and gather feedback regarding treatment and prevention service's needs at the county and regional level.

Local Regions' Accomplishments

Oregon Problem Gambling Services has directed its regional prevention/outreach providers to utilize the Center for Substance Abuse Prevention (CSAP) strategies as a research-based framework for implementing regional gambling prevention efforts (Appendix A). Because "best practices" in gambling prevention are still being developed, Oregon relies

on principles of alcohol and drug abuse prevention programs, whose efficacy is well documented, on the belief that many of the same risk and protective factors are at play.

A vast majority of the problem gambling prevention efforts across the state are targeted at the youth population. Updated Statewide Student Wellness Survey data reflects that significant numbers of Oregon youth gamble, even compared to other risk behaviors. Student Wellness Survey data is available upon request.

Of the CSAP strategies employed by Oregon providers the following were the most successful:

- *Information Dissemination* – since problem gambling is still a relatively new issue, regional prevention and outreach efforts have typically focused on building community awareness and the harms of problem gambling and the availability of treatment for problem gamblers and their families.
- *Community-Based Processes* – Several regions have come to see the advantages of working with groups and coalitions as a way to increase their ability to share information and strategies regarding problem gambling.

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

- *Education*- True prevention education activities are difficult to achieve in the field of problem because of limited resources, a lack of research on what work in gambling prevention and the generally time-consuming nature of prevention education.

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

Future Directions

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

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

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

15. SUMMARY

Gambler enrollments continued a downward trend to levels seen fourteen years ago. In FY 11-12 there was a slight rally that lasted for only one year and current enrollments were down about 13% for this report period over the previous year. Referrals from all access points have uniformly decreased with the Helpline seeing the greatest decrease this year.

Generally speaking the availability of treatment has remained good. Lag from initial call to first available have been within expectations except females generally are seeing a longer lag between call and first available and call and first seen. The proportion of females fell this year to below that of males, the first time in eight years and they tended to remain enrolled significantly longer than males. Overall, average length of enrollments was longer than last year, and subsequently the average cost per case also rose. Historically, as enrollments decrease, length of engagements increases.

There were no notable differences in average age of clients or of race/ethnicity. Nonetheless, the distribution of married clients enrolling dropped again this year to only 28.1%, the lowest seen thus far. There were no major changes in other demographic characteristics.

Primary gambling games remained to be machine-based (video poker, line games, and slot machines) and consequently the primary gambling venue remained to be video lottery retailers. The number of clients reporting a debt related to gambling was down this year and the average debt was also down slightly.

Abstinence rates at six and twelve-month follow remained stable at approximately 60% and non-completers reported an abstinence rate at six-months of 43.3%, up from last

year. Improvement in wellness was evident across a wide spectrum of key indicators with numerous being statistically significant. Satisfaction of program completers remained strong, while, non-completers was, as expected, low.

Helpline calls decrease again this year, with an across the board drop in all access sources except for Web and Internet which increased slightly. Residential enrollments also decreased by about one-third, but wait list time decreased.

The number of individuals participating in the home-based minimal intervention program remained stable. This year, the correctional institution program at Coffee Creek Correctional Facility for women was again included in the report. This program had been revised last year to include two tracks and participants in both tracks demonstrated significant improvement in knowledge and awareness across nearly all of the key indicators. Their levels of satisfaction with the program were also very remarkable with 100% endorsement.

OREGON PREVALENCE CITATIONS

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Moore, T., Jadlos, T., & Carlson, M. (2000). Findings and recommendations for the strategic plan: identification, prevention, and treatment of disordered gambling in Multnomah County. Portland, OR: Behavioral Health Division, Multnomah County

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Volberg, R. (2001). Changes in gambling and problem gambling in Oregon. Salem, OR: Oregon Gambling Addiction Treatment Foundation

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

BRIEF HISTORY OF LEGAL GAMBLING AND PROGRAM DEVELOPMENT

- 1933 Legislature legalizes pari-mutuel wagering on horses and dogs (same year repeals prohibition)
- 1973 Social gambling legalized in counties and cities
- 1976 Constitutional amendment legalizes charitable gambling (bingo, raffles)
- 1984 Constitutional amendment creates The Oregon Lottery (Scratch-its™ Megabucks™)
- 1987 Legislature legalizes off-track pari-mutuel wagering
- 1989 Multi-state lotteries incorporated into Lottery
- 1989 Lottery introduces Sports Action™ (Stopped in: NFL 1990; NBA 2007)
- 1991 Lottery introduces Keno™
- 1991 Contentious legislative session okays video poker but only with 3% of net to treatment (ORS 461.549 1992 – amount to 1%)
- 1992 Video Poker machines introduced
- 1992 Treatment programs established (ORS 409-435); Problem Gambling Treatment Fund created (ORS 409.430); Funding DAS to Counties (no apparent restrictions)
- 1993 First of nine IGCs established (Federal Indian Gaming Regulatory Act 1988)
- 1994 State Supreme Court rules PG treatment funding illegal under constitution. Legislature takes action and funded at 1%
- 1995 PG Treatment consolidated statewide Association of Community Mental Health Providers (OCMHP)
- 1995 Helpline established
- 1996 Governor's Taskforce (Executive Order 96-03)
- 1996 2nd Iteration of the Oregon Council established as Oregon Gambling Addiction Treatment Foundation
- 1997 Adult Gambling & Prevalence Study (Volberg)
- 1997 Adolescent Gambling Study (Moore & Carlson)
- 1998 Oregon Council received permanent IRS non-profit status finding
- 1999 Administration of Problem Gambling Services moved to AMH and at least 1% of lottery proceeds to services (SB 118) (ORS 409.435 and ORS 461.549).
- 2001 PG treatment & prevention services commences with state employees
- 2001 Win for Life introduced
- 2001 Adult Gambling Replication Study (Volberg)
- 2001 Older Adult Gambling Prevalence Study (Moore)
- 2003 PGS funding slated for elimination (HB5077 and the rejection of a surtax)
- 2002 Etiology of Pathological Study (Moore)
- 2003 Number of Lottery VLTs increases from five to six
- 2004 Emergency Board restores expenditure authority but budget reduced
- 2006 Adult Gambling Prevalence Replication Study (Moore)
- 2007 Line games introduces on VLTs

- 2009 Helpline incorporates live web chat
- 2010 Adolescent Gambling Study (Volberg)
- 2013 DOJ opinion Lottery funding treatment ads not legal
- 2013 HB 4028A Allows Lottery to resume treatment ad funding
- 2013 HB 2355 Stabilizes PGS funding to not go below 7.1.11 baseline
- 2014 PGS Office fully staffed!