State Of Oregon
Mental Health and Addiction Services
Department of Human Services

GAMBLING TREATMENT PROGRAMS EVALUATION UPDATE - 2003

July 1, 2002 Through June 30, 2003

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EXECUTIVE SUMMARY

This report is the annual update of the statewide problem gambling services efforts for the period of July 1, 2002 through June 30, 2003. The statewide problem gambling services system is comprised of three core elements including treatment, prevention and outreach, and quality management. The treatment element includes 25 traditional outpatient treatment programs, two short-stay crisis respite programs, and a home-based, telephone supported minimal intervention program. The prevention and outreach element is comprised of several county and regional education and awareness efforts, a statewide Oregon Lottery advertising campaign, and the very important toll-free, statewide Problem Gambling Helpline (1-877 2 STOP NOW [1-877-278-6766]). The third element is the quality control and management effort encompassed by the problem gambling services management and the evaluation efforts.

Based on empirical evidence stemming from studies conducted in Oregon, it is estimated that approximately 35,800 adult Oregonians are problem gamblers and an additional 23,000 are pathological gamblers. Most recent national estimates place the social-economic cost of problem gamblers at approximately $3,000 each and $11,000 for each pathological gambler – or an estimated social-economic cost in excess of $361 million for Oregonians.

During the report period, slightly over 1500 problem and pathological gamblers enrolled in treatment. This level of enrollment represents an increase of 6.7% over the previous year while the increase for the biennium was an exceptional 41.9%. Since consolidation of the treatment programs in 1995, the average annual rate of increased enrollments was 16.9%. These strong gains in enrollments are reflective of increasing treatment and outreach effectiveness.

Recent legislation has made way for a 20% increase in the number of Lottery operated Video Poker Machines and a new Native American Casino has been approved. Furthermore, discussion has been underway to add video slots to the Lottery's game mix. These actions to expand gambling are expected to increase the incidence of problem and pathological gambling. From a public policy perspective, the consistent and uninterrupted deployment of an effective statewide treatment and prevention system will be of paramount importance.

Recognition must be given to the Oregon Lottery for their continuing efforts of supporting the development and implementation of effective problem gambling awareness media campaigns. These campaigns stress three critical factors: "treatment is free, confidential and it works". Furthermore, printed materials include responsible gambling guidelines. Television advertisements and print material point callers to the Helpline that is staffed by qualified gambling counselors who provide crisis counseling, motivational interviews, and hands-on referral to the nearest treating agency. The Helpline is responsible for one-third of the referrals to treatment and is nearly three times more effective than any other referral source.

A critically important factor in an effective and efficient system is its ability to promptly respond to requests for help. Delays in providing services usually result in the temporary passing of the opportunity for the caller to enroll in treatment – to only return after the problems have become much worse. The problem gambling services treatment system has well demonstrated responsiveness with a very short average lag time between initial contact with the treating agency to first available appointment of only 3.5 calendar days.

Treatment effectiveness can be measured by the number of clients successfully completing treatment and by longer-term changes in behaviors. During the report period, the successful program completion rate increased to 37.2%, a sound rate for problem gambling treatment programs. Successful program completers reported abstinence rates of over 60% at 12 months and those who did not complete their entire course of treatment reported abstinence rates of over 41% at six months. Statistically significant changes were also reported at follow-up in critical life functioning and wellness behaviors. And, clients were well satisfied with the services they received.

A measure of efficiency is the average cost per case that was $828.44 overall and $1,685.11 for clients who completed their full recommended course of treatment. The average length of enrollment was 140 days and the average number of service hours overall was 18.1 and 40.5 hours for program completers.

There is a good deal of research that indicates that family involvement in treatment is a sound investment. There were 296 family members enrolled in family treatment programs. The findings indicate that not only did family members receive effective assistance, but very importantly, those gamblers who had a family member enrolled were significantly more likely to successfully complete treatment.

A summary of the key findings follows:

- During the report period, 1800 people were treated in 25 state-funded gambling treatment centers (1504 gamblers and 296 family members).
- Enrollment for the 2001 – 2003 biennium increased 44.2% over the previous biennium.
- The average treatment cost per case was $828.44 for all gamblers and $1,685 for those gamblers that completed their entire recommended course of treatment.
- Six months after gamblers left treatment, 80% reported that they either no longer gambled or gambled much less than before treatment.
- Over the past seven years the percentage of women utilizing gambling treatment rose from 37% to 46%.

- 53% of problem gambling clients worked full-time, the average income was $39,344, 41% were married, 41% owned their own home, and the average age was 44 years, 87% were Caucasian.

- Problem gamblers experience a complex array of mental health, social, and legal issues that challenge comprehensive treatment - 23% suicidal thoughts, 29% alcohol-related problems, 11% drug-related problems.

- Social consequences of problem gambling were observed in reports of jeopardizing or losing relationships (64%), poor job performance (14%), not paying bills on time (56%), and committing illegal acts to obtain gambling money (34%).

- The average gambling related debt was about $23,000. Over 60 clients reported gambling related debts of over $100,000. The total gambling related debt, of just those that obtained Lottery funded treatment in Oregon in 2003, exceeded $29.5 million.

- The average length of time between when a person first developed gambling related problems to the time they sought help was 4.7 years.

- Seventy-two percent of the problem gamblers who enrolled in treatment reported their game of preference was video poker followed by slot machines at 12%.

- Problem gamblers reported that their primary gambling location was lottery retailers (69.3%) followed by Native American Casinos (17.5%). Although the number of clients reporting Lottery locations has fluctuated, the number reporting Native American Casinos has steadily increased from 10.2% in FY 96-97 to the 17.5% reported this year.

- Gambling treatment programs that are within 50 miles of a casino treat three times the proportion of casino gamblers than other programs.

- Gamblers with an enrolled family member were significantly more likely to successfully complete treatment.

- Two residential crisis-respite centers, one incorporated into an alcohol and drug treatment center and the other into a mental health center, served 31 clients for an average length of stay of 7.6 days and average cost per case of $423.

- The Gambling Evaluation and Reduction Program (GEAR), a home-based, telephone supported minimal intervention program, enrolled 34 gamblers in 2003. Responses from 24 past participants at 12-month post-enrollment reported program satisfaction (67%) with 24% reported no gambling and 57% reported less gambling.

- Approximately $1.3 million were invested into problem gambling prevention and outreach efforts in 2003. County governments were provided $677,577 to implement regional problem gambling prevention programs and the Oregon Lottery spent $600,000 toward

the production and purchasing of statewide ads and educational materials addressing problem gambling.

- In 2003, the statewide Problem Gambling Help Line received 4403 calls and made 3455 referrals for treatment or Gamblers Anonymous meetings.

Conclusion

The increase in problem gambling treatment services over the past eight years has been nothing short of phenomenal. Looking at this treatment increase could be interpreted as an increase in the incidence of problem and pathological gambling. However, replicated prevalence studies suggest that there has not been a rise in the number of problem gamblers. The dramatic utilization increase in gambling treatment is most likely attributed to the successful efforts of the Oregon Lottery to advertise the availability and effectiveness of treatment, coupled with the prevention and outreach efforts of state and local government's problem gambling services.

Findings presented in this report strongly indicate a problem gambling services system that is successful in both encouraging problem and pathological gamblers to seek treatment as well as efficiently providing effective services. With very low average per case costs, strong successful treatment completion rates, and very good abstinence rates at follow-up, the system certainly supports sound public policy in keeping the social-economic and personal emotional costs of problem and pathological gambling in check.

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TAB 1. INTRODUCTION

This is the annual report of the Oregon Problem Gambling Services efforts for fiscal year 2002 – 2003 (FY 02-03) that included the period July 1, 2002 through June 30, 2003. The format of this report has been modified from previous annual reports in the hopes of making it friendlier for review and quick reference. The report is separated into 15 sections labeled "tabs" with four components for each tab. The components of each tab include a brief narrative summary of the highlights of the section; bulleted highlights for easy reference; a narrative discussion of the finding included in the section; and , the tables, charts, and graphs of data for each of the sections. In an effort to keep the narrative section as concise as possible, some of the information presented in the table and chart section may not be specifically addressed, but is included as information in the event the reader desires additional supporting information.

- **Tab 1: Introduction**
- **Tab 2: Background and History:** reviews the background and history of the gambling treatment and prevention efforts in Oregon since their inception in 1993. This section is included in all previous annual reports and is updated to provide an easy reference for the legislative processes by which gambling treatment and prevention came to be in Oregon, the challenges that have been faced over the years, and the current challenges facing the system.
- **Tab 3: Utilization:** discusses system utilization and capacity with cross-year comparisons of enrollments for both gamblers and family members as well as trends in treatment encounters.
- **Tab 4: System Performance:** presents the findings relating to access to treatment, treatment durations, and throughput including the rate of successful treatment completion.
- **Tab 5: Gambler Client Demographics:** includes a variety of demographic information including age/gender ratios, employment, education, ethnicity, marital status, employment, and income.

- **Tab 6: Gambling Characteristics:** discusses gambling behaviors and characteristics of the gamblers enrolling in treatment including game and location preferences, age of onset of problem gambling, duration of problem gambling, number of problem gambling episodes, gambling event times, gambling expenditures, and gambling patterns.
- **Tab 7: Gambling Consequences:** addresses findings related to the consequences of problem and pathological gambling as reported by gamblers at the time of enrollment including symptomology relating to gambling as well as mental health, gambling related debt, suicidality, criminality, and satisfaction with key wellness indicators.
- **Tab 8: Longitudinal Outcomes:** includes the findings from the follow-up of gambling clients, including both those who successfully completed treatment and those who left treatment early; addressing levels of gambling, satisfaction with key wellness indicators, consumer satisfaction, and comparisons between key enrollment and follow-up indicators.
- **Tab 9: Family Clients:** contains information relating to the family members who have enrolled in the family treatment components of the gambling treatment programs and includes access source, demographic characteristics, and successful program completion rates.
- **Tab 10: Minimal Intervention Program:** discusses the consolidated findings from the minimal intervention program that is a home-based, workbook-focused intervention that includes telephone consultation with a gambling treatment professional.
- **Tab 11: Prevention and Outreach:** presents the findings from several efforts that have been implemented throughout the state that focus on prevention and case finding.
- **Tab 12: Helpline:** discusses the innovative state-wide problem gambling helpline and caller characteristics.
- **Tab 13: Respite Care:** includes a description of these unique programs and includes preliminary findings including utilization.
- **Tab 14: Evaluation Methodology:** provides a discussion of the evaluation study design, methodology, and data collection rates upon which this report is based.
- **Tab 15: Summary**

TAB 2. BACKGROUND AND HISTORY

Questions addressed in this section:

What gaming activities are available in Oregon?
Why did Oregon fund gambling treatment from Lottery revenues?
What challenges have been faced in keeping treatment available in Oregon?

Synopsis

Oregon, like nearly all states in the U.S., chose to expand gambling opportunities in the 1980's in an effort to increase revenues for special needs including economic development and schools. With efforts to further expand the Lottery to include video poker games arose a concern among many legislators regarding the potential problems that might be created by expansion. Attached to the 1991 legislation that enacted video poker, was the creation of funding for problem gambling treatment services. After years of budget instability, the 1999 Legislative Assembly, with Senate Bill 118, provided a minimum of 1 percent of the Oregon Lottery's proceeds be designated to a Gambling Treatment Fund and assigned the Department of Human Services with responsibility for administering these funds. The Problem Gambling Unit within the Office of Mental Health and Addiction Services (OMHAS) manages Oregon Problem Gambling Services. These services include a statewide system of 26 outpatient treatment centers, two statewide residential crisis-respite programs, a statewide minimal intervention program, a statewide gambling help-line, 18 community prevention programs, a statewide workforce development program, and an extensive program evaluation project. 6.4 million dollars of Oregon State Lottery proceeds funded these services during the 2001-2003 biennium. Although Oregon has been a leader in supporting the needs of problem gamblers and their families, this effort has not been without serious challenges. In 2003, funding for problem gambling services significantly decreased while gambling expansion continued.

Key Findings

- Oregon has had a long history of legal, grey, and illegal gambling.
- Current gaming encompasses a full scope of lottery games including VLTs, eight IGCs, pari-mutual on and off track, card rooms, and charitable wagering.
- Oregon has the most comprehensive array of problem gambling services in the nation that are based on a public health model.
- Funding for problem gambling services has not been stable even with legislative acts designed to create stability.

Several pilot 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 with the Association of Community Mental Health Programs (AOCMHP) and the current evaluation activities commenced. In 2001, management of the statewide treatment and prevention efforts was taken in-house by the State Office of Mental Health and Addiction Services (OMHAS) under the direction of the Problem Gambling Services Manager. There were 25 outpatient programs open during the report period along with two short-term residential, or crisis respite, programs for pathological gamblers[1] as well as a home-based program with limited telephone access to qualified gambling counselors.

In the summer of 2001, several special project contracts were initiated with provider organizations throughout the state by OMHAS to enhance local outreach and prevention. Prior to this, there were only two definitive county-based ongoing prevention and education efforts – one for the general population and one for adolescents identified as having substance abuse problems. Prevention activities are more fully discussed in Tab 11.

[1] A third respite program was slated for opening in the summer of 2002.

Gambling Opportunities

Oregon, like most states, has dealt with illegal and gray gambling[2] since statehood was achieved. In 1933 the State passed legislation that allowed for pari-mutuel wagering on horses and dogs. From the mid-1950's through 1991, various modifications and new rules were adopted covering pari-mutuel wagering and in 1987 off-track betting was legalized. Since legalization, pari-mutuel wagering has been governed by the Oregon Racing Commission.

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 33 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.

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

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 Powerball from 1992), Sports Action (1989) the first and only state lottery game based on the outcome of professional sporting events, Keno (1991), Video Poker (1992), Pick 4 (2000), and Win for

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

Life (2001). Chart 2-1 is a presentation of the annual Lottery sales since inception (the 2004 figure is a projection).

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.[4] There were approximately 1400 traditional game retailers in the state; 800 video game retailers; and 1100 retailers that sell both traditional games and video poker at the time of this report.

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 that allowed tribes to offer any and all forms of gaming that are otherwise legal in the state. With the combination of charitable, social, and Lottery games regulated in Oregon, the eight[5] IGCs were able to offer all gaming customarily associated with "Las Vegas" style casinos.

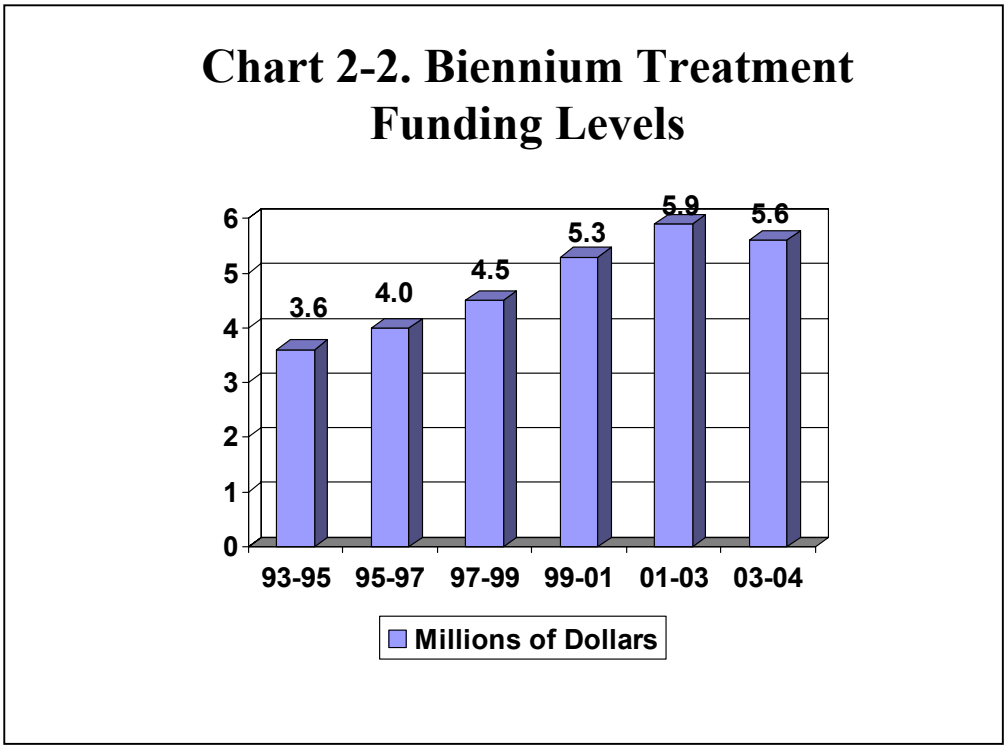
Program Funding

In 1991 the State Legislative Assembly asked the Oregon Lottery to operate Video Lottery games that were 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 disorder 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

[4] Of note, is the continuing discussion of adding line games to the VLTs. This action would increase the lottery revenues by an estimated 70 to 100 million dollars. However, due to the political nature of such action, and the complications of forthcoming negotiations with the retailers regarding their commission on sales, few politicians have made noises regarding such implementation.
[5] The ninth IGC was in the planning stages at the time this report was written.

establishments made them into casinos that 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. Chart 2-2 is a presentation of the actual program funding levels that do not reflect the set-aside.

During the report period, the State was entangled in the worst economic crisis experienced in more than 50 years. Unspent monies in the Problem Gambling Treatment Fund (approximately 15% of the annual budget for the report period) were taken from the fund and redistributed. 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. If the surtax does go to the voters in a special election scheduled for February 2004, and is not passed, the gambling services will lose essentially all funding for services. 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 April legislative emergency board that their expenditure authority be restored for these funds to preserve problem gambling services. At the time this report was written, the outcome of that request was unknown.

Estimating Treatment Needs

In 1997, the Oregon Gambling Addiction Treatment Foundation (OGATF) commissioned an adult prevalence study of problem and pathological gambling in the State. The study, completed in August, 1997, estimated the lifetime problem gambling prevalence at 3.1 percent and the probable pathological lifetime gambling at 1.8 percent. The study estimated the current year problem gambling rate at 1.9% and the current year probable pathological gambling prevalence at 1.4% for a combined current year disordered gambling prevalence of 3.3%, suggesting that the number of admissions of gamblers to the programs each year should be between 600 and 1400 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 study commissioned by OGATF and 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 recent 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

[6] Copies of all studies sponsored by OGATF can be downloaded from www.gamblingaddiction.org .

was available, Volberg reported increases in the markers of gambling and disordered gambling.

Nonetheless, applying the most recent current year estimates of combined prevalence for problem and probable pathological gambling[7] to the most recent estimate of the adult population in Oregon,[8] the projected enrollments should be between 1175 and 2430.[9]

As has been discussed in previous annual reports, in 1998 OGATF commissioned a study to estimate the prevalence of disordered gambling among adolescents (13 years to 17 years old). That study estimated 11.2% of adolescents were Level 2 (in-transition) gamblers and 4.1% were problem gamblers (Carlson, M. and Moore, T., 1998).[10] The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals. Nonetheless, subsequent anecdotal investigation[11] 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.

In 2000, OGATF commissioned a study to estimate the prevalence of disordered gambling among Oregon adults aged 62 years or more that found 58% of this population reported past year gambling and an estimated 1.2% were problem gamblers with an additional 0.3% probable pathological gamblers (Moore, T., 2001b).

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[7] This rate is 2.3% ± 0.8% (Volberg, 2001)
[8] This estimate provided by OMHAS is 2,612,500 adults 18 years and older.
[9] This calculation presumes that approximately 3.0% of those with problems will seek treatment (penetration rate).
[10] 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.
[11] 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.

Gambling Treatment System Design

Background

Formal programs for the treatment of disordered gambling in Oregon were first established as pilot programs in 1993. Agencies applying for state funding[12] 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 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.[13] 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 ten years the programs have evolved and currently the vast majority of programs follow a cognitive behavioral approach.

As education, training, and counselor certification efforts, led and implemented by the informal gambling treatment providers' association,[14] blossomed within the state, most

[12] All state funding was directed through the counties. Each agency's contract was with the county in which they operated.
[13] This is arguably a generalization.
[14] 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 has met monthly ever since and has provided a great deal of insight and guidance to the formation of treatment, treatment program standards, and counselor certification.

programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.[15]

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. As of October 1, 2001, these rates were increased to $27.52 and $82.52 respectfully. There is no charge to Oregon residents who enroll in the programs.

Description of Current Treatment Services[16]

Oregon's newly redesigned 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 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.

A frequent access point to treatment is a call made to the state's Problem Gambling Help-Line (877-2-STOP-NOW). The Help-Line is staffed 24 hours a day by professional counselors with problem gambling expertise. Callers are informed that problem gambling treatment services in Oregon are free of charge and confidential. When appropriate, counselors conduct brief assessments and motivational interviews with callers. The counselor

[15] Many programs have specialized treatment efforts for family members that are not contingent upon the gambler being also enrolled.
[16] This subsection has been adapted with the authors' permission from an article published on www.cmah.net/egambling/issue9 by J. Marotta.

then makes referrals based on screening information, clinical judgment and available resources. To facilitate a successful referral, Help-Line counselors use three-way calling to place the caller in contact with the referral agency and offer follow-up calls to provide further support.

The treatment system follows a stepped-care approach. That is, treatment intensity increases with negative outcomes both within programs and between programs. Oregon's treatment delivery system is composed of intervention programs broadly classified as Level .05 interventions, Level I treatments, and Level II treatments.

Level .05 interventions are considered the least restrictive approaches and consist of either local Gamblers Anonymous groups or the Gambling Evaluation And Reduction (GEAR) Program. Participants utilizing the GEAR program are mailed a manual for self-change and provided the opportunity to review workbook assignments with a counselor during scheduled telephone sessions. All GEAR participants receive 24-month evaluation and referral services.

Level I treatment is broadly defined as outpatient, professionally delivered, face-to-face intervention. Level I treatment involves a biopsychosocial assessment, individual treatment planning, one-to-one counseling and/or case management sessions, group counseling, family involvement, if appropriate, and aftercare planning. Oregon operates 25 Level I treatment programs throughout the state. Included in the Level I services are culturally specific programs targeting African American and Hispanic populations.

Level II programs are composed of a network of regional centers that offer crisis-respite services after referral from an outpatient gambling treatment program. Oregon operates two crisis-respite programs that offer short-term residential services. One center is

medically based and the other is operated out of a residential alcohol and drug treatment facility.

Oregon Gambling Helpline

In 1995, when program management was consolidated[17] contractually with AOCMHP, a decision was made to initiate a statewide Helpline. The initial purpose of this Helpline was to facilitate access to treatment by conducting a very brief screening and then referring the callers to the nearest provider. The toll-free phone number was provided in all media advertisements[18] as well as placards placed in each of the establishments that had state-regulated video lottery terminals (video poker machines). Although not mandated to do so, some of the Indian casinos in the state posted the Helpline number.

On July 1, 2001, the contractor for the Helpline was changed through a competitive bid process. The successful bidder was an agency that also housed the second largest gambling treatment program in the state (ACES Meridian in Lane County). With this transition to the new contractor, two major changes occurred. First, the Helpline was answered 24/7 by a qualified gambling treatment counselor, where in the past it had been answered by a qualified mental health specialist. Second, the new Helpline staff implemented a "positive" referral process. Instead of simply providing the caller with contact information for the nearest provider agencies, they would solicit approval to both let the referred agency know that the individual had been referred and to also allow a counselor from the Helpline staff call the individual back within 72 hours to check on how the referral went.

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[17] It should be made clear that, with few exceptions, treatment providers contract directly with their county and only policy development had been centralized.

[18] See discussion below regarding the role of the Oregon Lottery in advertising treatment and prevention.

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 Gambling Services Manager also identified the necessity to move prevention activities away from generalized requirements of the treatment programs and to performance based contracts with the counties. Nonetheless, in some situations, the treatment provider remained involved in prevention activities, but now with specific outcomes.

Definitionally, problem gambling prevention programs are directed at avoiding or reducing the 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) six core prevention strategies and delivered by three separate, yet related administrative bodies.[19]

The state's Department of Human Services'(DHS), Problem Gambling Services develops and maintains policies, provides technical assistance, and coordinates the problem gambling prevention activities that take place in the state. DHS Problem Gambling Services orchestrates the annual Problem Gambling Awareness Week, submits editorials and other press releases, develops and circulates information pamphlets, and provides materials and

[19] Material for this section of the report was provided by Dr. Jeffery Marotta, Problem Gambling Services Manager.

workshops at over a dozen annual statewide conferences and training events. The department is also responsible for all contracting with the counties and regions.

As identified above, the Oregon Lottery developed and operated a play responsibly campaign and invests 10% of their overall marketing budget (approximately $600,000 a year during this report period) in problem gambling awareness campaigns that use TV, radio, and print media. These statewide activities remind people that lottery games are for fun and entertainment and should be played as such, and inform the public and lottery retailers about problem gambling and treatment availability.[20]

[20] These programs have received national recognition.

TAB 3. UTILIZATION

Questions addressed in this section:

How many gambler and family clients have enrolled?
What have been the trends in growth of the programs?
What are the 28 programs and how many were treated at each?

Synopsis

Problem gamblers as a group are notorious for not seeking treatment. In order to decrease the impact of problem gambling, it is important to increase treatment utilization and intervene in a problem gambling episode before catastrophic harm is done. Therefore, a primary goal of Oregon's problem gambling service system has been to increase utilization. Looking at the increases on a biennium basis, beginning in 1995, the average rate of increase in enrollments was 38.6% for gamblers, 49.8% for family clients, and 39.9% overall. During this report year, 1504 gamblers enrolled in one of Oregon's 25 outpatient problem gambling treatment centers. The current year saw the overall increase in enrollments only at 8.9%, the second lowest increase of demand for services since program inception. It is hypothesized that this decrease in the growth rate is due to the effects of the worst economic situation the State has experienced in over 50 years, and the ensuing actual and proposed budget cuts to the problem gambling fund and the state-funded mental health and addictions programs in which the gambling programs are housed. The turbulent budget and loss of funds caused programs to lose infrastructure and momentum.

Key Findings

- Since inception, enrollments have increased at an average annual rate of 16.9%
- Annual recidivism remains very low at 2.9%
- Treatment services were provided by 25 traditional outpatient programs, two short-stay residential respite programs, and one innovative, home-based minimal intervention program.

Findings based on
1504 Gambler Enrollments
296 Family Enrollments

Since consolidation statewide of the programs in 1995, the number of gamblers seeking treatment increased at an average annual rate of 16.9% and family clients increased at an average annual rate of 28.5%. Combined enrollments increased at an average annual rate of 18.5%. However, looking at the increases on a biennium basis, that corresponds to the State's budget planning cycle, the average rate of increase in enrollments was 38.6% for gamblers, 49.8% for family clients, and 39.9% overall. Recidivism[21] has remained relatively low since inception of the programs. Of the 1504 gamblers enrolled during the report year the recidivism rate for gamblers was only 2.9% and in fact, of the total 8,141 total enrollments over the past eight years combined, has only been 14.4%. (See Table 3-1)

The plateauing in the number of gamblers enrolling in treatment in FY 00-01 was hypothesized to have been influenced by two primary factors. In the spring of 1999 a successful legislative effort[22] 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

[21] Based on in-program re-enrollment.
[22] Senate Bill 118

with the AOCMHP,[23] to a state agency. The unintended consequences of the passage of legislative action was an 18 month period of contractual uncertainty including short term funding cycles, continual discussions of varying funding levels, and general loss of statewide coordination of outreach and treatment efforts. Effects of this uncertainty permeated throughout most provider agencies[24] until the state placed the services under the OMHAS and hired the current Problem Gambling Services Manger (PGSM). (Moore, T., 2001c)

The second potentially intervening variable that may have 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 purchase of media appeared to decrease during the year. Anecdotally, the Lottery's advertising efforts have been viewed by many as the primary mechanism by which Oregonians have become aware of the treatability of disordered gambling. A new campaign was aggressively deployed in the fall of 2001 and, as this report is being written, a revised media campaign is in development.

The phenomenal growth in FY 01-02 is speculated to have been influenced by four factors. The first two factors are 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 PGSM with counties for localized outreach and prevention efforts, and the fourth is most likely an artifact of better record keeping by the providers.

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[23] 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.
[24] This conclusion is based on extensive, informal contact by the evaluator with program managers and counselors throughout the state.

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 significant[25] difference. The artifact of a change in the funding source that required a client be "enrolled" before the provider was able to receive fee-for-service credit may have accounted for an increase in 100 to 150 enrollments. Another potential artifact of the more precise reporting[26] 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.

The current year saw the overall increase in enrollments only at 8.9%, the second lowest rate of demand for services since program inception. It is hypothesized that this decrease in the growth rate was due to the devastating effects of the worst economy the State has experienced in over 50 years and the ensuing massive budget cuts to the state-funded mental health and addictions programs in which the gambling programs are housed. It is further hypothesized that the budget cuts already experienced by the gambling programs during the report period, compounded by the concern of potential decimating cuts to the gambling services with the pending ballot measure to rescind the income surtax, had caused programs to simply lose momentum from the loss and pending loss of infrastructure.

During the report period there were 25 outpatient treatment programs as well as the state-wide minimal intervention project and two short-stay residential respite programs.

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[25] chi square $P < .01$. Statistical significance is only reported in this document where $p < .05$.
[26] Providers are required to close cases if the client has been inactive for a period greater than 30 days.

TAB 3. UTILIZATION – TABLES AND CHARTS

Table 3-1. Utilization of Treatment
Total Admissions and Rate of Change
By Fiscal Year

FY	Gambler Admits (n)	Gambler Rate of Increase From Previous Year (%)	Gambler Biennium Increase (%)	Family Admits (n)	Family Rate of Increase From Previous Year (%)	Family Biennium Increase (%)	Total Clients (n)	Total Rate of Increase From Previous Year (%)	Total Biennium Increase (%)
95-96	524			63			587		
96-97	565	7.8		114	81.0		679	15.7	
97-98	738	30.6		138	21.1		876	29.0	
98-99	835	13.1	44.4	159	15.2	67.8	973	11.1	46.1
99-00	1021	22.3		192	20.8		1213	24.6	
00-01	1032	1.1	30.5	171	(10.9)	22.2	1203	(0.8)	30.7
01-02	1409	36.5		276	61.4		1685	40.1	
02-03	1504	6.7	41.9	296	7.2	57.5	1800	6.8	44.2
Total	**7628**			**1409**			**9016**		
Average Change		**16.9**	**38.9**		**27.9**	**49.2**		**18.5**	**40.3**

Table 3-2. Active Programs FY 02-03				
County / Region	**Agency**	**Gambler Admits**	**Family Admits**	**Total Admits**
Clackamas	Clackamas County	102	7	109
Columbia	Columbia County	36	3	39
Coos	ADAPT Coos County	40	2	42
Curry	Curry County	5	0	5
Deschutes	Deschutes County	35	4	39
Douglas	ADAPT	63	8	71
Hood	Mid-Columbia (Gilliam, Hood, Wasco)	10	2	12
Jackson	Addiction Recovery Center	19	0	19
Jackson	On Track	34	0	34
Josephine	Josephine	9	0	9
Klamath	Klamath County	2	0	2
Lane	Addictions Counseling Services	175	54	229
Lincoln	Lincoln County	15	0	15
Linn/Benton	Linn/Benton Counties	56	3	59
Marion	Cascadia Behavioral Health	124	18	142
Marion	Serenity Lane	23	0	23
Multnomah	Cascadia Behavioral Health	322	118	440
Multnomah	ChangePoint	3	0	3
Multnomah	OHSU Behavioral Health Clinic	97	10	107
Multnomah	Tualatin Valley Centers (CCMH)	33	2	35
Polk	Polk County	9	3	12
Tillamook	Tillamook Family Counseling	7	8	15
Umatilla	Umatilla (Baker, Grant, Morrow, Union, Umatilla, Wheeler)	30	2	32
Washington	Tualatin Valley Centers	170	48	218
Yamhill	Yamhill County	23	4	27
Statewide	Cascadia Minimum Intervention Project	32	0	32
Statewide	Columbia County Respite Care	23	0	23
Statewide	Josephine County Respite Care	7	0	7
	TOTAL	**1504**	**296**	**1800**

ENROLLMENTS BY MONTH SINCE IMPLEMENTATION OF FEE FOR SERVICE 7/1/01

Chart 3-1. Actual Gambler and Family Enrollments by Month

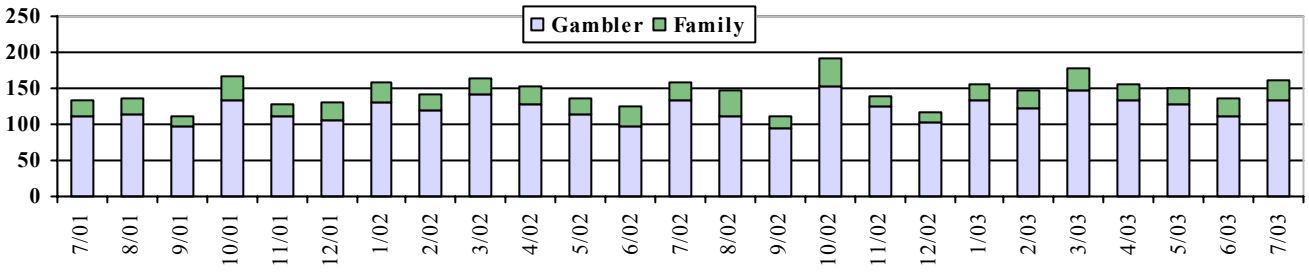


Chart 3-2. Trend Line of Gambler Enrollments

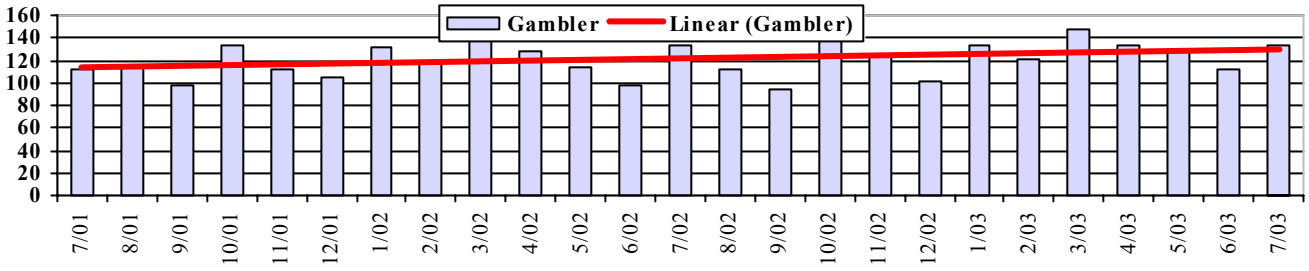
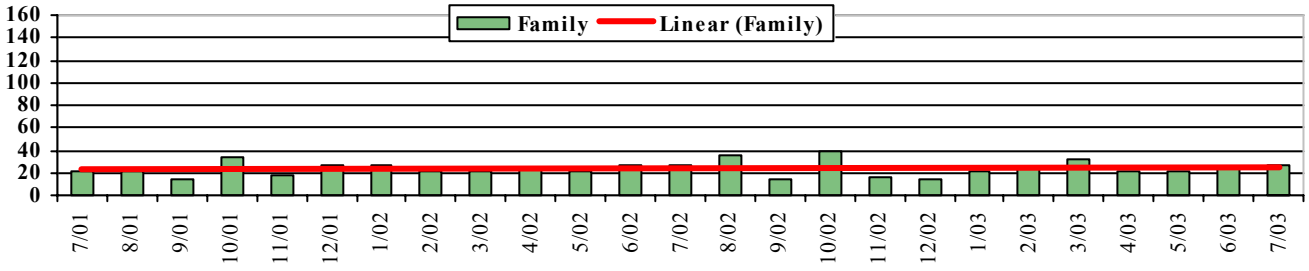


Chart 3-3. Trend Line of Family Enrollments



TAB 4. SYSTEM PERFORMANCE

Questions addressed in this section:

How are prospective clients accessing treatment?
How long do clients wait before being seen in treatment?
How long do clients remain in treatment?
What are the levels of services utilized?
What are the successful program completion rates?

Synopsis

With the new contracts established between the State and the Counties on July 1, 2001, performance objectives regarding wait times for treatment, successful program completion rates, and timely reporting requirements were implemented. These performance objectives not only provided clear system performance goals, but also demonstrated that a statewide public treatment system could be very responsive. The average number of calendar days between first call and first available appointment was a mere 3.5 days and the average commute time to treatment was less than 19 minutes. On average, gamblers remained in treatment for 140 days and received a little over 18 hours of service. The average cost per case was $828.44 for all gamblers and $1,685 for those gamblers that completed their entire recommended course of treatment. Successful program completion rates were high for outpatient, publicly funded programs at 37.2%.

Key Findings

- Problem Gambling Helpline most frequent access point to care
- Appointments were available within 3.5 days of initial call
- Average commute time to treatment was only 18.6 minutes
- Average case cost per successful treatment completion was only $1,685
- Strong successful program completion rate of 37.2%

*** Findings based on***
1504 Gambler enrollments
296 Family enrollments
1184 Gambler discharges
220 Family discharges

Access

Gamblers were approximately three times as likely to cite the Helpline as the referral source to their treatment program than any other source. (See Table 4 – 1). The Helpline toll free number (1-877-2-STOP-NOW) was widely disseminated in television and print advertising through the Lottery's aggressive play responsible campaign and was also required to be placed near each of the approximately 9,000[27] video poker machines at lottery retailer locations throughout the state. Although there were no requirements to do so, many of the eight IGC also displayed the statewide helpline number. The second most frequent source of referrals of gamblers to the treatment programs (12.4%) were present or past treatment program clients, followed by friends/family, and finally yellow page ads.

Family members seeking treatment were more likely to have been referred to the treatment program by a family or friend (33.8%). This is expected since many of the treatment programs routinely (with proper authorizations from the gambler) contact family members and alert them to the availability and appropriateness of family member treatment

[27] At the time of this report lottery retailers were being allowed to put in a sixth machine that could eventually increase the number of video lottery terminals to approximate 11,400.

and family members are also more likely to recruit, or encourage, other family members to participate in the care.

Nonetheless, the Helpline was cited nearly as frequently (27.4%) as family/friend as the referral source, followed distantly by program clients (9.1%) and Yellow Page ads.

By contract, treatment providers were required to provide services within five work days of the initial call for assistance. State-wide, the average number of days from initial call to first available appointment was only 3.5 days and a large number of clients, especially in the metropolitan areas with large, or multiple programs, were able to be seen on the same, or next day. Due to client's choosing not to take the first available appointment, the lag time between initial call and first face-to-face visit was 4.7 work days (or 5.4 calendar days).

The lag between initial call by family members and first available appointment was a mere 2.6 days, while the lag between initial call and first face-to-face was only 4.3 days (3.8 calendar days).

Location of treatment has also long been considered a critical element in the formula for effectiveness. With the 25 traditional outpatient programs located strategically throughout the state, the average length of time for gamblers to commute to treatment was only 18.6 minutes while family members indicated a commute time of 17.9 minutes on average.

Without reciting the extensive literature that has been amassed regarding the criticalness of quickly available treatment when the client is ready for help, these findings most strongly suggest one of the most effective publicly funded systems seen.

Length of Time Enrolled

The average length of time gamblers were enrolled in the traditional outpatient programs was 140.0 days. Those 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 significantly[28] longer at approximately 226 days.

The adjusted[29] successful completion rate for gamblers was 37.2%. Nearly 40% of the gamblers simply stopped coming to treatment[30] and approximately 12% did not attend more than one or two sessions and were considered as not becoming engaged in treatment. Approximately 47% were referred to Gamblers Anonymous following treatment.

Family clients remained in treatment an average of 149.8 days and those successfully completing their treatment plans remained significantly[31] longer in treatment at 236.5 days. The successful program completion rate for family clients was 48.2%.

Level of Effort

The average number of service hours for all gamblers was 18.1 while the average for those successfully completing the program was significantly more at 40.5 hours. The average cost per case was $828.44 for all gamblers and $1,685.11 for those who successfully completed their course of treatment. Family members average 10.8 services hours (successful completers averaged 23.2 hours) and the average cost per family client was $563.12 and for those successfully completing their treatment the average cost was $1,106.91. All the differences between all program participants and successful program completers were significant.[32]

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[28] t test $p < .01$
[29] The method of calculating the successful completion rate removes the neutral reasons from the equation (see Table 4-10 for each of these categories).
[30] Clients that simply dropped out of treatment should not necessarily be considered treatment failures because many of them remain problem free at follow-up – please see the outcomes section of this report.
[31] t test $p < .01$
[32] t test $p < .01$

TAB 4. SYSTEM PERFORMANCE – TABLES AND CHARTS

Table 4-1. Access Source Gamblers

Access Source	Percent
Helpline	33.8
Program Client	12.4
Family/Friends	8.8
Yellow Page Ad	4.3
Mental Health Agency	3.1
Television Ad/PSA	2.3
Private Health Professional	1.8
Self Help Group	1.3
Probation	1.3
Jail – City or County	0.6
All Others	23.9
Unknown\ Not Coded	6.4
Total	100.0

Table 4-2. Access Source Family Clients

Access Source	Percent
Family/Friends	33.8
Helpline	27.4
Program Client	9.1
Web/Internet	2.4
Yellow Page Ad	5.1
Self Help Group	0.7
Unknown\ Not Coded	10.8
All Other	10.7
Total	100.0

Table 4-3. Lag Time to First Available Appointment - Gamblers

n	Average Lag (Days)	sd
1501	3.5	5.0

Table 4-4. Lag Time to First Available Appointment - Family

n	Average Lag (Days)	sd
294	2.6	3.4

Table 4-5. Lag Time to First Seen - Gambler			
	n	**Average Lag (Days)**	**Sd**
Calendar Days	1504	5.4	7.4
Work Days	1504	4.7	5.2

Table 4-6. Lag Time to First Seen - Family			
	n	**Average Lag (Days)**	**sd**
Calendar Days	295	4.3	6.2
Work Days	295	3.8	4.4

Table 4-7. Commute Time to Treatment Gamblers & Family (In Minutes)			
	n	**Average Time**	**sd**
Gamblers	1258	24.4	18.6
Family	263	26.9	17.9

Table 4-8. Average Length of Enrollment All Gambler Clients By Gender (In Days)								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1184	140.0	164.1	634	141.4	169.7	549	137.7	157.0

Table 4-9. Average Length of Enrollment Successful Program Completer Gambler Clients By Gender (In Days)								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
441	226.0	196.2	231	238.7	208.7	210	212.0	180.3

Table 4-10. Treatment Termination Status – Gambler Clients By Gender (In Percent)			
Case Status at Termination	**All**	**Males**	**Females**
Successfully Completed Treatment (Adjusted)*	***37.2***	***36.4***	***38.3***
Stopped Attending – Against Staff Advice*	39.7	37.9	41.7
No Show for Initial Appointments *	11.7	14.4	8.6
Non-Compliance with Rules*	0.8	0.8	0.9
(Neutral Reasons)			
Moved from Catchment Area	2.5	2.2	2.9
Further Services Not Appropriate at Provider	1.5	1.4	1.6
Incarcerated	0.4	0.6	0.2
Conflicting Hours	1.4	1.6	1.3
Physical or Mental Illness	1.1	1.7	0.4
Program Cuts	2.9	2.4	3.5
No Transportation	0.1	0.0	0.2
Unknown	0.7	0.6	0.4

* Adjust Rate

Table 4-11. Referral After Treatment Gamblers	
Referred To	**Percent**
Gamblers' Anonymous	47.2
Traditional Outpatient	8.1
Minimal Intervention	7.8
Outpatient - Therapist	1.3
Residential – long-term	0.5
Residential – mid-term	0.3
Unknown	4.2
None	30.7
Total	100.0

Table 4-12. Average Length of Enrollment All Family Clients By Gender (In Days)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
220	149.8	176.4	53	160.4	216.7	165	146.8	162.4

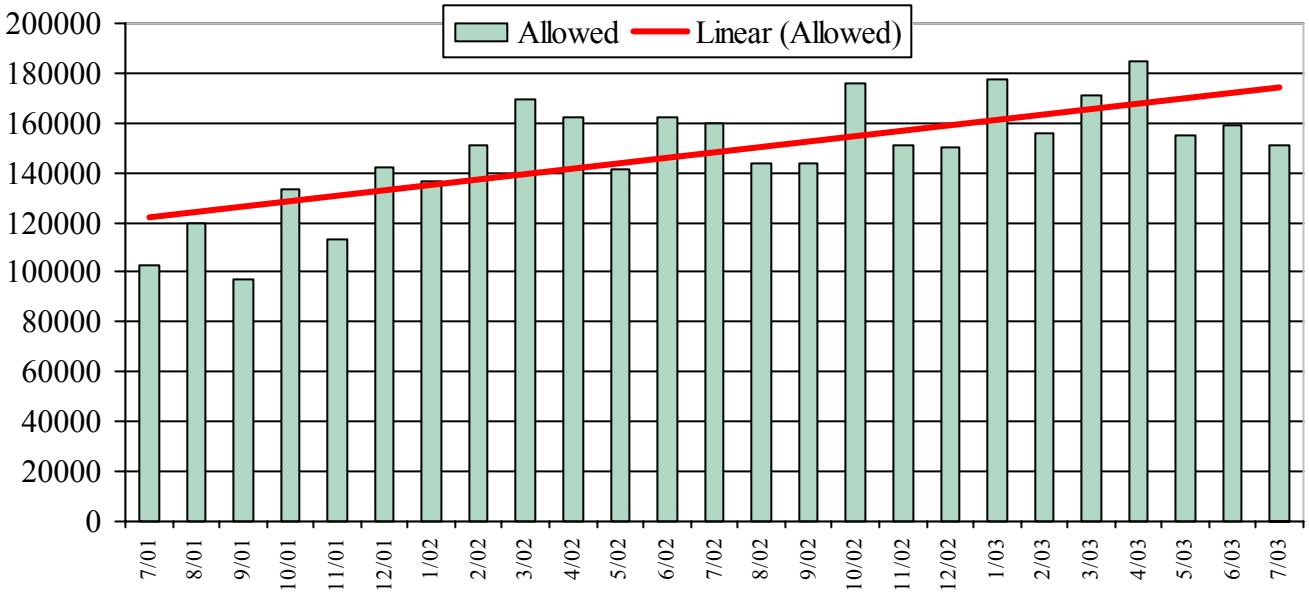
Table 4-13. Average Length of Enrollment Successful Program Completer Family Clients By Gender (In Days)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
106	236.5	209.6	27	266.9	256.8	78	227.5	190.6

Table 4-14. Treatment Termination Status – Family Clients By Gender (In Percent)			
Case Status at Termination	**All**	**Males**	**Females**
Successfully Completed Treatment (Adjusted)*	***48.2***	***50.9***	***47.3***
No Show for Initial Appointments *	21.4	24.5	20.6
Stopped Attending – Against Staff Advice*	23.6	18.9	24.8
Non-Compliance with Rules*	0.0	0.0	0.0
(Neutral Reasons)			
Further Services Not Appropriate at Provider	1.4	1.9	1.8
Physical or Mental Illness	1.8	1.9	1.8
Program Cuts	0.0	0.0	0.0
Non-Compliance with Rules	0.0	0.0	0.0
Moved from Catchment Area	1.8	1.9	1.8
Conflicting Hours	1.4	0.0	1.8
Incarcerated	0.0	0.0	0.0
No Transportation	0.0	0.0	0.0
Unknown	0.4	0.0	0.1

Table 4-15. Average Service Hours (In Hours)						
	All			**Successful Completers**		
	n	**Mean**	**sd**	**n**	**Mean**	**sd**
Gamblers	871	18.1	27.4	181	40.5	40.4
Family	167	10.8	15.0	48	23.2	21.3

Table 4-16. Average Service Cost (In Dollars – Including 5% Administration Fee)						
	All			**Successful Completers**		
	n	**Mean**	**sd**	**n**	**Mean**	**sd**
Gamblers	871	828.44	1047.63	181	1685.11	1455.63
Family	167	563.12	680.15	48	1106.91	894.93

Chart 4-1. Actual and Trend Line of Fee-for-Service by Month in Dollars



TAB 5. GAMBLING CLIENT DEMOGRAPHICS

Questions addressed in this section:

What are the demographic characteristics of Oregonians who enroll in gambling treatment programs?
What populations does Oregon need to target for gambling treatment case-finding?

Synopsis

Demographic information provides us important insight about which sub-groups within the Oregon population are more inclined to enter gambling treatment. One interesting finding is the steadily increasing proportion of women seeking treatment. Over the past seven years the percentage of women utilizing gambling treatment rose from 37% to 46%. It is also interesting to find that although prevalence studies find higher rates of problem gambling in younger populations, the average age of treatment utilizers is 44 years old. Underscoring the belief that most problem gamblers look like ordinary hard working people, most clients worked full-time (53%), had good paying jobs (average income of $39,344), many owned their own home (41%), and had private health insurance (48%). The racial brake down mirrored Oregon's general census information with the majority of the clients reported as Caucasian (87%). Other information suggests that the rate of problem gambling is greater among ethnic minority groups. Therefore, ethnic minorities are presumably accessing treatment services at a rate lower than Caucasians. This demographic information suggests that Oregon needs to provide greater outreach efforts to younger and more racially diverse populations.

Key Findings

- Males and females are nearly equally represented in treatment
- Over 53% were working full time
- Median income was $32,000 and the mean incomes was $39,344
- Nearly 41% were married and over 41% owned their own home
- Nearly 48% had private health insurance - 25.5% had none
- Average age was 44.2 years
- Minorities were under-represented in treatment

*** Findings based on***
1504 Gambler admissions

Problem Gambling Client Demographics

Approximately 53.8% of the individuals seeking treatment within the state-funded system were males. Except for this report period, where the ratio of males to females seeking treatment decreased slightly from the previous year, the portion of males has steadily decreased from 62.8% in 1995.[33]

The average age of gamblers was 44.2 years. Males were significantly [34] more likely to be younger than females with an average age of 43.1 years compared to 45.5 years. Interestingly, since 1998 the average age of males accessing treatment had increased from 40.6 years to 43.1 years [35] while the average age of females seeking treatment simply fluctuated during the same period. No gambler clients were reported with ages less than 18 years at the time of enrollment and 49 were reported as being 65 years or older.

The ratio of whites to other races and ethnicities has remained relatively stable at approximately 87.7%. Although there is a tendency for fewer non-white females to enroll in

[33] chi square $p < .01$
[34] t test $p < .01$
[35] t test $p < .01$

treatment than males, the difference was not significant. It should be noted that this racial mix of clients is reflective of the state's population, but research would suggest that the prevalence of problem and pathological gambling among non-white populations is much higher than within the white category.[36]

The average number of years of education for clients was 12.9 years with males being significantly more likely [37] to have reported completing more schooling (13.0 years compared to 12.7 years). The average number of years of education has not significantly changed since the inception of the treatment programs.

Nearly 41% of the gambler clients were married at the time of enrollment, 23.1% were divorced, and 20.1% never married. Nearly 41.1% owned their own home and 37.8% rented. Slightly over 53% were working full time with males being significantly [38] more likely to be working full-time than females. These statistics have remained relatively constant since 1995.

In FY 01-02 the average annual household income was approximately $39,344. In past years, males were significantly more likely to report higher annual household incomes than females. Nonetheless, for this report period the difference in annual household income between male and female clients was not statistically significant. The median income was reported as $32,000, the average income was $39,344, and the maximum reported was $325,000. Fifty-nine clients reported household incomes in excess of $100,000; 94 with incomes between $75,000 and $99,999; and 226 with incomes between $50,000 and $74,999. Source of income was most frequently (70.0%) reported as wages. Only 6.3% were reported as having no income.

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[36] 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.
[37] t test $p < .01$
[38] chi square $p < .01$

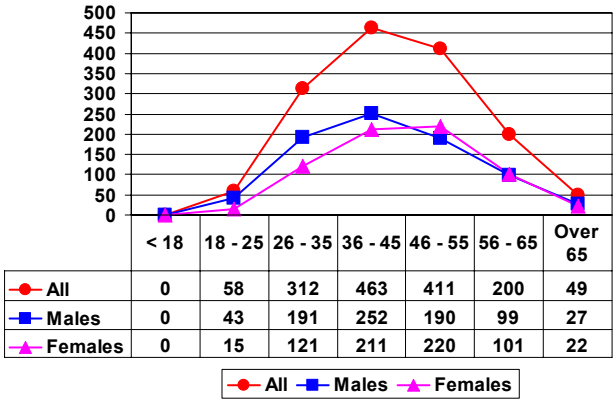
Nearly 47.9% reported having some form of private health insurance, 19.8% with public health insurance (6.7% OHP), and 25.5% had no health insurance at the time of enrollment. It must be noted that, except for very rare cases, private health insurance will not pay for the treatment of pathological gambling without the presence of a co-occurring mental condition that is covered.

TAB 5. GAMBLER CLIENT DEMOGRAPHICS - TABLES & CHARTS

Table 5-1. Average Age of Gamblers By Gender (In Years)								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1493	44.2	11.2	802	43.1	11.5	690	45.5	10.7

Females were significantly older than males (t test $p < .01$).[39]

Chart 5-1. Gambler Age by Strata and Gender



	< 18	18 - 25	26 - 35	36 - 45	46 - 55	56 - 65	Over 65
All	0	58	312	463	411	200	49
Males	0	43	191	252	190	99	27
Females	0	15	121	211	220	101	22

[39] The reader will notice an apparent discrepancy between the numbers of clients in each of the demographic fields when compared to the total number reported in the Utilization section. This is due to missing data submitted by providers.

Table 5-2. Race/Ethnicity of Gamblers *(In Percent of Distribution)*			
Race/Ethnicity	**All**	**Males**	**Females**
White	87.7	85.2	90.6
Black	2.2	2.7	1.6
Asian	2.1	2.5	1.6
Hispanic	2.0	2.8	1.1
Southeast Asian	1.7	2.3	1.0
Native American	1.3	0.9	1.7
Other	3.0	3.6	2.4
			0
Total	100.0	100.0	100.0

(No significant differences between males and females.)

Table 5-3. Average Number of Years Education Gamblers - By Gender (In Years)								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1450	12.9	2.1	776	13.0	2.3	673	12.7	1.9

Males were significantly more likely to report a higher level of education than females. (t test $p < .01$)

Table 5-4. Marital Status of Gamblers - By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Married	40.9	41.2	40.5
Divorced	23.1	21.1	25.4
Never Married	20.1	24.7	14.7
Separated	6.7	5.3	8.4
Living As Married	5.4	5.1	5.6
Widowed	2.7	1.0	4.6
Missing Data	1.1	1.6	0.8
Total	100.0	100.0	100.0

Males were significantly more likely to report never married than married when compared to females. (chi square $p < .01$)

Table 5-5. Living Situation of Gamblers - By Gender (In Percent of Distribution)			
Living Situation	**All**	**Males**	**Females**
Spouse with Children	26.3	27.4	27.3
Spouse/SO	23.9	20.9	25.0
Alone	18.1	19.7	16.3
Parents/Relatives	12.6	12.9	12.3
Friends/Others	9.3	12.1	6.1
Alone with Children	6.8	4.0	10.1
Institution/Group	0.5	0.2	0.7
Foster Parents	0.2	0	0.4
Missing Data	2.3	2.8	1.8
Total	100.0	100.0	100.0

Females were significantly more likely to report living alone with children than males (chi square $p < .01$) and males were more likely to report living with friends/others than females (chi square $p < .01$).

Table 5-6. Household Size Gamblers - By Gender								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1476	2.3	1.4	792	2.3	1.5	683	2.3	1.3

Table 5-7. Household Size by Age Group By Gender				
	Under 6 Years Old	**6 – 17 Years Old**	**18 – 65 Years Old**	**Over 65 Years Old**
	n **mean sd**	**n** **mean sd**	**n** **mean sd**	**n** **mean sd**
All	216 1.4 0.7	411 1.8 1.0	1418 1.6 0.7	71 1.4 0.8
Males	136 1.5 0.7	205 1.8 1.2	758 1.6 0.7	35 1.4 0.7
Females	80 1.4 0.7	206 1.7 0.8	659 1.6 0.7	36 1.5 0.9

Key: Top number in the cell is the number (n) of clients that reported having dependents living with them within the age range. The first number on the second line of the cell is the average number of dependents within the age range reported and the second number on that line is the standard deviation.

Table 5-8. Housing Type By Gender (In Percent of Distribution)			
Housing Type	**All**	**Males**	**Females**
Own	41.1	38.4	44.3
Rent – No Subsidies	37.8	39.1	36.2
Other Situation/Not paying Rent	8.3	8.3	8.2
Rent – With Subsidies	4.2	8.3	4.5
Institution/Group Home	1.5	1.7	1.2
Homeless/Shelter	1.5	2.3	0.6
Unknown/Not Coded	5.6	1.9	5.0
			0
Total	100.0	100.0	100.0

Table 5-9. Employment Status By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Full-Time	53.2	58.0	47.6
Not Employed – Looking	17.3	18.0	16.5
Not Employed – Not Looking	14.3	12.0	16.9
Part-Time	10.0	7.4	13.1
Irregular	3.3	2.1	4.8
Unknown/Not Coded	1.9	2.5	1.1
Total	100.0	100.0	100.0

Table 5-10. Employability By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Employable/Working	73.7	74.0	73.5
Disabled	6.7	6.4	6.9
Student	4.3	4.6	3.9
Retired	3.9	4.2	3.5
Temporary Layoff	2.3	2.6	2.0
Homemaker	1.5	0.0	3.3
Incarcerated	0.5	0.6	0.3
Seasonal Worker	0.3	0.5	0.1
Unknown/Not Coded	6.8	7.1	6.5
Total	100.0	100.0	100.0

Table 5-11. Average Annual Household Income of Gamblers By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1312	39343.70	30132.00	706	40772.60	29312.10	605	37730.8	30976.2

Table 5-12. Source of Income of Gamblers By Gender (In Percent)			
Income Source	**All**	**Males**	**Females**
Wages	70.0	69.5	70.7
Pension/Unemployment	8.2	9.3	6.9
Social Security	4.8	4.3	5.3
SSI - Federal	2.8	2.3	3.2
Welfare	0.8	0.6	1.0
Dividends/Interest	0.2	0.2	0.1
Alimony/Child Support	0.7	0.1	1.4
OSP State	0.6	0.6	0.6
Other	3.7	4.4	2.7
No Income	6.3	6.1	6.6
Unknown/Not Coded	1.9	2.6	1.5
Total	100.0	100.0	100.0

Table 5-13. Health Insurance By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Other Private	35.2	34.5	36.1
Blue Cross/Shield	12.7	12.0	13.6
OHP	6.7	5.9	7.5
MEDICARE	4.7	3.8	5.8
Other Public	4.2	3.7	4.8
VA	2.4	3.5	1.2
MEDICAID	1.5	1.6	1.2
CHAMPUS	0.3	0.2	0.3
None	25.5	28.2	22.4
Unknown/Not Coded	6.8	6.6	7.1
Total	100.0	100.0	100.0

TAB 6. GAMBLING CHARACTERISTICS

Key questions addressed in this section:

What types of games do problem gamblers prefer and where are they playing?
What is the course of problem gambling?

Synopsis

Oregon has a unique gambling landscape in that there are many different types of gambling venues and many different types of games offered. From looking at the problem gamblers who entered gambling treatment programs, the most problematic form of gambling in Oregon is video poker (game of choice for 71% of clients). This is not surprising when considering speed of play, low initial bet size, and reward structure of video poker, combined with the public's ease of access to the game (the Oregon Lottery maintains over 9000 video poker machines in about 2000 bars and taverns). The second most preferred gambling venue for problem gamblers are Native American casinos with slots (12%) and cards (6%) rounding up the most problematic games of choice. While the popularity of Lottery outlets is holding steady, the rate of problem gamblers with a preference for casino venues is rapidly growing. Also changing is the increasing average age that gamblers are first experiencing problems with their gambling (35 for males and 39 for females). Perhaps more troubling is the lengthy period of time between when a gambler first develops problems to the time they seek help (average of nearly 5 years). The problem gamblers reported gambling an average of one in every three days and on those days gambling they spend an average of $325 over an average of about 4 and half hours. The majority of clients (74%) reported gambling on an ongoing basis, about 7% reported episodic periods of problematic gambling lasting for weeks to months, and about 8% reported that they experienced episodes lasting less than two weeks between long problem-free periods. Treatment programs that have an Indian Gaming Center within approximately 50 miles are about three times more likely to have clients who report their primary gambling venue is a casino.

Key Findings

- Video Poker remains the primary game of choice at 71.7%
- Slot machines continue to gain popularity especially with females
- IGC popularity continues to grow at a significant rate
- Age of onset of problem gambling increased at a significant rate
- Average length of current gambling episode was 4.7 years
- Females spent significantly more time each gambling session thanmales

*** Findings based on***
1504 Gambler enrollments

Since inception of the programs, the most popular game of choice has been video poker (71.1%). Over the years, the distribution of this game as the primary choice has fluctuated from a low of 67.8% in FY 00-01 to a high of 76.3% in FY 96-97 with no trend. Conversely, the choice of slot machines (non-lottery) has demonstrated a relatively stable, increasing trend from a low distribution of 3.7% in FY 96-97 to a high of 11.8%[40] for this current report period. Card gambling was reported as the third most frequently cited game of choice (6.2%).

As expected and found in the analysis for earlier years, there are differences in preference for the type of games played. Females were significantly[41] more likely to report slots as their primary game of choice (17.7%) than males (6.8%) while males were significantly[42] more likely to report cards (8.8%) than females (3.2%). It is interesting to note that while video poker is commonly believed to be perceived as a skill game, that

[40] This difference is statistically significant. chi square $p < .05$
[41] chi square $p < .01$
[42] chi square $p < .01$

theoretically would be more attractive to males, there was no significant difference in the distribution of this game as the primary choice between males and females.

As would be expected, the primary location for the primary gambling activity was lottery retailers with the VLTs (69.3%) followed by IGC/casinos (17.5%). Although the number of clients reporting Lottery locations has fluctuated, the number reporting IGC/casinos has steadily increased from 10.2% in FY 96-97 to the 17.5%[43] reported this year. The frequency of individuals reporting gambling at an IGC/casino is significantly higher in those programs that are within approximately 50 miles of an IGC/casino.

The average distance traveled to the primary gambling location was 15.4 miles that, interestingly, is approximately the same average distance traveled to treatment.

Males were significantly [44] more likely to report their first gambling experience at an earlier age (20.6 years) than females (26.7 years)[45] and were also significantly[46] more likely to report a younger age of onset of problems (34.6 years old) than females (38.8 years old).

Unexpectedly, the age of onset of problem gambling experienced a large and significant[47] jump to 36.5 years of age. This increasing age of onset was first seen in FY 01-02 but came on the tail of a five year trend of decreasing age for onset and at that time was viewed as a potential anomaly. Although two years does not constitute a trend, seeing dramatically increasing average age of the onset of problem and pathological gambling is troubling and not easily explained.

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[43] Statistically significant. chi square $p < .01$
[44] t test $p < .01$
[45] This field was added to the data in FY 01-02 therefore there is no trend analysis possible.
[46] t test $p < .01$
[47] t test $p < .01$

The length of the current problem gambling episode was reported at 4.7 years. Males were significantly [48] more likely to report a longer average episode (5.2 years) than females (4.2 years).[49] Males were also significantly [50] more likely to report more episodes (2.2) than females (1.7).

The average number of days gambled in the 30 days prior to entering treatment was 11.0, the average number of hours gambled per event was 4.6 hours, and the average daily expenditure per gambling day was $325. Females were significantly [51] more likely to report longer gambling event times (5.2 hours) than males (4.1 hours).

The majority of clients (74.3%) were reported as "regular gamblers."[52] Approximately 6.6% were "type 2" gamblers – able to maintain 30 or more days abstinence during the past 12 months with lapses back to problem/pathological gambling of 14 to 180 days' duration. Seven and one-half percent of the clients were reported as "type 3" gamblers – able to maintain 30 or more days abstinence in the past 12 months with lapses of one to fourteen days duration.

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[48] t test $p < .01$
[49] This field was added to the data in FY 01-02.
[50] t test $p < .05$
[51] t test $p < .01$
[52] These definitions were constructed for this evaluation..

TAB 6. GAMBLING CHARACTERISTICS - TABLES & CHARTS

Table 6-1. Primary Gambling Preferences
By Gender
(In Percent of Distribution)

Game	All	Males	Females
Video Poker	71.7	72.4	70.7
Slot Machines	11.8	6.8	17.7*
Cards	6.2	8.8	3.2
Animals	1.0	1.9	0.0
Keno	1.8	2.2	1.3
Bingo	0.7	0.1	1.4
Sports (not Lottery)	0.5	1.0	0.0
Breakopens/Scratch	1.3	1.1	1.4
Power Ball /Daily 4 /Mega Bucks	0.3	0.4	0.1
Dice	0.3	0.6	0.0
Video Line Games	0.3	0.2	0.4
No Preference	0.1	0.2	0.0
Other/None	4.7	4.3	3.8
Total	100.0	100.0	100.0

* t test $p < .01$

Table 6- 2. Primary Location for Gambling
By Gender
(In Percent of Distribution)

Location	All	Males	Females
Lottery Retailer (Video)	69.3	71.3	66.8
Casino	17.5	13.8	21.8*
Food/Convenience Store	2.0	1.7	2.3
Track/Off Track Wagering	1.1	2.0	0.0
Restaurant/Pub (No VLT)	0.7	0.7	0.7
Bingo Hall (Non Indian)	0.9	0.5	1.4
WWW/Internet/Phone	0.9	1.1	0.7
Family/Friend Home	0.2	0.2	0.1
Card Room - Public	0.9	1.4	0.3
Private Club	0.3	0.2	0.3
Other	2.6	3.3	2.3
Unknown	3.6	3.8	3.3
Total	100.0	100.0	100.0

Table 6- 3. Distance Traveled to Primary Gambling Activity By Gender (In Miles)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1323	15.4	45.9	696	15.8	58.6	626	14.9	25.0

Table 6-4. Age of First Gambling Experience By Gender (In Years)*								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1377	23.4	11.3	742	20.6	10.1	634	26.7	11.8

Table 6-5. Age of Onset of Gambling Problems By Gender (In Years)*								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1378	36.5	12.0	725	34.6	12.3	622	38.8	11.3

Table 6-6. Total Problem Gambling Episodes By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1118	2.0	3.6	604	2.2	4.4	513	1.7	2.4

Table 6-7. Length of Current Problem Gambling Episode By Gender (In Months)*								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1292	4.7	5.4	701	5.2	5.8	590	4.2	4.7

* t test $P < .01$

Table 6-8. Average Number of Days Gambled in Past 30 Days By Gender At Admission (In Days)*								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1276	11.0	7.9	689	10.7	7.9	586	11.3	7.9

Table 6-9. Average Gambling Event Time By Gender (In Hours)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1310	4.6	5.9	699	4.1	4.9	610	5.2	6.8

Table 6-10. Average Daily Gambling Expenditure By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1257	325	589.1	674	313.4	644.7	582	338.1	517.5

Table 6-11. Gambling Pattern By Gender (In Percent)			
Pattern	**All**	**Males**	**Females**
Type 1 Regular	74.3	72.3	76.6
Type 2	6.6	7.8	5.2
Type 3	7.5	8.0	6.9
Other	0.5	0.7	0.4
Not Gambling	11.1	11.2	10.9

Table 6-12. Casino Gambling By Proximity to Casino

COUNTY/REGION	Percent of Clients With Casino Gambling	Casino Within 50 Miles (Approximately)
CLACKAMAS	7.5	
COLUMBIA	6.2	
COOS	69.0	*
CURRY	43.1	
DESCHUTES	0.8	
DOUGLAS	26.5	*
EOHSC/PENDLETON	36.6	*
JACKSON	12.6	
JOSEPHINE	17.5	
KLAMATH	40.0	*
LAKE	20.0	
LANE	9.0	
LINCOLN	59.0	*
LINN	15.6	
MARION	29.9	*
MID-COLUMBIA	10.0	
GEAR/Minimum	28.4	
MULTNOMAH	9.2	
POLK	50.0	*
TILLAMOOK	47.3	*
UNION	0.3	
WASHINGTON	1.2	
YAMHILL	38.8	*

TAB 7. CONSEQUENCES AND RELATED CONDITIONS AT ENROLLMENT

Key questions addressed in this section:

What types of gambling related consequences are clients reporting?
How do problem gambling clients compare to other mental health clients?
How can treatment providers utilize this information to improve treatment outcomes?

Synopsis

Problem gambling is considered a public health issue because of the effects on the individual, the family, and the community. Information collected from the 1504 persons entering Oregon's publicly funded gambling treatment programs in 2003 support this view point. Individuals' suffering from problem gambling report an array of symptoms with the degree of symptom severity varying from mild to severe. On average, the degree of psychological distress is on par with the general outpatient mental health population. One area of particular concern for problem gambling clients is suicide. Forty-four clients (males 20, females 24) reported suicidal attempts during the six months prior to enrollment while 267 (23%) reported to have experienced suicidal thoughts. From looking at the information of alcohol and drug use, it appears that most clients don't manifest drug and alcohol problems (approximately 29% experienced alcohol-related problems and 11% drug-related problems), but most reported use of tobacco products (73%). Family and social consequences of problem gambling can be observed in reports of jeopardizing or losing relationships (64%), poor job performance (14%), not paying bills on time (56%), and committing illegal acts to obtain gambling money (34%). The most visible consequence of problem and pathological gambling is the devastating financial impact on the gambler and the gambler's family. The gambling related debt reported by clients was about the same as their annual household income, an average of about $23,000. Over 60 clients reported gambling related debts of $100,000 or more with six over $500,000. The total gambling related debt, of just those that obtained gambling treatment in Oregon in 2003, exceeded $29.5 million.

Key Findings

- Gamblers experience a complex array of mental health, social, and legal issues that challenge comprehensive treatment
- Average ratio of gambling debt to income is 1:1
- Mental health symptomology compares at the 50 percentile to outpatient psychiatric patients
- Clients who leave treatment prior to completion reported greater severity at enrollment than those who completed treatment
- Gamblers appear to have more intact social networks than other populations seeking publicly funded treatment. This network should provide value in the form of family treatment and long-term recovery

Findings based on
1504 Gambler enrollments

The most visible consequence of problem and pathological gambling is the devastating financial impact on the gambler and the gambler's family. The average gambling related debt reported by clients was $23,155.64. However, when comparing the gambling related debt to annual household income on an individual basis, the overall average ratio was 1:1, demonstrating that many clients had gambling debts that were equal to their annual household income.[53] In fact, over 60 clients reported gambling related debts of $100,000 or more with six over $500,000.

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.

The primary mechanism for diagnosing

[53] This was calculated by including only those clients who were reported with both a gambling debt and an income.

pathological gambling is the clinical criteria found in the Diagnostic and Statistical Manual published by the American Psychiatric Association. The average number of criteria endorsed by the clients was 7.6 with preoccupation, chasing, unsuccessful efforts to stop, and lies to conceal extent of gambling as the most frequently endorsed items. Interestingly, females were significantly[54] more likely to endorse using increasing amounts of money, restless when cutting back, gambling to escape, and relying on others for money to gamble[55]. Males were significantly[56] more likely to report jeopardizing or losing significant relations as a result of gambling. Approximately 34.1% endorsed the item regarding committing illegal acts.

Clients presenting for admission reported a spectrum of symptomology that placed them, on the average, within the 47th to 50th percentile range based on gender-specific outpatient psychiatric patient standardized scores utilizing the Brief Symptom Inventory (BSI). Interestingly, males were significantly[57] more likely than females to report more severe symptomology in the dimensions of depression, hostility, phobic anxiety, and paranoid ideation.[58]

Brief Symptom Inventory (BSI)

The BSI, a 53-item self-report inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients. The instrument is well-validated and a widely used symptom inventory. All items on the BSI are rated by the client on a 5-point scale of distress ranging from "not-at-all" (0) at one pole to "extremely" (4) at the other pole. The inventory is scored and profiled in terms of nine primary symptom dimensions, and 3 global indices of distress. The dimensions include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The three global indices include global severity, positive symptom distress, and positive symptom total score.

Simply looking at the average percentile scores does not necessarily present a complete picture. Approximately 5.6% of the clients scored above the 60th percentile,

[54] chi square $p < .01$
[55] chi square $p < .05$
[56] chi square $p < .01$
[57] t test $p < .01$
[58] t test $p < .05$

suggesting a high severity of symptomology while approximately 15.5% responded below the 40th percentile indicating a wide span of severity among clients.

As has been reported in previous years, clients who left treatment before completion ,as a group scored significantly[59] higher standardized severity scores at enrollment in the dimensions of obsessive compulsive, hostility, paranoid ideation, and general severity than those who eventually completed their course of treatment. It has been hypothesized that clients with somewhat greater severity may be more likely to leave treatment early once some relief of symptoms has been experienced – although this has not be fully substantiated[60] because nearly all non-completers simply abandon treatment.

Sixty-seven (4.5%) of the clients reported either attempting suicide, making suicidal gestures, or having suicidal ideation. Of these, forty-four clients (males 20, females 24) reported suicidal attempts during the six months prior to enrollment and 23 reported either (or both) suicidal gestures or ideation and no attempt. What is interesting is that this information is reported by the counselors and may not fully be reflective of the full extent of the ideation. In response to the written self-report survey provided at enrollment, 2.8% of the respondents reported always having thoughts of suicide, 6.3% often, 14.0% sometimes, and 23.1% rarely[61] that is approximately 46% of the entire sample.

Males were significantly[62] more likely to report the loss of a significant relationship due to gambling than females. Slightly over 30% of males and 23.0% of females (27.0% of all clients) reported, on average, the loss 1.5 of relationships due to gambling. Males were

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[59] t test $p < .05$ to $p < .01$
[60] See the section on Outcomes and non-completers.
[61] The enrollment survey is mirrored in the discharge and follow-up surveys. The questions utilize a five-point Likert type scale to rate the extent of agreement with a variety of statements. The scale consists of never, rarely, sometimes, often, and always.
[62] chi square $p < .01$

also significantly[63] more likely to report job related problems (average of 1.6) than females (1.3 occurrences) while only 14.9% of all clients were reported as having any job problems as a result of gambling.

Approximately 6.6% of the clients reported having legal problems as a result of gambling while 52.2% of those reporting legal problems also reported having been incarcerated. The average number of months of incarceration was 22.8[64] months. Although males spent significantly more time incarcerated, they were no more likely to be incarcerated than females. Approximately 1.4% of the clients reported, on average, 2.7 violent charges as a result of their gambling.

Based on self-reported responses to the survey, within the domain of general life satisfaction, clients indicated they were most satisfied with their physical health (53.4%[65]), followed in descending order by satisfaction with life in general (40.7%), spiritual wellbeing (37.1%), and finally emotional wellbeing (33.5%). Satisfaction with key relationships were more positive with satisfaction with children (64%) being the most satisfying, followed in descending order by friends (58.0%), other family members (54.8%), and finally with spouse or significant other (44.8%). These relatively high levels of satisfaction suggest two important potentialities. First, a major portion of the clients coming into treatment are presenting with an intact social network and second, there is a wide disparity of levels of social disintegration resulting from gambling represented in the treatment population.

Approximately 86.3% of the clients reported accomplishing responsibilities at work always or often while 59.2% reported accomplishing responsibilities at home. Nonetheless,

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[63] chi square $p < .05$
[64] One male was reported with 25 years and another with over 17 years of incarceration.
[65] The percent of those responding always or often to the question.

only 44.1% reported paying bills on time. Approximately 24.1% reported committing illegal acts to obtain money with which to gamble.[66]

Approximately 71.1% reported using alcohol during the past six months and 28.9% reported experiencing problems with their alcohol use. Nearly 22.4% reported using illegal drugs and 11.1% reported having problems associated with their illegal drug use. Slightly over 73% reported using tobacco products.

Nearly 47% of the clients indicated they maintained a supportive network of family and friends,[67] 45.6% indicated they ate healthy foods, 27.2% indicated they exercised, and 25.6% took time off to relax.

It is clear that individuals enrolling in treatment present a very wide spectrum of symptoms and associated problems that challenge the treatment professionals. Recent research supports the notion that pathological gambling is commonly seen as cooccurring with a myriad of mental health (including substance abuse and dependence) problems and those diagnosed as pathological gamblers most likely will have a history of warning signs as well as preoccurring mental health diagnoses that can date back, in many cases, to early childhood[68].

One of the more encouraging characteristics of the treatment population in Oregon is that they appear to differ from the expected populations seeking publicly funded treatment. They have more intact social networks that can be effectively utilized in the form of family treatment to greatly strengthen the likelihood of successful, long term recovery.

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[66] This figure does not agree with that reported from the DSM screening. The survey frames the questions "in the past six months" while the DSM looks back at the past 12 months.
[67] Again using the responses of always and often.
[68] See Moore, T., Jadlos, T., (2001) The Etiology of Pathological Gambling. Oregon Gambling Addiction Treatment Foundation. Available at www.gamblingaddiction.org

In an effort to better understand the complexity of the presenting symptoms of the pathological gambler, the data collection protocol called for the recording of the DSM Axis I and Axis II diagnostic codes for primary, secondary, and if present, tertiary illnesses. Of note has been the historical difficulty in obtaining a high degree of precision in using the DSM codes. For example, one program used the code "321.xx" when, in fact, there are no diagnostic codes in this range. It is presumed they had intended to use "312.31" for pathological gambling, but had transposed the number into a nonsensical code. Additionally, the ability to get secondary Axis I diagnoses or Axis II diagnoses was very difficult with a very large amount of missing data. Although it is possible that the majority of clients were not presenting with secondary diagnoses, it is more plausible that clients were simply not assessed by a mental health professional qualified to render diagnoses utilizing the DSM. This explanation is born out in the data with the finding that gambling treatment programs either based in mental health agencies, or those with a larger staff and more likely to have a mental health professional familiar with the DSM classification system were also more likely to provide such data. Those programs based primarily in substance abuse treatment and relying greatly on professional substance abuse counselors were less likely to provide DSM classification codes presumably due to the lack of specific training with those procedures. As a result, the data collection protocol has been revised and in place of calling for DSM classification codes, generalized diagnostic impression codes will be employed.

Nonetheless, and as would be expected, the most frequently (96.5%) cited Axis I diagnosis for clients entering treatment was pathological gambling. This was followed very distantly by depressive and anxiety disorders. Only 6.3% of the cases were coded with a primary Axis II classification and these represented a wide variety of classifications.

Approximately 21.5% of the cases included a secondary Axis I classification code. Of these, 22.3% were classified with depressive disorders, 20.1% with substance abuse and dependence disorders, 10.2% bi polar disorders, 7.1% anxiety disorders, 7.1% dysthymic disorder, and 5.3% with narcissistic personality disorder.

Nearly 23.4% of the clients were reported with having received prior formalized treatment (other than self-help) for their gambling. The average number of previous treatments was 1.4. Similarly, 18.7% reported prior alcohol and drug treatment (average was 1.6 treatments), 15.9% reported on average 1.7 prior mental health treatment episodes. Approximately 16.3% had received only prior gambling treatment, 10.6% only prior alcohol and drug treatment, and 9.3% had received only prior mental health treatment.

Males were significantly[69] more likely to report a larger number of serious attempts[70] (average 3.8 times) to stop gambling than females (average 2.9 times). Approximately 53.6% of those reporting, however, made the serious quit attempts without help. Only 26.6% of the clients entering treatment reported making serious attempts to quit gambling (1.7 times on average) that were assisted by a professional or by participation in self-help such as Gamblers Anonymous.

Although the diagnostic classification data is considered incomplete for the reasons cited above, it is clear that the indication is one that supports the notion that the clinical requirements for those entering treatment for pathological gambling are highly complex requiring skill and knowledge in both mental health and addictions treatment.

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[69] t test $p < .01$

[70] Serious quit attempts was defined as having at least 30 days abstinence as a result of the quit attempt.

TAB 7. GAMBLING CONSEQUENCES - TABLES & CHARTS

Table 7-1. Average Gambling Related Debt By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1282	23155.64	51714.54	687	22794.38	45792.95	603	23597.74	57679.50

Table 7-2. Average Debt to Income Ratio By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1024	1.0	2.8	527	0.9	2.1	496	1.2	3.3

Table 7-3. Average Number of DSM Criteria Endorsed By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1300	7.6	2.0	707	7.5	2.0	592	7.7	2.0

Table 7-4. Frequency of Endorsement of DSM Items By Gender (In Percent)			
DSM Criteria	**All**	**Males**	**Females**
1. Preoccupation	89.6	90.1	88.9
2. Increasing amounts of money *	80.4	77.4	84.1
3. Unsuccessful efforts to control	85.9	86.3	85.7
4. Restless when cutting back *	77.3	74.0	81.3
5. Gambles to escape *	85.6	81.1	91.2
6. Chasing	88.6	88.7	88.5
7. Lies to conceal gambling	84.9	84.5	85.3
8. Commits illegal acts	34.1	31.9	36.8
9. Jeopardize or lost relationships *	64.4	68.8	59.0
10. Relies on others for money **	65.7	64.0	67.8

* p < .01 ** O < .05

Table 7-5. BSI Average Standardized Scores at Enrollment By Domain and Gender (In Percentile Score)

BSI Domain	n	Mean	sd
Somatization			
All	1078	48.28	8.89
Males	581	47.81	8.16
Females	497	48.83	9.64
Obsessive Compulsive			
All	1077	50.24	9.31
Males	580	50.56	8.78
Females	497	49.87	9.89
Interpersonal Sensitivity			
All	1077	49.62	9.04
Males	580	50.04	8.37
Females	497	49.13	9.74
Depression			
All	1078	50.42	8.00
Males *	581	50.91	7.65
Females	497	49.85	8.36
Anxiety			
All	1077	47.61	8.51
Males	580	47.68	8.20
Females	497	47.53	8.86
Hostility			
All	108	50.54	8.07
Males *	581	51.20	8.42
Females	497	49.76	7.56
Phobic Anxiety			
All	1078	47.09	7.63
Males *	581	47.75	6.97
Females	497	46.31	8.27
Paranoid Ideation			
All	1078	48.83	8.79

Males **	581	48.87	8.63
Females	497	47.80	8.94
Psychoticism			
All	1077	51.00	8.85
Males	581	51.28	8.32
Females	496	50.66	9.42
General Severity			
All	1077	48.41	9.24
Males	580	48.71	8.94
Females	497	48.06	9.57

* p < .01 ** p < .05

Table 7-6. Suicide Gestures in Last Six Months By Gender

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
36	1.5	0.6	23	1.4	0.5	13	1.7	0.6

Table 7-7. Suicide Attempts in Last Six Months By Gender

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
44	1.8	1.5	20	2.2	2.0	24	1.6	0.9

Table 7-8. Average Number of Significant Relationship Lost Due to Gambling By Gender

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
403	1.5	1.5	244	1.5	1.5	159	1.4	1.6

Table 7-9. Average Number of Job Problems Due to Gambling By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
223	1.5	1.7	134	1.6	2.0	89	1.3	0.9

Table 7-10. Average Number of Legal Problems Relating Gambling By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
99	2.9	6.5	52	3.2	8.5	47	2.6	2.8

Table 7-11. Average Number of Months Incarcerated for Gambling Offenses By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
52	22.8	49.9	25	37.8	68.1	27	9.0	9.9

Table 7-12. Average Number of Violent Charges Filed Related to Gambling By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
21	2.7	4.9	14	2.7	5.6	7	2.7	2.8

Chart 7-1. General Life Satisfaction (Gambler at Enrollment) Previous Six Months

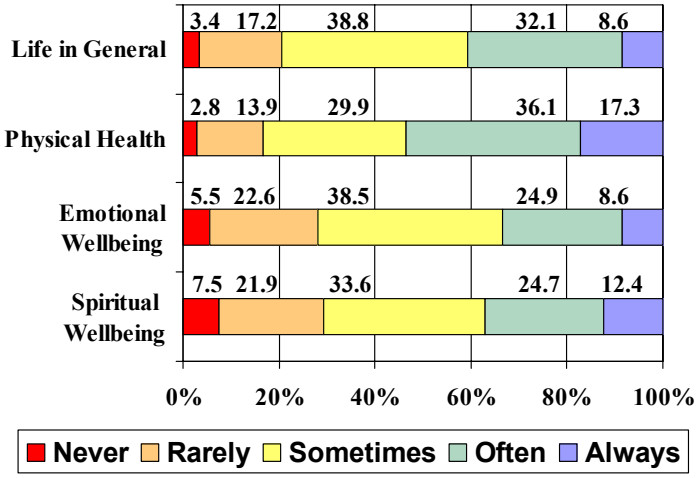

Chart 7-2. Satisfaction with Key Relationships (Gambler at Enrollment) Previous Six Months

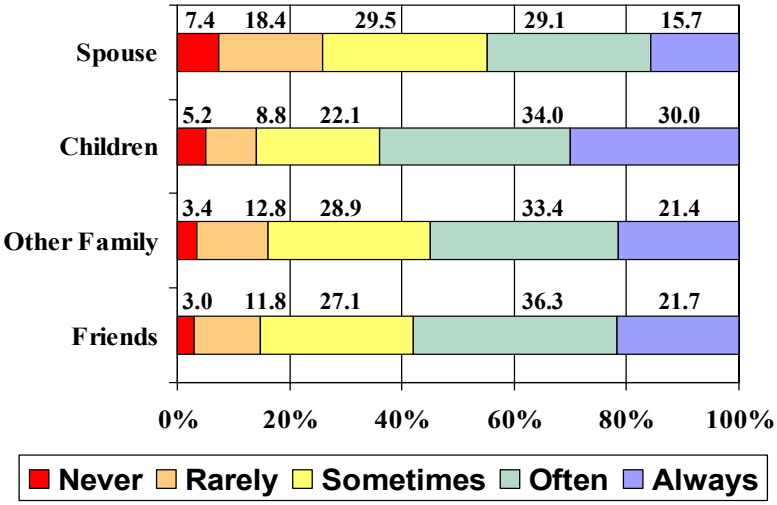

Chart 7-3. Critical Activities Completed (Gambler at Enrollment) Previous Six Months

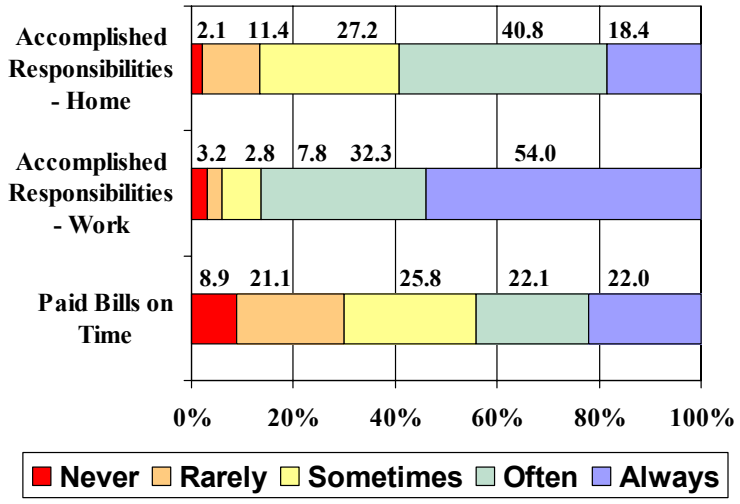

Chart 7-4. Other Problems (Gambler at Enrollment) Previous Six Months

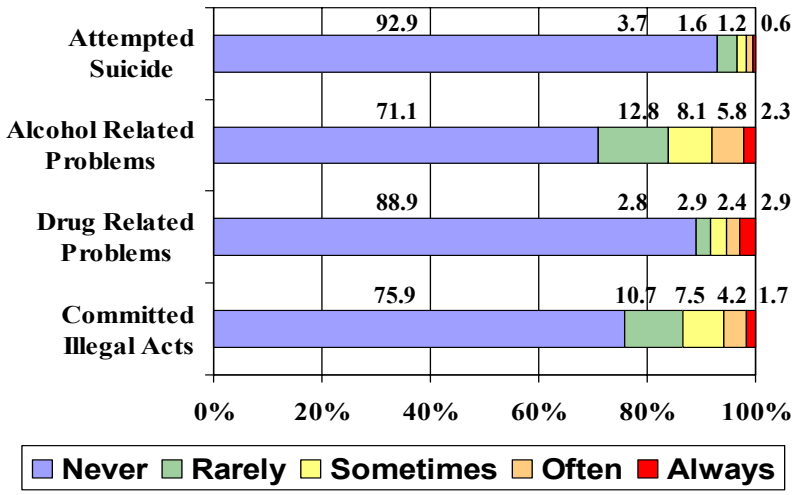

Chart 7-5. Wellness Activities (Gambler at Enrollment) Previous Six Months

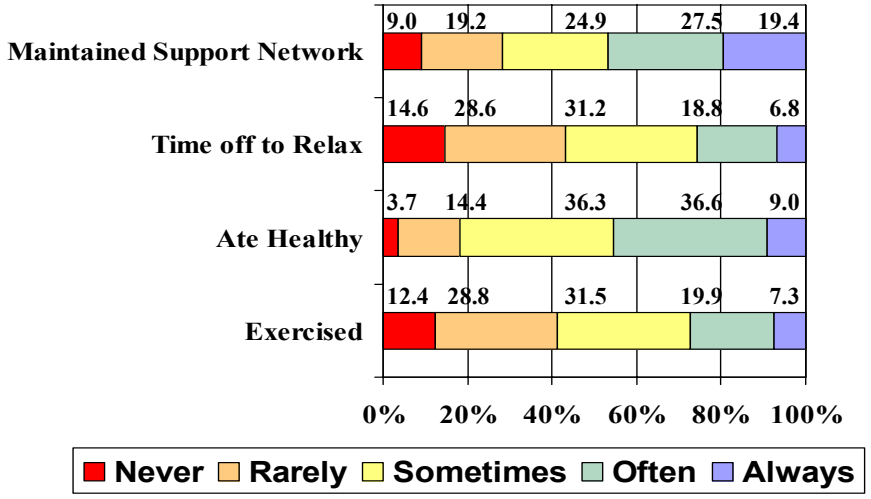

Chart 7-6. Substance Use (Gambler at Enrollment) Previous Six Months

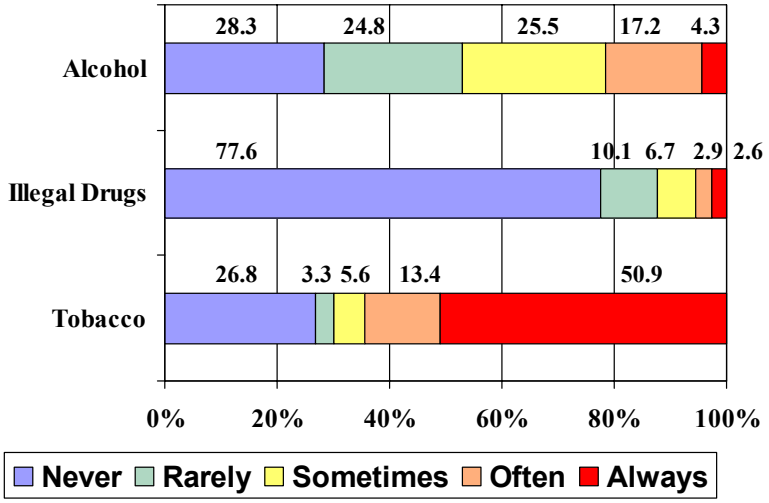

Table 7-13. Average Number of Prior Formal Gambling Treatment Episodes By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
349	1.4	0.7	187	1.4	0.7	162	1.4	0.7

Table 7-14. Average Number of Prior Formal Alcohol/Drug Treatment Episodes By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
279	1.6	1.3	186	1.6	1.3	93	1.7	1.3

Table 7-15. Average Number of Prior Formal Mental Health Treatment Episodes By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
238	1.7	1.6	105	1.5	1.0	132	1.9	1.9

Table 7-16. Serious Attempts to Stop or Control Gambling By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
728	3.4	5.0	408	3.8	5.6	320	2.9	4.1

Table 7-17. Assisted Serious Attempts to Stop or Control Gambling By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
397	1.7	1.4	217	1.7	1.5	180	1.6	1.3

TAB 8. OUTCOMES

Key questions addressed in this section:

Does participation in problem gambling treatment result in lasting positive change?
Are clients satisfied with the treatment they received?
Does problem gambling treatment improve public health?

Synopsis

An important component of determining an intervention program's effectiveness is evaluating longer term change. In general, clinicians believe that most individuals who complete their recommended course of treatment will experience lasting positive changes. The data collected during this evaluation support this clinical maxim. For the treatment completers, 93% of those assessed at 12-months post-treatment reported either no gambling or greatly reduced gambling. Because so many problem gambling clients stop coming to treatment before their full-course of treatment, we were interested in determining if treatment participation benefited these non-completers. Evaluators contacted treatment non-completers at 90-days and again at 6-months after they left treatment to assess for change and determine why they left treatment early. The findings suggest that most of these people received the help they needed to change their gambling behavior (73% reported either no gambling or much less gambling than before treatment). Other information found that the majority of the participants were satisfied with the treatment program and made life changes that benefited themselves, their family, and their community. About three-fourths of the participants reported satisfaction with their relationships, physical health, emotional well-being, and spiritual well-being. Over 80% reported a return to paying bills on time and being responsible at work and home. The great majority of the treatment participants reported being free of alcohol and drug problems well after treatment ended. The only area that little change was observed was gambling related debt. Not surprisingly, even after 12 months of no gambling, most of the former problem gamblers were still in debt, but making progress.

Key Findings

- ❑ Over 63% of program completers report no gambling for 12-months;
- ❑ Another 30% report gambling much less than before entering treatment
- ❑ Over 41% of non-completers report abstinence for six-months;
- ❑ Another 32% report much less gambling than before treatment
- ❑ As would be expected, no statistically significant changes in gambling debt are being reported by 12 months; nonetheless, these strong outcomes are expected to have a significant impact eventually on the over $29.5 million owed by gamblers as a result of gambling
- ❑ Overall satisfaction with the program was rated very high
- ❑ Statistically significant changes were reported in key life-function indicators for both completers and non-completers.

*** Findings based on***

Non-completers 90-day window n=116, 48.7% of sample[71]
Non-completers 180-day window n=213, 61.0% of sample
Completers 6-month window n=178, 86.0% of sample
Completers 12-month window n=139, 77.7% of sample

Follow-up for gambling clients includes surveying at six and twelve months for those who successfully complete the treatment program. For those who leave treatment prior to formal completion, follow-up is accomplished at ninety days and six months. Follow-up is only undertaken for clients who have provided informed consent to participant in the program evaluation.

The longitudinal outcomes for gamblers continued to be very positive especially for the most critical indicator of program success. At six-months post discharge, those gamblers who successfully completed treatment, reported an abstinence rate of 56.2% while another

[71] See Tab 14 for a complete discussion of the eligible sample sizes and data capture rates. The reason for the small sample at 90 days is due to the allowable lag time for programs to report terminations and by the time the contractor was notified of the non-successful termination, the 90-day window had passed.

31.9% reported gambling much less than before starting treatment. Importantly, non-program completers at six-months post discharge reported an abstinence rate of 40.9% while another 32.4% reported gambling much less than before treatment. Less than two percent from each of these groups reported gambling more than they were before treatment.

For those who gambled, the choice of game was essentially the same as that reported at admission with 73.3% indicating video poker as the game of choice and 10.0% reporting slots.

Although there are no robust studies that have determined, with precision, the personal and social costs associated with problem gambling, it is not unreasonable to conclude that these levels of recovery will eventually have a profound impact, at least in the reduction of the approximate $29.5 million total gambling related debt represented by the gamblers enrolling in treatment during the report period. Nonetheless, debt reduction should not be expected to be overcome quickly.

As expected, there were no statistically significant changes when comparing gambling debt at admission and follow-up for completers or non-completers at six and twelve months post discharge. Nonetheless, there was good evidence in the data that the amount of gambling debt reported at admission was minimized by the client when comparing debt reported at admission and debt reported at follow-up for those who had not gambled.

Importantly, a large majority of clients who successfully completed treatment reported their aftercare plan as being helpful to their recovery. Although most of those who did not complete their planned course of treatment reported their aftercare plan was helpful, the

distribution of those reporting the lack of helpfulness of an aftercare plan was significantly[72] larger than those who had completed treatment.

One of the more intriguing findings to emerge from the data is the notion that separating the sample into completer and non-completer groups may be misleading to system performance. Although non-completers are significantly[73] more likely to have gambled the same or more at six-months follow-up than completers, they report abstinence or reduced gambling at a substantially important rate.

A similar pattern emerged when comparing baseline scores on the self-report survey to follow-up scores. Successful program completers demonstrated significant improvements [74] in several indicators such as satisfaction with life in general, emotional wellbeing, relationship with spouse or partner, job, and spiritual wellbeing. However, those classified as non-completers also demonstrated significant improvements in these key areas, but additionally demonstrated significant improvements in their satisfaction with physical health, relationships with friends, and relationships with family.

In the domain of healthy activities, completers reported significant improvement in their accomplishment of responsibilities at home, reduction of thoughts of suicide, and increases in taking time off to rest and relax. Non-completers also reported significant changes in these indicators, but also in the accomplishment of responsibilities at work, paying bills on time, reduced use of tobacco products, better maintenance of supportive network of friends and family, exercise, and eating healthy foods.

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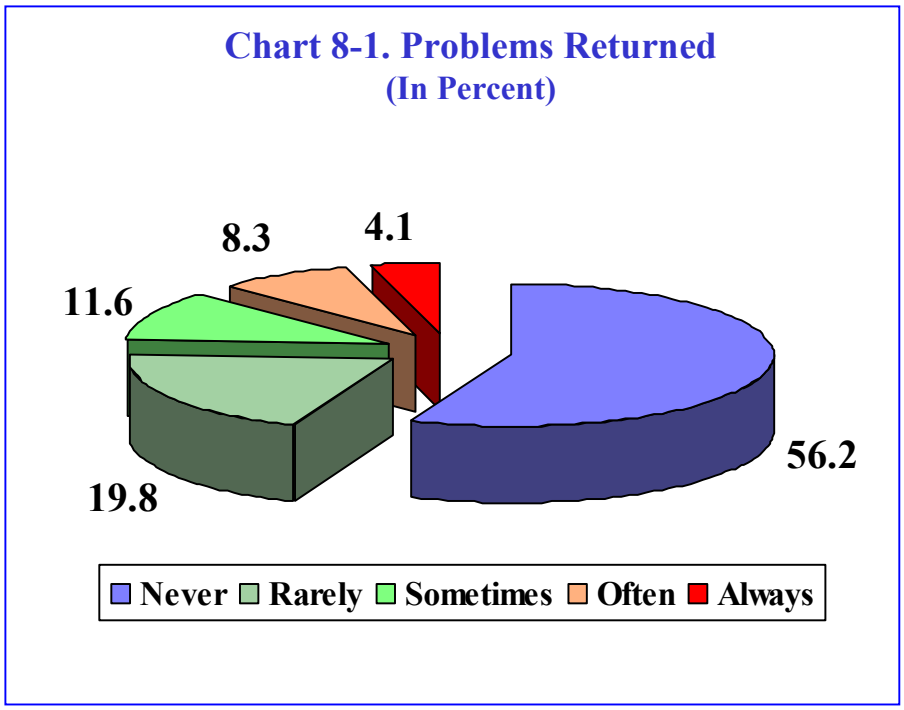
[72] Completers and non-completers at six months. Chi square $p < .01$
[73] chi square $p < .01$
[74] ANOVA $p <. 05$ to $p < .01$

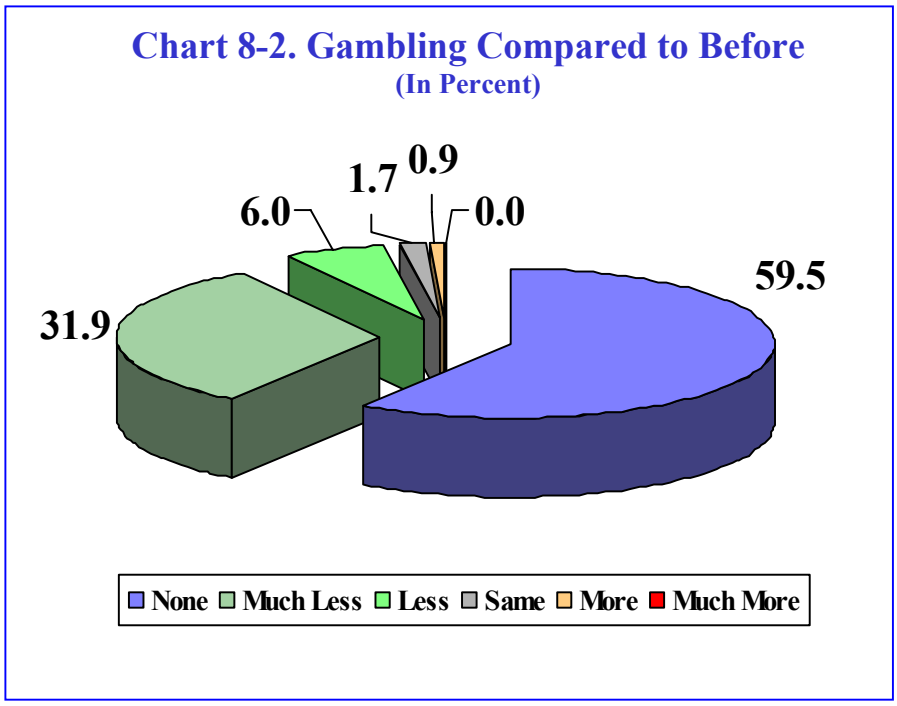
On the surface, these findings appear to be counter intuitive. Nevertheless, when considering the fact, as reported earlier, that those individuals who leave before completing the planned course of treatment report more severe symptoms at admission than those who complete their treatment plan, is more logical. It has been hypothesized that the non-completers tend to achieve a relatively greater amount of perceived relief from their more severe symptoms quicker than others see changes and subsequently see less value in remaining in treatment longer.

Willingness of clients to recommend the program to others was very high at six-months post discharge. Slightly over 99% of program completers were positive while over 84% of the non-completers indicated a positive response. This willingness to recommend to others is viewed as a very strong affirmation of the perceived value of the program.

TAB 8. OUTCOMES – TABLES AND CHARTS

Outcomes Reported at Six Month-Program Completers





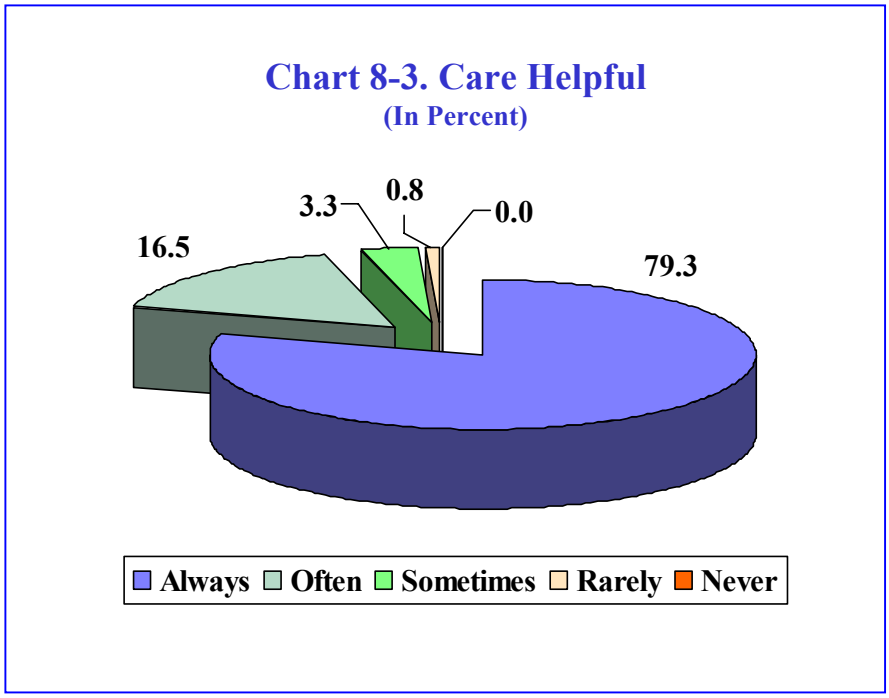


Chart 8-3. Care Helpful
(In Percent)
3.3
0.8
0.0
16.5
79.3
Always
Often
Sometimes
Rarely
Never

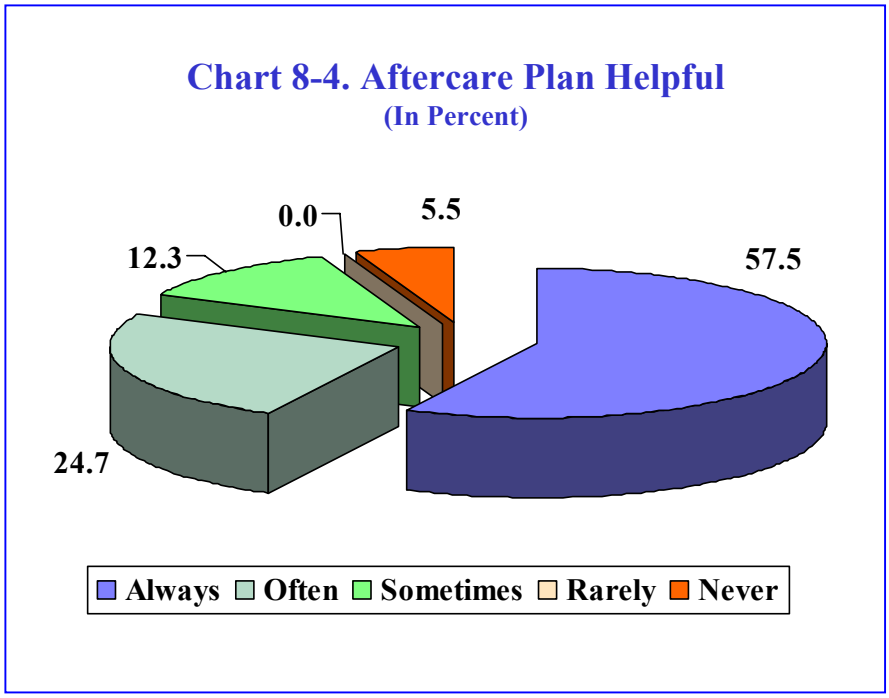


Chart 8-4. Aftercare Plan Helpful
(In Percent)
0.0
5.5
12.3
57.5
24.7
Always
Often
Sometimes
Rarely
Never

Chart 8-5. General Life Satisfaction

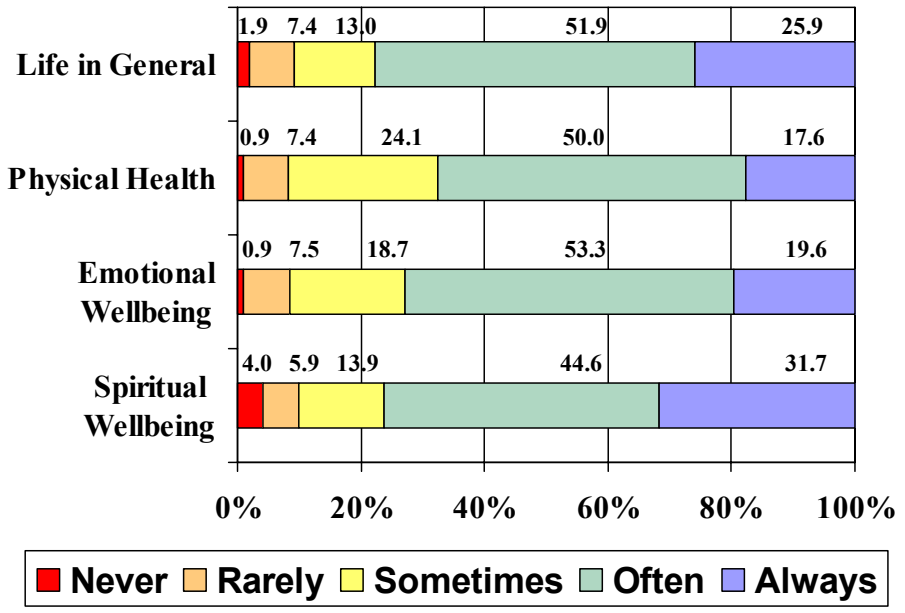


Chart 8-6. Satisfaction with Key Relationships

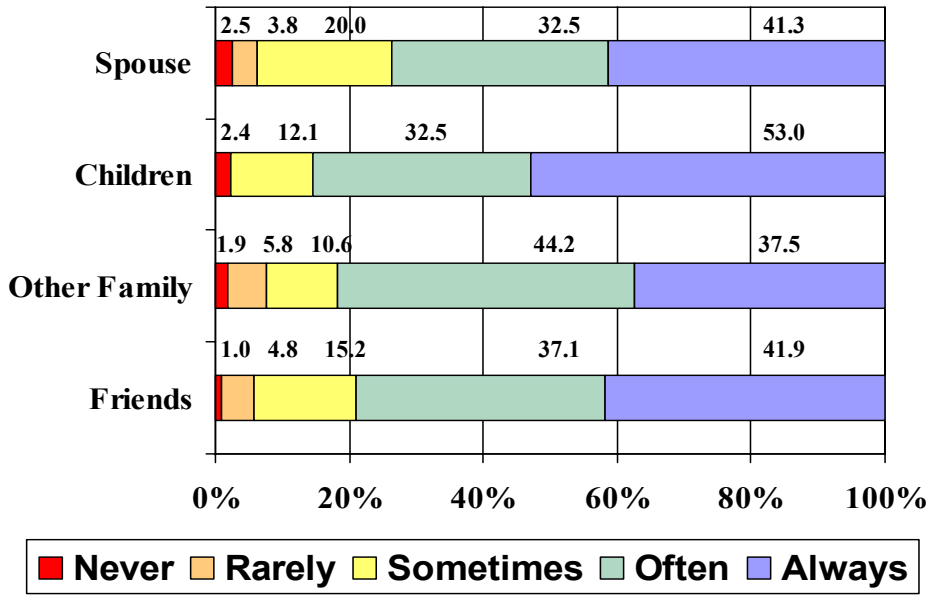


Chart 8-7. Critical Activities Completed

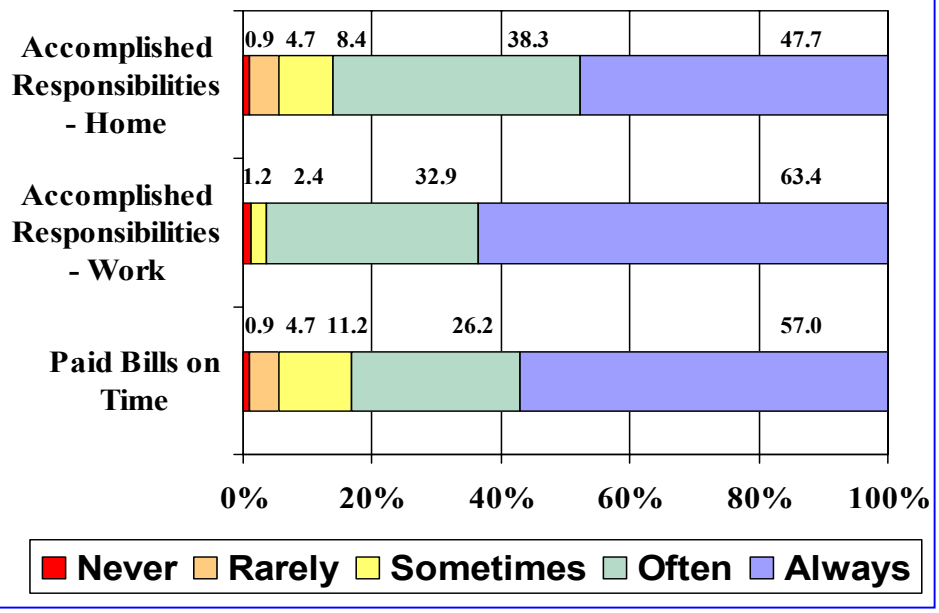
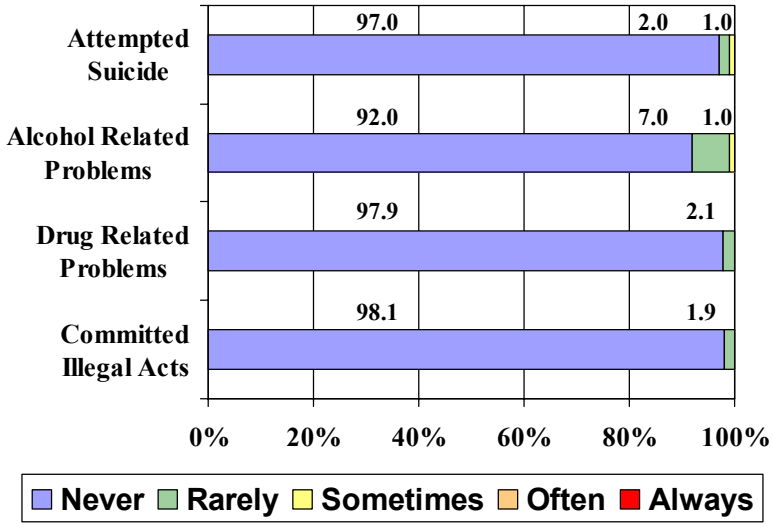


Chart 8-8. Other Problems



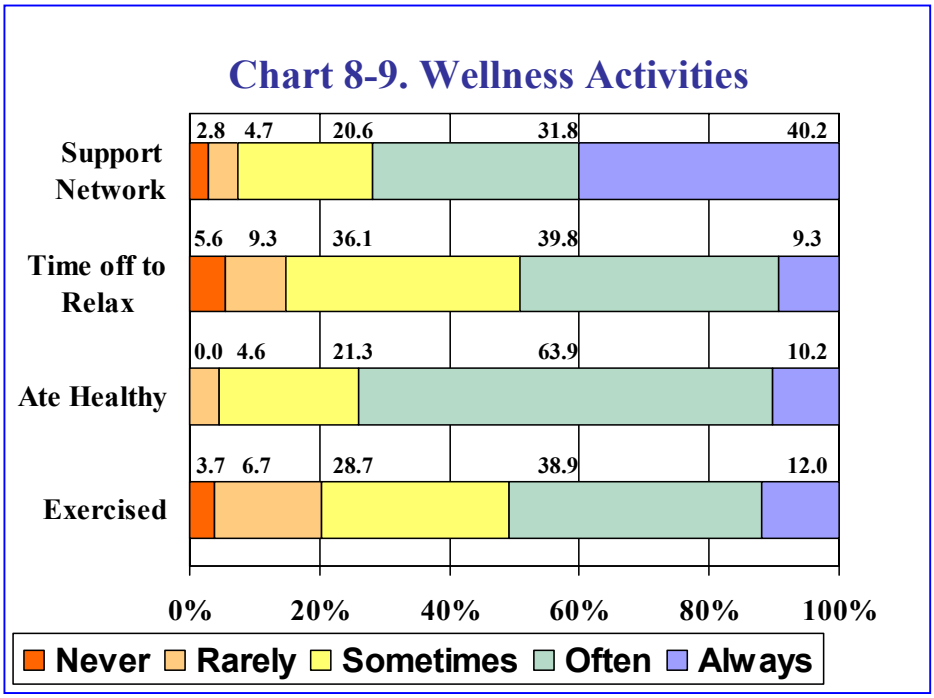


Chart 8-9. Wellness Activities
Support Network
2.8
4.7
20.6
31.8
40.2
Time off to Relax
5.6
9.3
36.1
39.8
9.3
Ate Healthy
0.0
4.6
21.3
63.9
10.2
Exercised
3.7
6.7
28.7
38.9
12.0
0%
20%
40%
60%
80%
100%
Never
Rarely
Sometimes
Often
Always

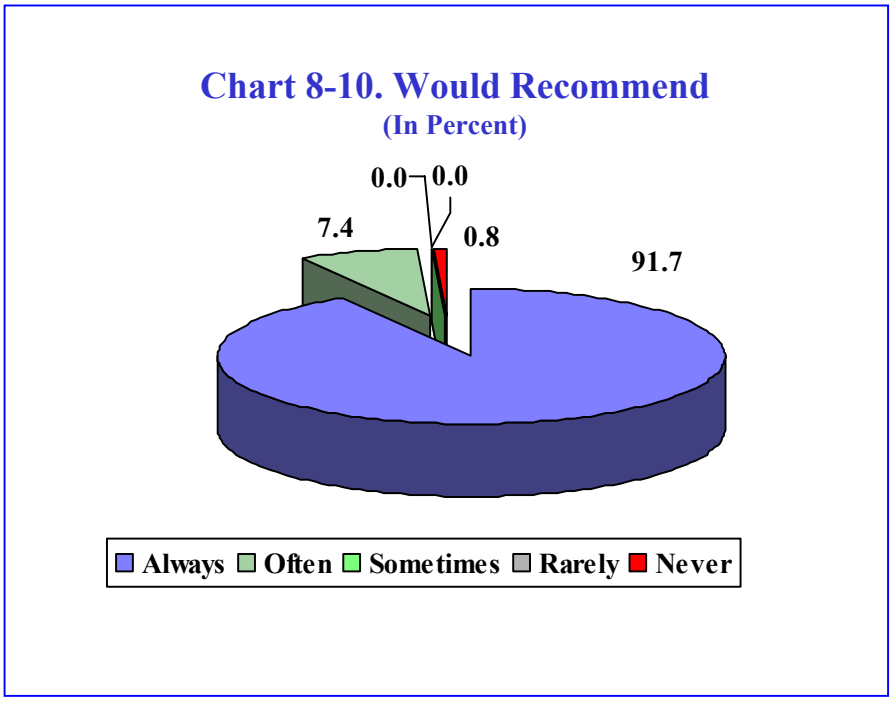
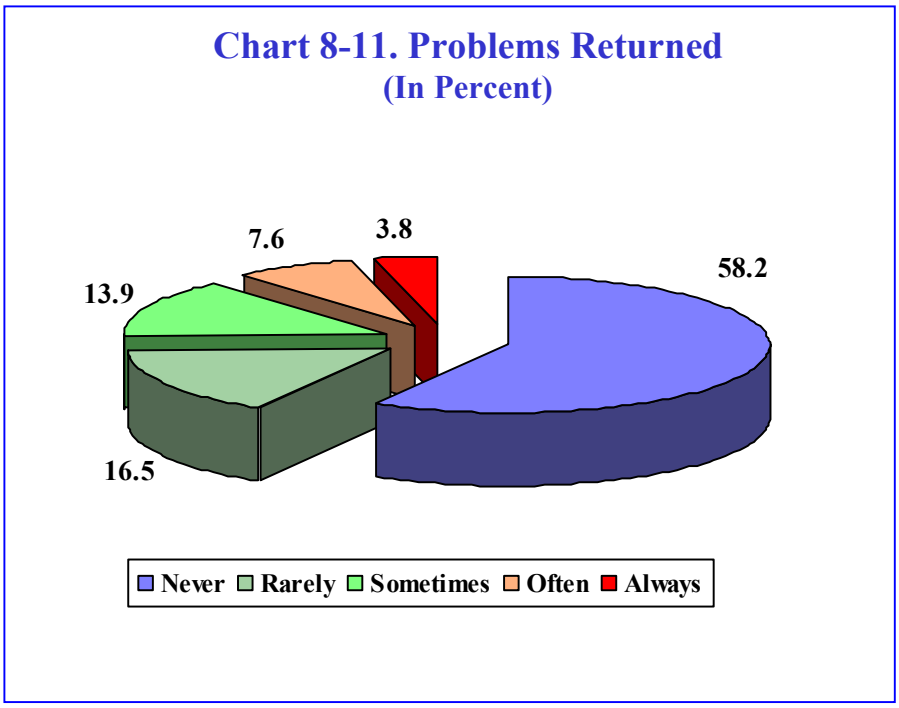


Chart 8-10. Would Recommend
(In Percent)
0.0
0.0
7.4
0.8
91.7
Always
Often
Sometimes
Rarely
Never

Outcomes Reported at Twelve Month-Program Completers



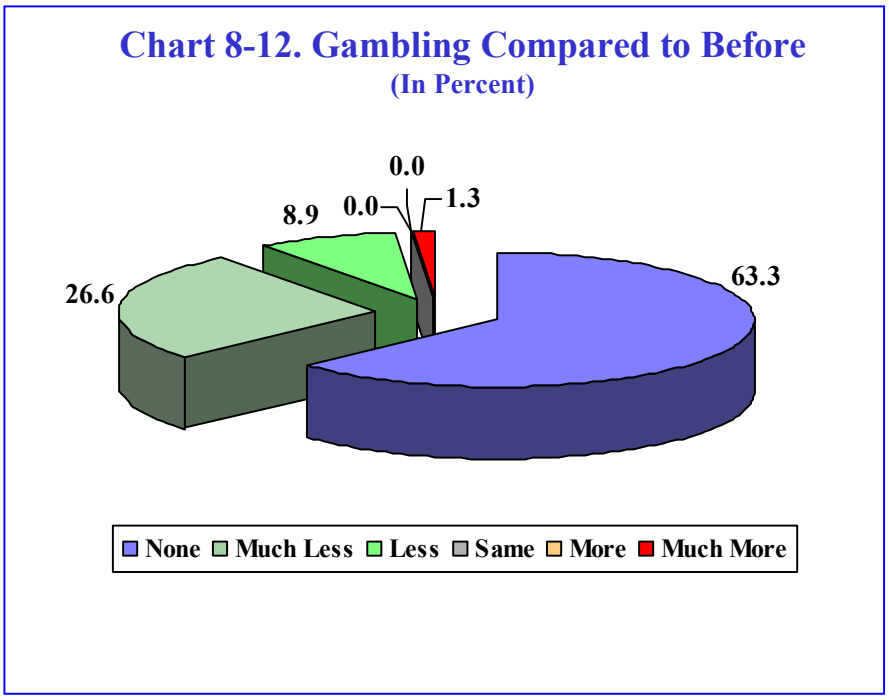


Chart 8-13. Care Helpful
(In Percent)

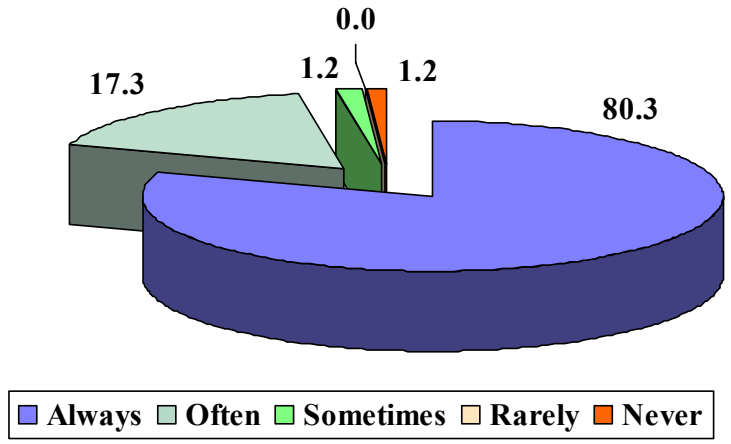


Chart 8-14. Aftercare Plan Helpful
(In Percent)

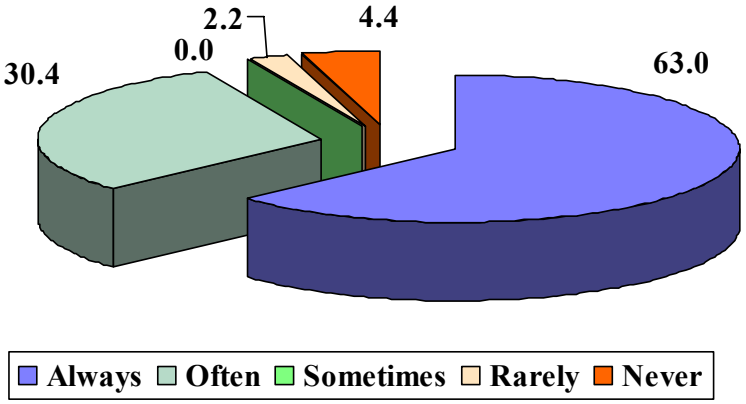


Chart 8-15. General Life Satisfaction

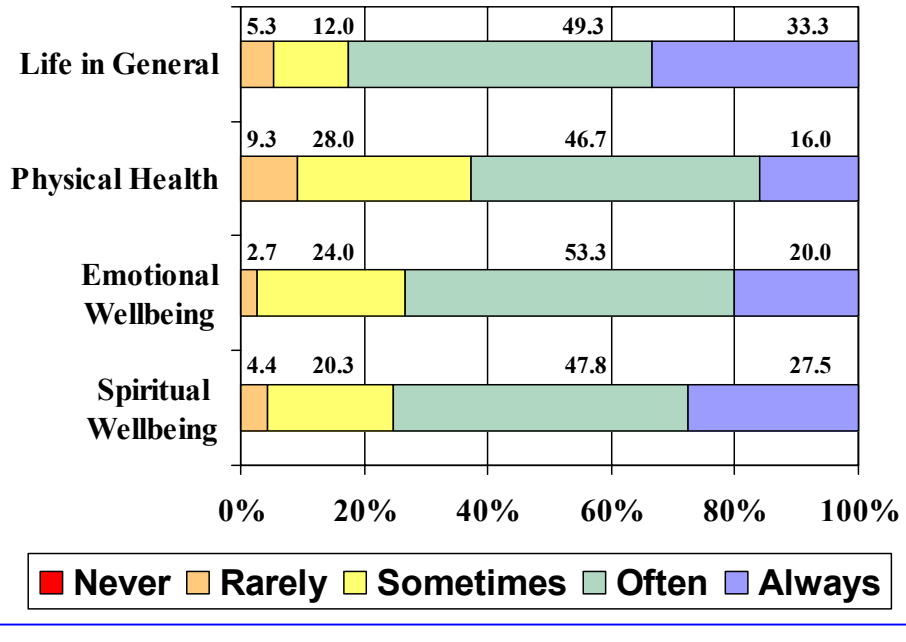


Chart 8-16. Satisfaction with Key Relationships

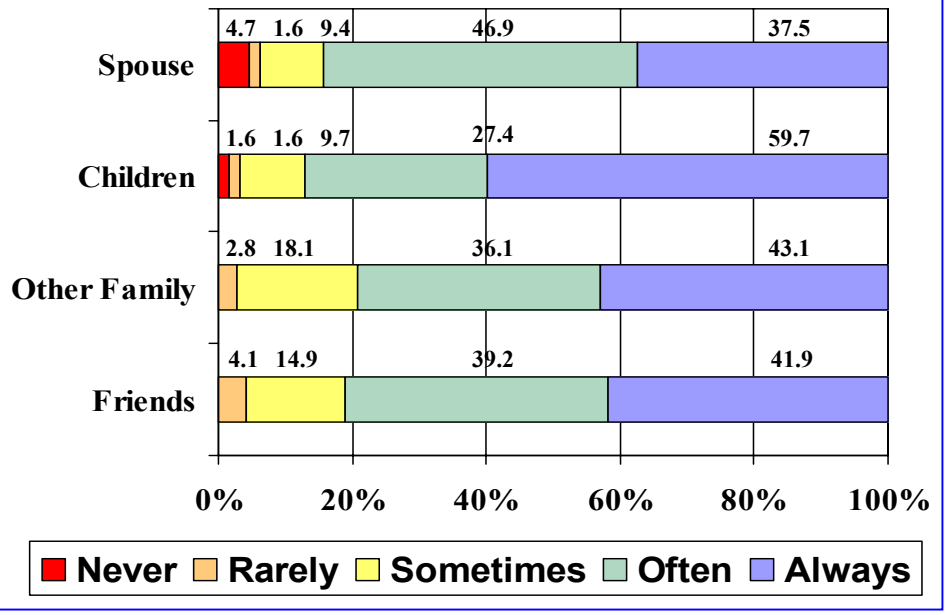


Chart 8-17. Critical Activities Completed

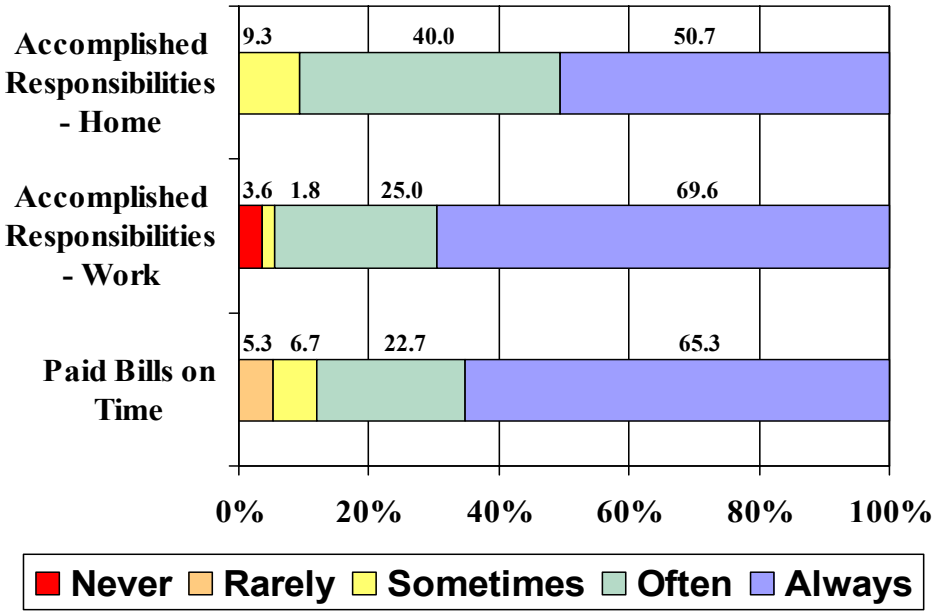
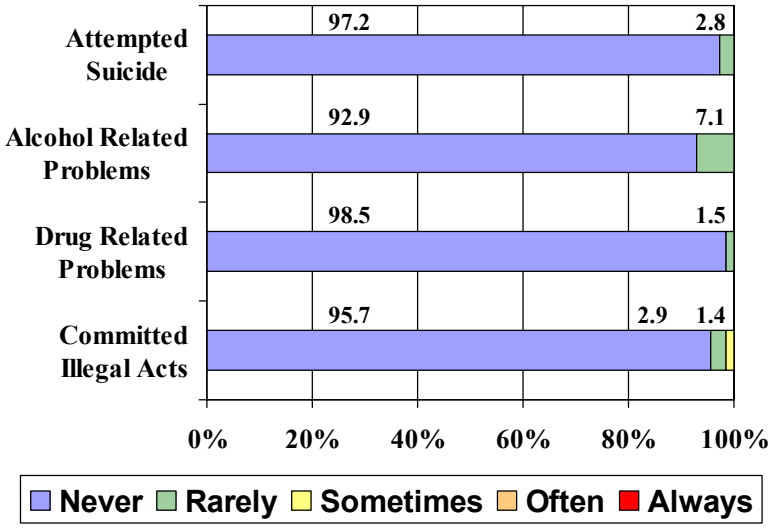


Chart 8-18. Other Problems



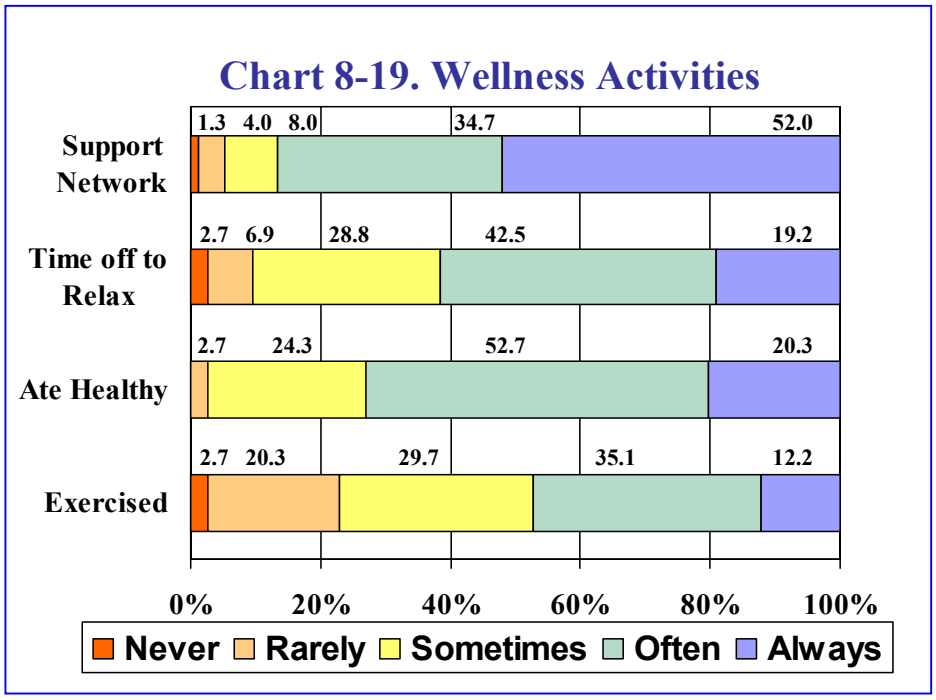


Chart 8-19. Wellness Activities
Support Network
1.3
4.0
8.0
34.7
52.0
Time off to Relax
2.7
6.9
28.8
42.5
19.2
Ate Healthy
2.7
24.3
52.7
20.3
Exercised
2.7
20.3
29.7
35.1
12.2
0%
20%
40%
60%
80%
100%
Never
Rarely
Sometimes
Often
Always

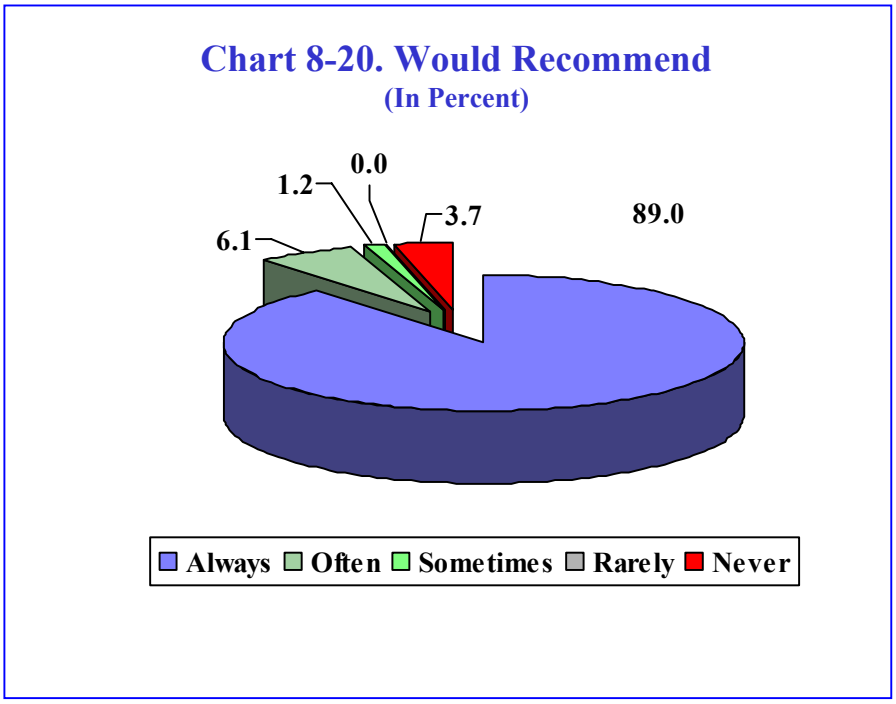
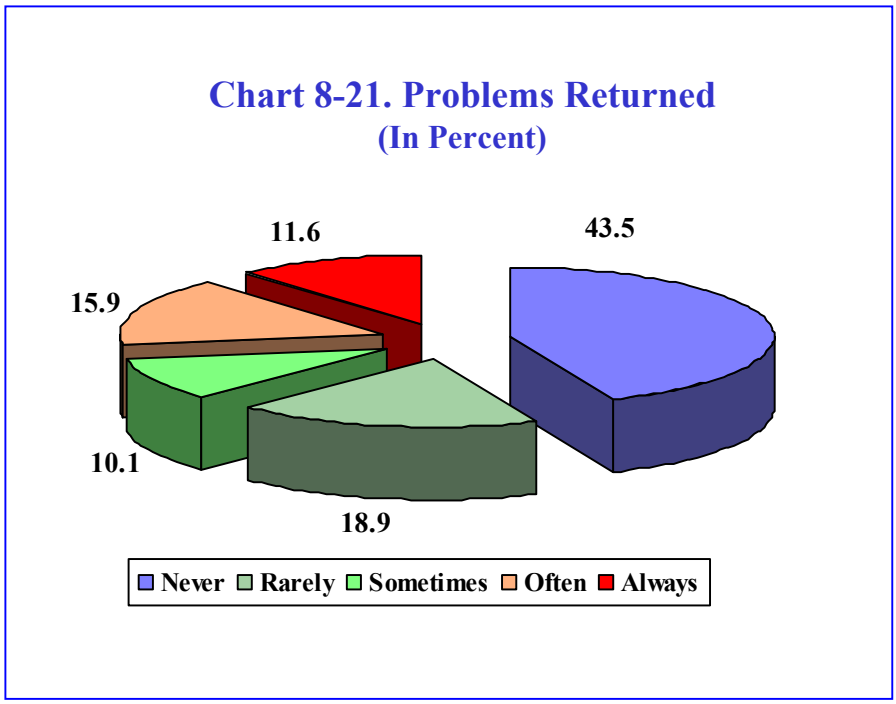
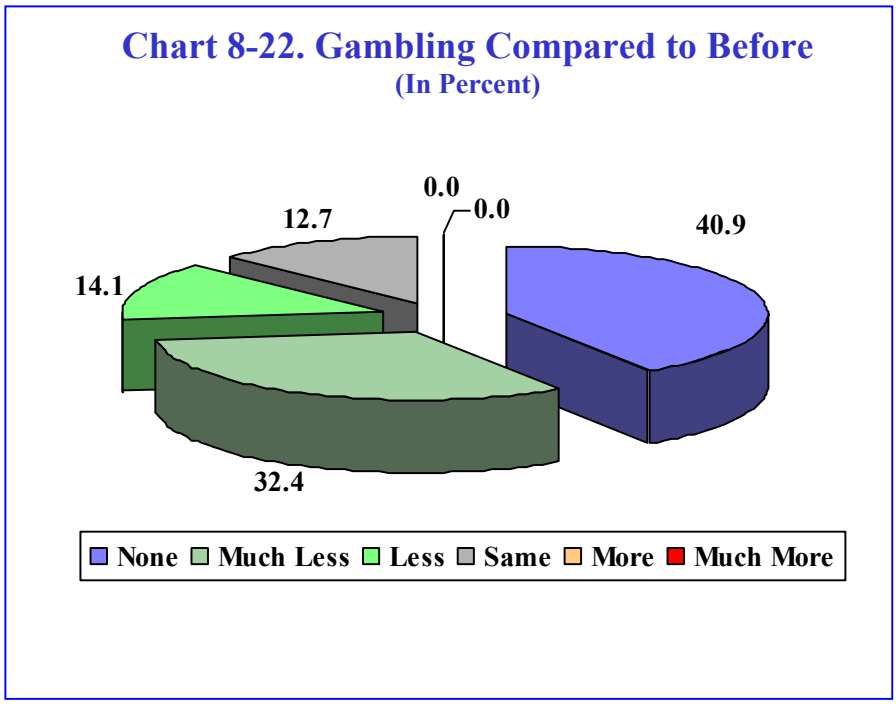


Chart 8-20. Would Recommend
(In Percent)
0.0
1.2
3.7
89.0
6.1
Always
Often
Sometimes
Rarely
Never

Outcomes Reported at Three Months - Program Non-Completers





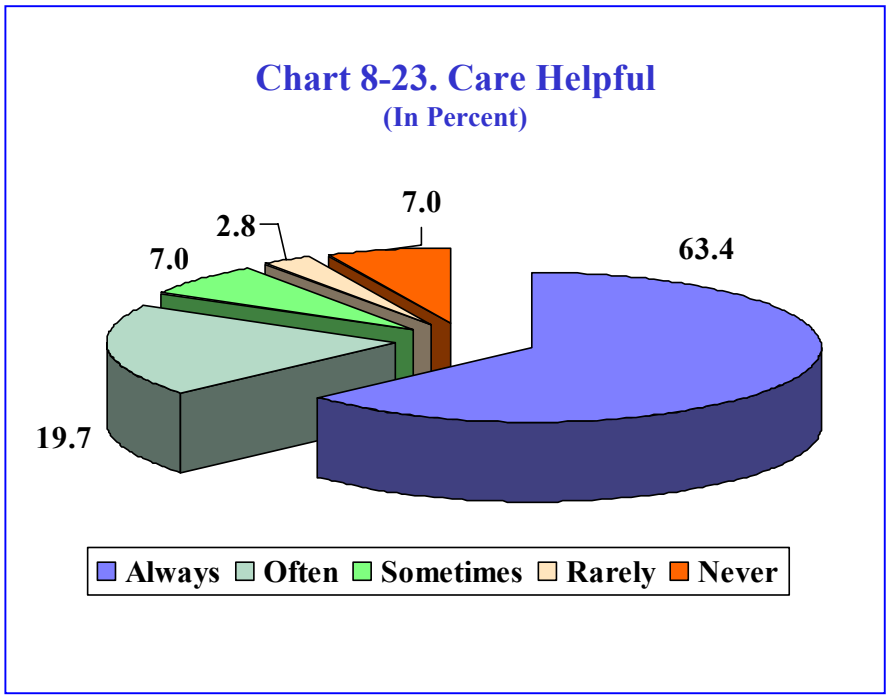


Chart 8-23. Care Helpful
(In Percent)
7.0
2.8
7.0
63.4
19.7
Always
Often
Sometimes
Rarely
Never

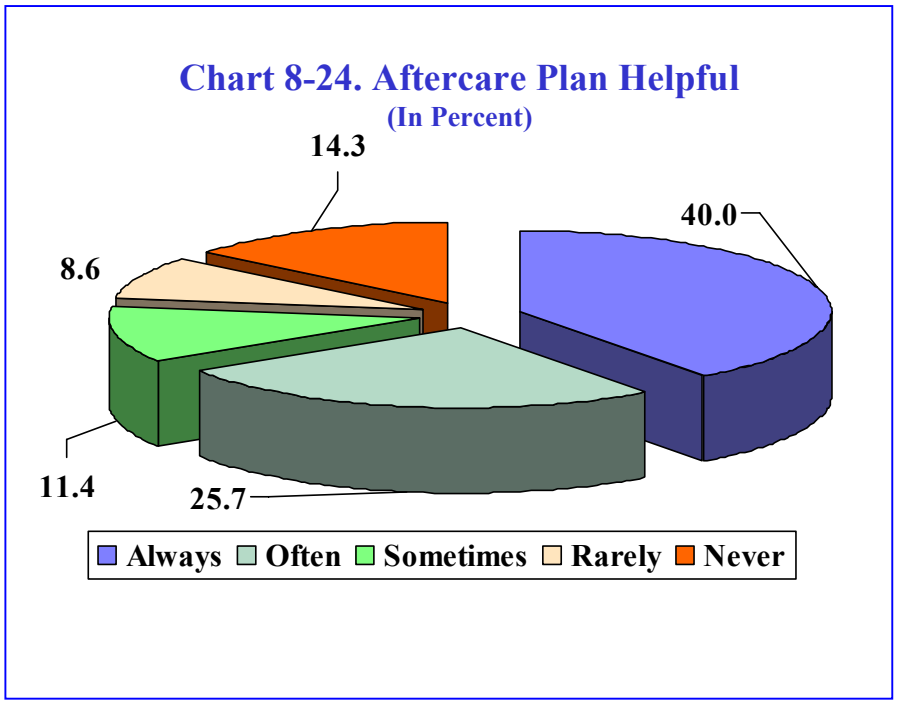


Chart 8-24. Aftercare Plan Helpful
(In Percent)
14.3
40.0
8.6
11.4
25.7
Always
Often
Sometimes
Rarely
Never

Chart 8-25. General Life Satisfaction

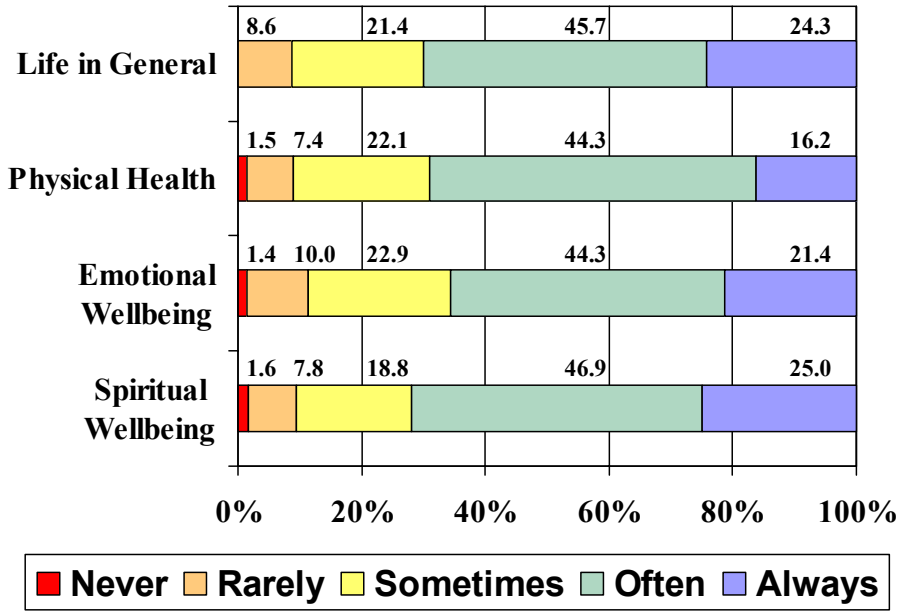


Chart 8-26. Satisfaction with Key Relationships

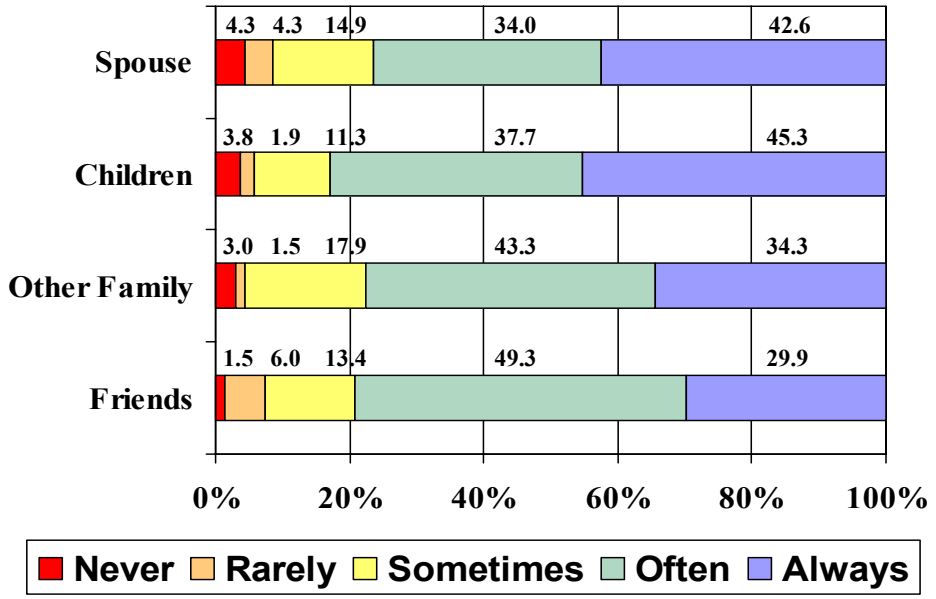


Chart 8-27. Critical Activities Completed

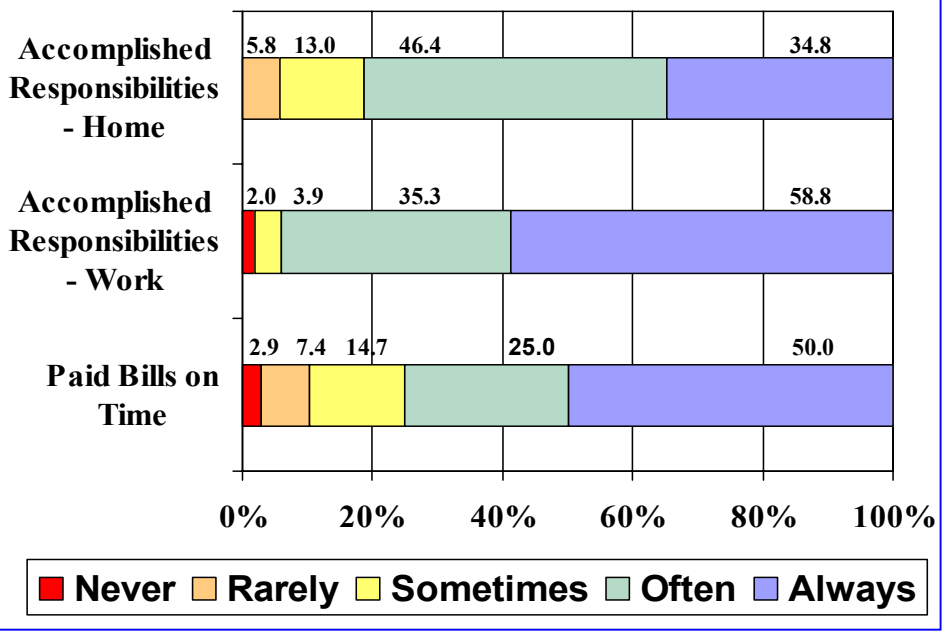


Chart 8-28. Other Problems

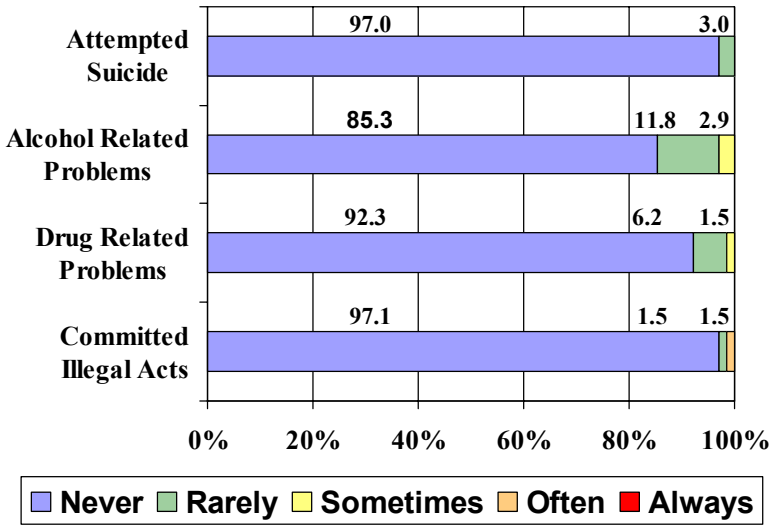


Chart 8-29. Wellness Activities

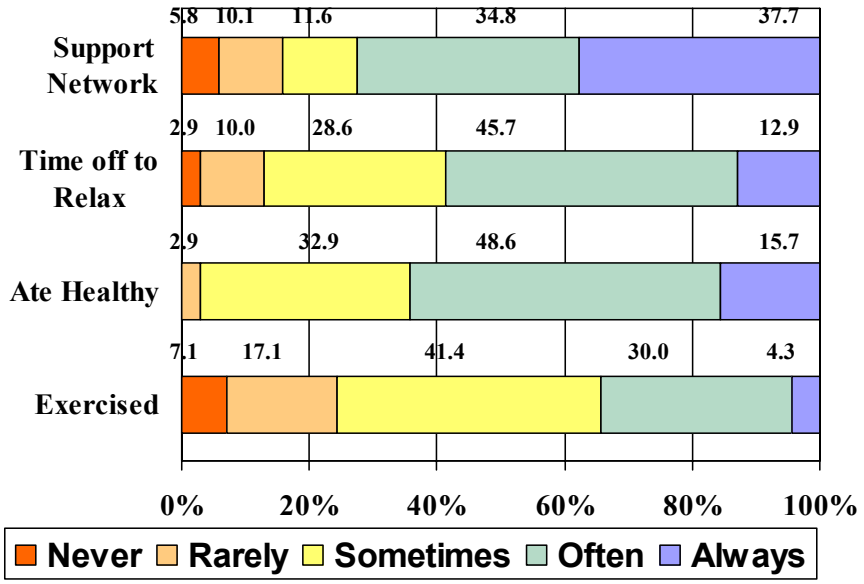
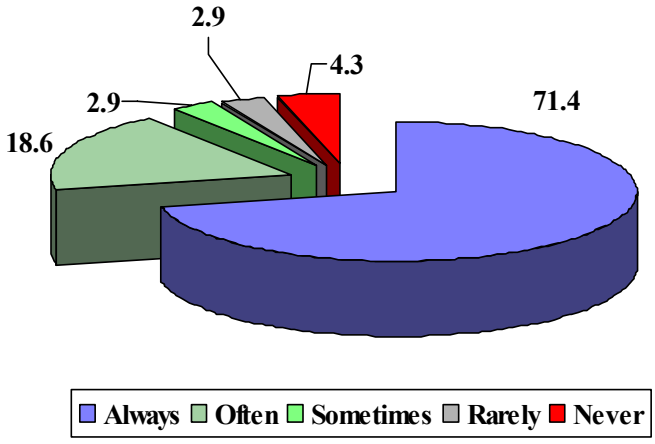
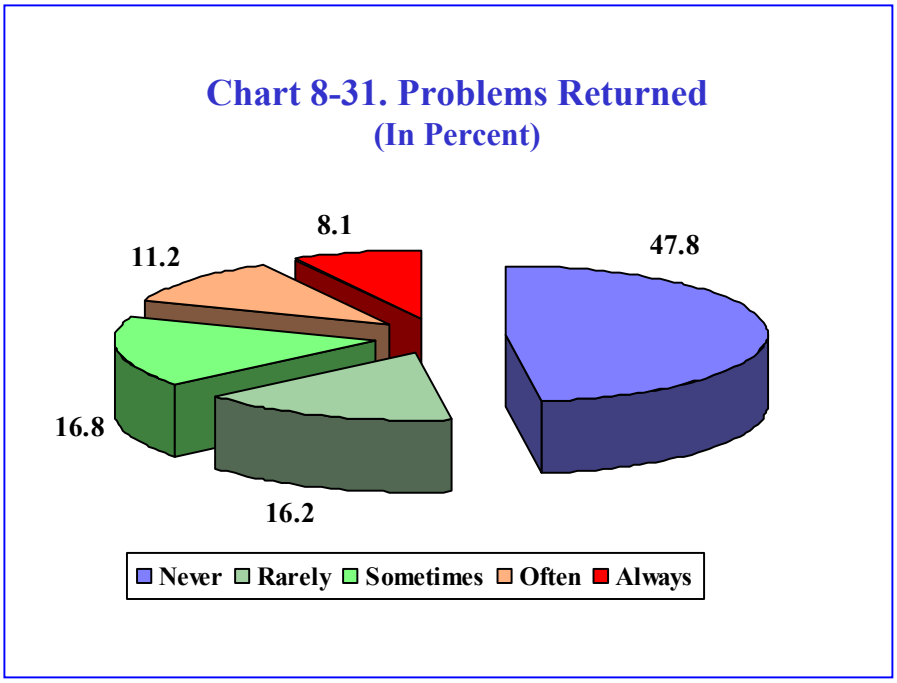


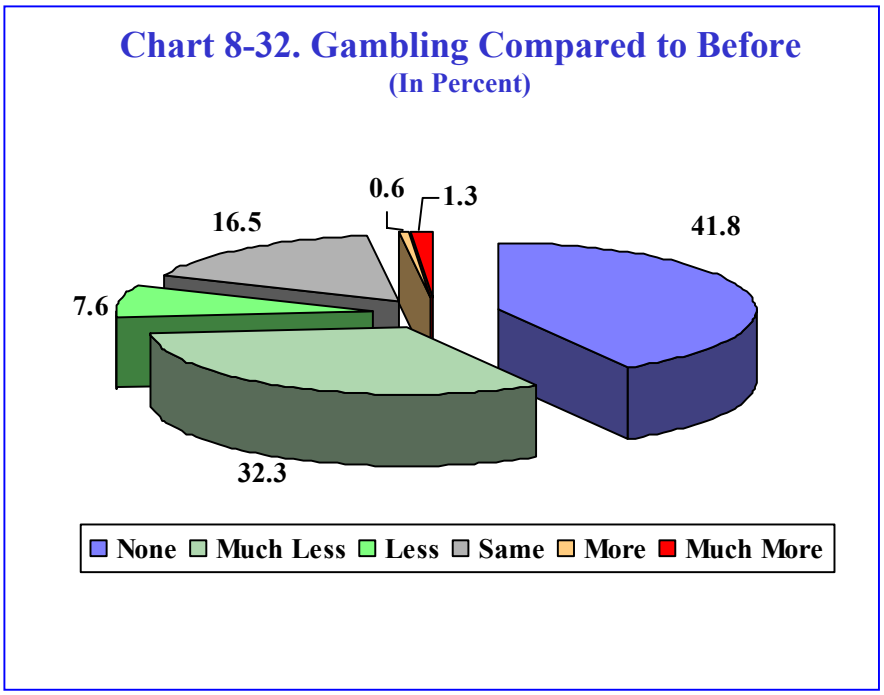
Chart 8-30. Would Recommend

(In Percent)



Outcomes Reported at Six Month-Program Non-Completers





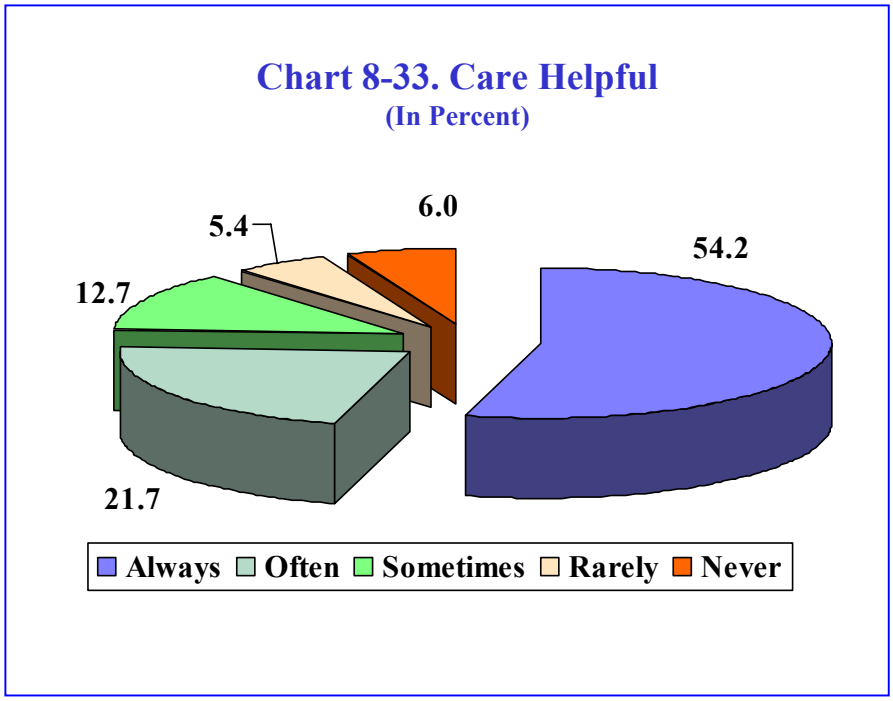


Chart 8-33. Care Helpful
(In Percent)
54.2
21.7
12.7
5.4
6.0
Always
Often
Sometimes
Rarely
Never

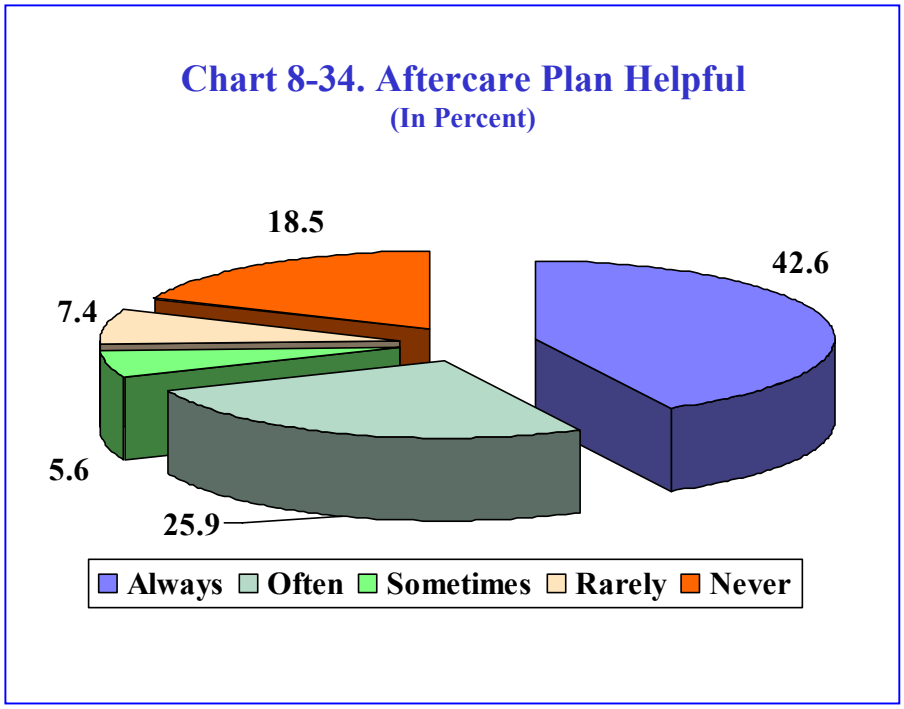


Chart 8-34. Aftercare Plan Helpful
(In Percent)
42.6
25.9
5.6
7.4
18.5
Always
Often
Sometimes
Rarely
Never

Chart 8-35. General Life Satisfaction

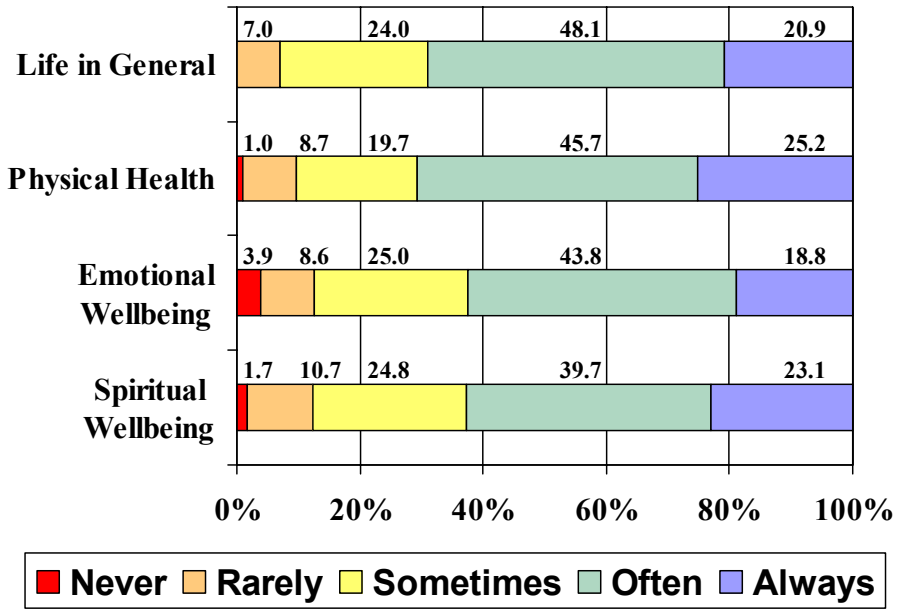


Chart 8-36. Satisfaction with Key Relationships

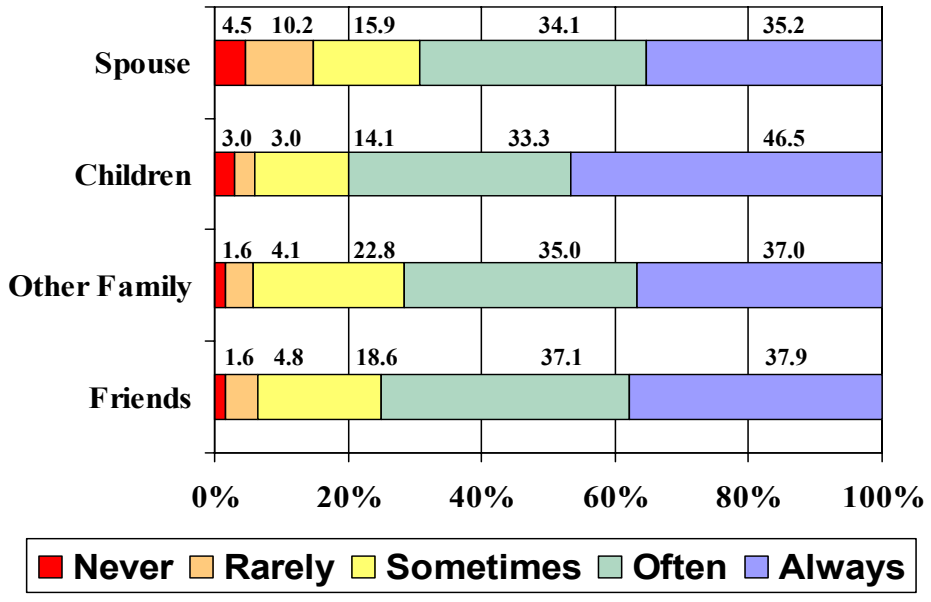


Chart 8-37. Critical Activities Completed

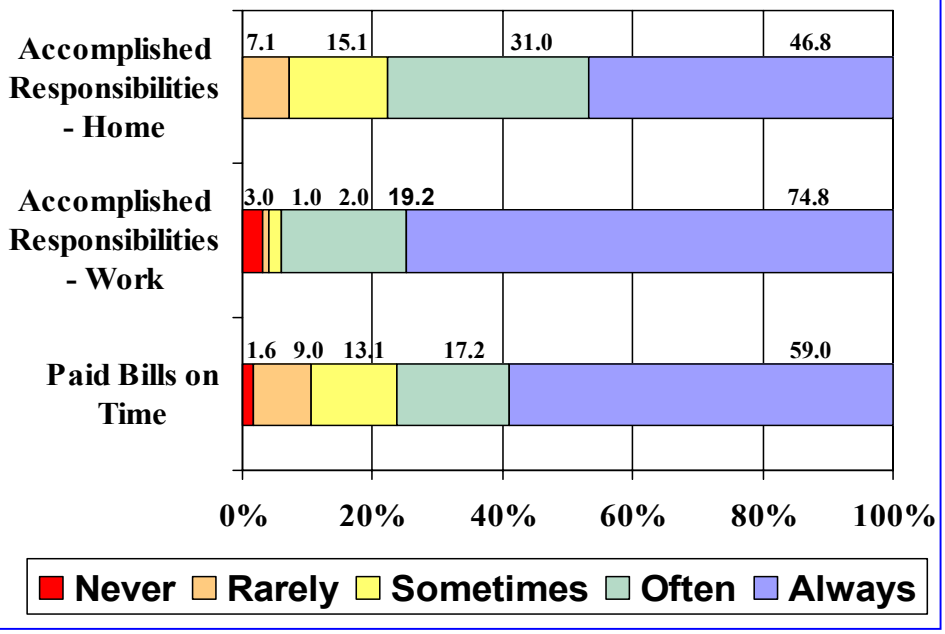
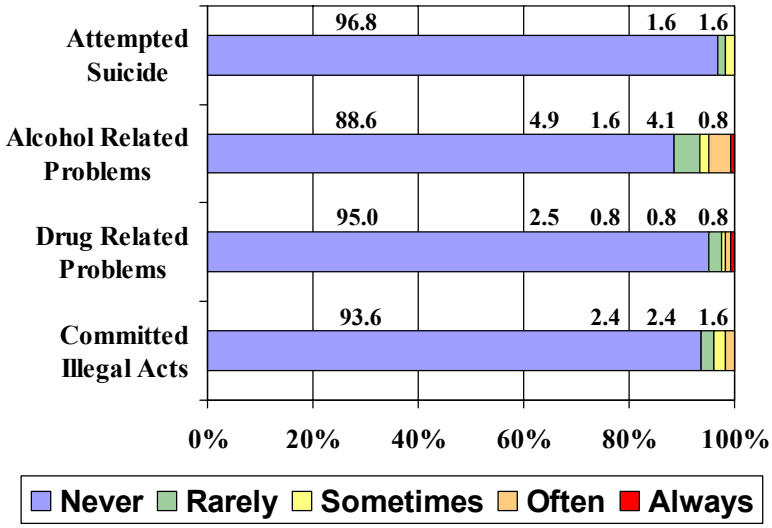


Chart 8-38. Other Problems



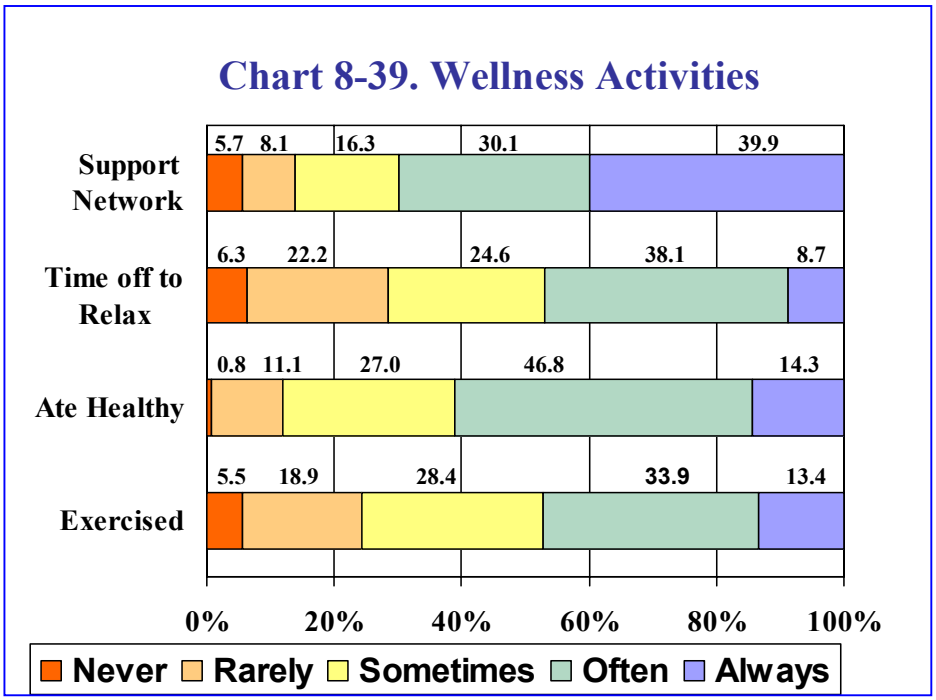


Chart 8-39. Wellness Activities
Support Network
5.7
8.1
16.3
30.1
39.9
Time off to Relax
6.3
22.2
24.6
38.1
8.7
Ate Healthy
0.8
11.1
27.0
46.8
14.3
Exercised
5.5
18.9
28.4
33.9
13.4
0%
20%
40%
60%
80%
100%
Never
Rarely
Sometimes
Often
Always

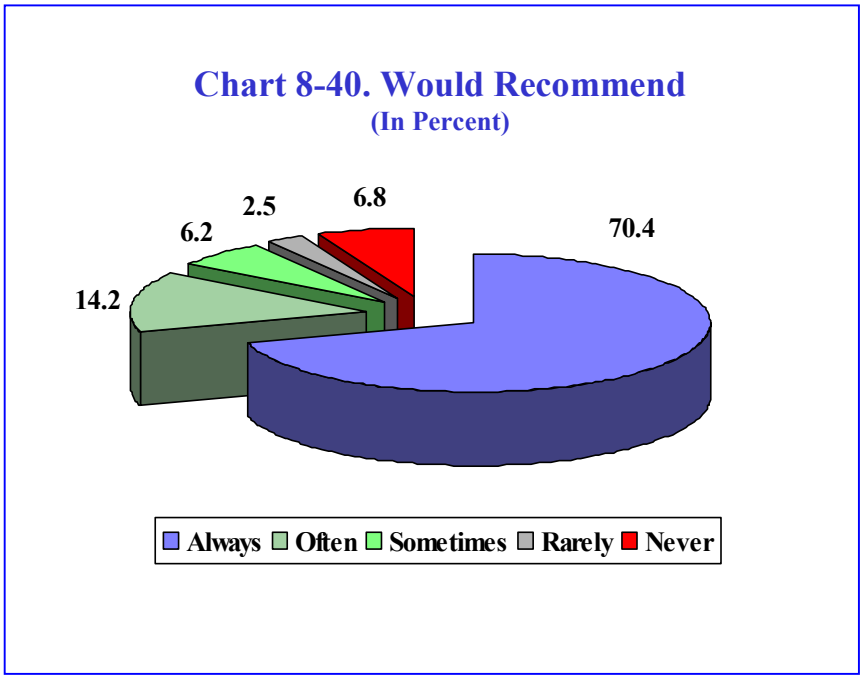


Chart 8-40. Would Recommend
(In Percent)
6.8
2.5
6.2
14.2
70.4
Always
Often
Sometimes
Rarely
Never

Comparisons of Gambler Responses-Admission to Follow-up

Table 8-1. ANOVA Changes in Self- Report Admission to Follow-Up				
Category/Question	**Successful Completers**		**Unsuccessful Completers**	
	Six Months	**Twelve Months**	**90 Days**	**Six Months**
Satisfaction With				
Life in General	p < .05	na*	p < .01	p < .01
Physical Health	ns	p < .01	ns	p < .05
Emotional Wellbeing	p <.01	na	p < .05	p < .01
Relationship with Spouse/SO	p <.05	na	p < .05	p < .01
Relationship with Children	ns	na	ns	ns
Relationship with Friends	ns	na	ns	p < .05
Relationship with other Family	ns	na	ns	p < .05
Job	p < .01	na	ns	ns
School	ns	na	ns	ns
Spiritual Wellbeing	p < .01	p < .01	ns	p < .01
Activities				
Accomplish Responsibility at Home	p < .01	p < .01	ns	p < .01
Accomplish Responsibility at Work	ns	p < .01	ns	p < .05
Pay Bills	ns	na	p < .05	p < .01
Thoughts of Suicide	p < .05	p < .01	p < .05	p < .01
Attempt to Commit Suicide	ns	p < .01	ns	ns
Drink Alcohol	ns	p < .01	ns	ns
Problems with Alcohol	ns	na	ns	ns
Use Illegal Drugs	ns	na	ns	ns
Problems with Illegal Drugs	ns	na	ns	ns
Use Tobacco	ns	ns	ns	p < .01
Commit Illegal acts to get Money	ns	na	ns	ns
Maintain Supportive Friend/Family	ns	na	ns	p < .01
Take off Time to Rest/Relax	p < .05	na	ns	p < .01
Eat Health Foods	ns	na	p < .01	p < .05
Exercise	ns	na	ns	p < .01
Attend Gamblers Anonymous	ns	na	ns	ns
DSM Criteria				
Thinking about gambling	p < .01	na	p < .01	p < .01
Gambling with more money	p < .01	p < .01	p < .01	p < .01
Unsuccessful attempts to stop	p < .01	p < .01	p < .01	p < .01
Restless when attempting to control	p < .01	p < .01	p < .01	p < .01

Gambled to escape	$p < .01$	$p < .01$	$p < .01$	$p < .01$
Chasing	$p < .01$	na	$p < .01$	$p < .01$
Lying to hide gambling	$p < .01$	na	$p < .01$	$p < .01$
Illegal ways to get money	ns	na	ns	$p < .05$
Risk/lost significant relationship	$p < .01$	na	$p < .01$	$p < .01$
Borrowed from others	$p < .01$	na	$p < .01$	$p < .01$

* Many of the clients in the 12 month follow-up sample enrolled in the programs before the revised survey was implemented. Although several of the key indicators were contained in the previous survey, many were not. Those indicators in the new survey, without corresponding baseline data were not included in the calculations.

Tab 9. Family Client Demographics

Questions addressed in this section:

What is the impact on gambler client treatment completion rates when a family member is enrolled in a family program?
What are the demographic characteristics of individuals participating in family counseling?

Synopsis

A small portion of male gamblers in treatment and a significantly smaller portion of female gamblers in treatment had a family member also enrolling in a significant other program. Importantly, gamblers who did have an enrolled family member were significantly more likely to successfully complete their course of treatment. This finding suggests that females going through the recovery process may face greater challenges, as they are less likely to have family support.

Even with a lack of involvement by the problem gambler, individuals who participated in the family programs reported positive experiences and results at follow-up. There is good evidence that treating the family member as a primary client does result in overall positive outcomes. Successful program completion rates for family enrollees were quite high.

Key Findings

- Gamblers with an enrolled family member were significantly more likely to successfully complete treatment
- Males were significantly more likely to have an enrolled family member suggesting that females may experience greater difficulty in recovery without knowledgeable family support
- 67.4% were the spouse of a gambler
- 11.9% were the parent of a gambler
- 7.8% were the child of a gambler
- Successful program completion rates were very high at 44.6%

Findings based on
296 Family enrollments
220 Family discharges
Family non-completer 90-day follow-up, n=12, 50.0% of sample
Family non-completers 180-day follow up, n=35, 60.3% of sample
Family Completers 6-month follow-up, n=39, 90.7% of sample
Family Completers 12-month follow-up, n=38, 82.6% of sample

It is generally accepted that mental as well as physical illnesses are most effectively treated within the milieu of a well-informed and supportive social setting. It is also generally accepted that mental illness, including addictions, present within the social setting establish dynamics that allow for the enmeshment of family members. This dynamic process is frequently identified as an important factor in the short-term and long-term deterioration of well-being of family members as well as a critical factor in the long-term development of mental illness within family members. A recent study conducted in Oregon confirmed this by finding that approximately 47% of pathological gamblers had a close family member who had

preceded them in pathological gambling, 69% had a family member with any mental illness, including addictions, and 73% reported preoccurring trauma.[75]

In 1995, when the pilot programs were consolidated, a well-supported decision was made to incorporate funding support 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 developing strategies to effectively break unhealthy family interactions, even if the gambler was not concurrently enrolled in treatment.

As would be expected, family treatment programs varied greatly from program to program. By virtue of economies of scale, larger programs were able to provide family treatment that comprised a continuum of services ranging for psycho-educational groups, multiple-family focused group therapy, individual therapy, couples counseling, and conjoint therapy, that was delivered by therapists with specialized family treatment expertise. For smaller rural programs, family therapy most often was delivered by the same counselor in individual and couples counseling sessions.

By definition, family members included immediate family, extended family (e.g., parents of adult children who were 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). The primary relationship to the gambler of the 296 family members enrolling in treatment was spouse or significant other (67.4%), parent (11.9%), child[76] (7.8%),

[75] See Moore, T., Jadlos, T., (2001) The Etiology of Pathological Gambling. Oregon Gambling Addiction Treatment Foundation. Available at www.gamblingaddiction.org
[76] This includes adult children.

sibling (6.7%), other family member (4.1%), friend or co-worker (1.6%), and other relationship (0.5%).

Family treatment did not comprise a major element of the state-wide treatment efforts, although on a program by program basis, some programs had very active and well developed efforts. Only 10.6% of gamblers enrolled during the period had at least one family member who was also enrolled. Males (62.9% of those with an enrolled family member) were significantly[77] more likely than females to have a family member enroll. This finding suggests that females, although reporting similar rates of marriage have significantly less family support while in treatment and may subsequently have more difficulty in long-term recovery without knowledgeable family supports.

Importantly, the unjustified successful program completion rate for gamblers with an enrolled family member (27.8%) was significantly[78] higher than those without a family member (19.9%). This finding, in itself, suggests that the family component of care is cost effective in increasing program completion rates.

The general demographic characteristics for the family members were quite reflective of the gambling population when it came to age, education, and employment.

At six months follow-up, family clients reported very positive responses in regards to their care being helpful and that a helpful after care plan was provided. Over satisfaction as measured by their willingness to refer others to the program was somewhat lower than expected with 83.4 percent positive responses. Only about 13.5% reported the severity of the problems that had brought them to treatment remained. This last finding points to the

[77] chi square < .05
[78] chi square < .01

difficulty in attempting to measure outcomes and satisfaction for a program that for some, may not result in the gambler entering treatment or, if enrolled, may not necessarily result in success for the gambler that is expected to contribute significantly to lessening the well-being of the family member.

Please refer to Tab 4: System Performance for information regarding family completion rates, lengths of stay, and referral sources.

TAB 9. FAMILY CLIENT DEMOGRAPHICS - TABLES & CHARTS

Table 9-1. Average Age of Family Client By Gender (In Years)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
289	44.7	13.5	68	46.7	12.9	220	44.1	13.7

Table 9-2. Race/Ethnicity of Family Clients
(In Percent of Distribution)

Race/Ethnicity	All	Males	Females
White	92.2	89.0	93.2
Black	0.3	1.4	0.0
Asian	1.4	1.4	1.4
Hispanic	1.7	2.7	1.4
Southeast Asian	0.7	0.0	0.9
Native American	0.7	0.0	0.9
Other	0.7	1.4	0.5
Unknown/Not Coded	2.3	4.1	1.7
Total	100.0	100.0	100.0

Table 9-3. Average Number of Years Education Family Clients - By Gender (In Years)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
264	13.8	2.3	59	14.0	2.7	204	13.8	2.2

Table 9-4. Marital Status of Family Clients - By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Married	64.9	65.8	64.4
Divorced	8.4	2.7	10.4
Never Married	12.5	16.4	11.3
Separated	3.4	4.1	3.2
Living As Married	6.1	4.1	6.8
Widowed	2.0	1.4	2.3
Missing Data	2.7	5.5	1.6
Total	100.0	100.0	100.0

Table 9-5. Living Situation of Family Clients - By Gender (In Percent of Distribution)			
Living Situation	**All**	**Males**	**Females**
Spouse with Children	39.5	35.6	40.5
Spouse/SO	36.1	43.8	33.8
Alone	7.4	1.4	9.5
Parents/Relatives	5.4	5.5	5.4
Friends/Others	2.0	1.4	2.3
Alone with Children	5.4	5.5	5.4
Institution/Group	0.0	0.0	0.0
Foster Parents	0.0	0.0	0.0
Missing Data	4.2	6.8	3.1
Total	100.0	100.0	100.0

Table 9-6. Household Size Family Clients - By Gender								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
285	2.8	1.3	66	2.8	1.2	218	2.8	1.4

Table 9-7. Household Size by Age Group By Gender				
	Under 6 Years Old	**6 – 17 Years Old**	**18 – 65 Years Old**	**Over 65 Years Old**
All	65	87	271	22
	1.4 0.6	1.8 0.9	1.9 0.6	1.5 0.5
Males	11	21	64	2
	1.3 0.4	2.0 1.0	2.0 0.5	2.0 0.0
Females	54	66	206	20
	1.4 0.7	1.8 0.9	1.8 0.7	1.5 0.5

Table 9-8. Housing Type By Gender (In Percent of Distribution)			
Housing Type	**All**	**Males**	**Females**
Own	64.2	56.2	66.7
Rent – No Subsidies	23.3	20.5	24.3
Other Situation/Not paying Rent	3.7	8.2	2.3
Rent – With Subsidies	1.0	2.7	0.5
Institution/Group Home	0.3	0.0	0.5
Homeless/Shelter	0.0	0.0	0.0
Unknown/Not Coded	7.5	12.4	5.7
Total	100.0	100.0	100.0

Table 9-9. Employment Status By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Full-Time	54.4	63.0	51.4
Not Employed – Looking	5.7	2.7	6.8
Not Employed – Not Looking	22.0	20.5	22.5
Part-Time	10.5	5.5	12.2
Irregular	3.4	0.0	4.5
Unknown/Not Coded	4.0	8.3	2.6
Total	100.0	100.0	100.0

Table 9-10. Employability By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Employable/Working	66.6	65.8	66.7
Disabled	4.4	4.1	4.5
Student	6.7	11.0	4.5
Retired	7.4	6.8	4.5
Temporary Layoff	0.3	0.0	0.0
Homemaker	8.4	1.4	10.8
Incarcerated	0.3	1.4	0.0
Seasonal Worker	0.0	0.0	0.0
Unknown/Not Coded	5.9	9.5	9.0
Total	100.0	100.0	100.0

Table 9-11. Average Annual Household Income of Family Clients By Gender (In Dollars)								
All			**Males**			**Females**		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
235	55531.6	45553.8	52	63592.3	55319.3	182	52940.2	42008.6

Table 9-12. Source of Income of Family Clients By Gender (In Percent)			
Income Source	**All**	**Males**	**Females**
Wages	76.0	72.6	77.0
Pension/Unemployment	2.4	2.7	2.3
Social Security	5.7	5.5	5.9
SSI - Federal	2.4	1.4	2.7
Welfare	0.0	0.0	0.0
Dividends/Interest	0.3	0.0	0.5
Alimony/Child Support	0.3	0.0	0.5
OSP State	0.0	0.0	0.0
Other	4.4	1.4	5.4
No Income	2.0	6.8	1.4
Unknown/Not Coded	6.5	9.6	4.3
Total	100.0	100.0	100.0

Table 9-13. Health Insurance By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Other Private	40.9	41.1	40.5
Blue Cross/Shield	20.3	20.5	20.3
OHP	3.0	1.4	3.6
MEDICARE	5.7	6.8	5.4
Other Public	5.7	4.1	6.3
VA	0.3	0.0	0.5
MEDICAID	0.7	1.4	0.5
CHAMPUS	1.0	0.0	1.4
None	10.5	8.2	12.2
Unknown/Not Coded	11.9	16.5	9.3
Total	100.0	100.0	100.0

Table 9-14. Relationship to Gambler (In Percent of Distribution)			
Relationship	**All**	**Males**	**Females**
Spouse/SO	67.4	71.1	66.7
Parent	11.9	11.1	12.2
Child	7.8	6.7	8.2
Sibling	6.7	0	8.2
Other Family	4.1	8.9	2.7
Friend/Co-Worker	1.6	2.2	0.7
Other	0.5	0	1.3
Total	100.0	100.0	100.0

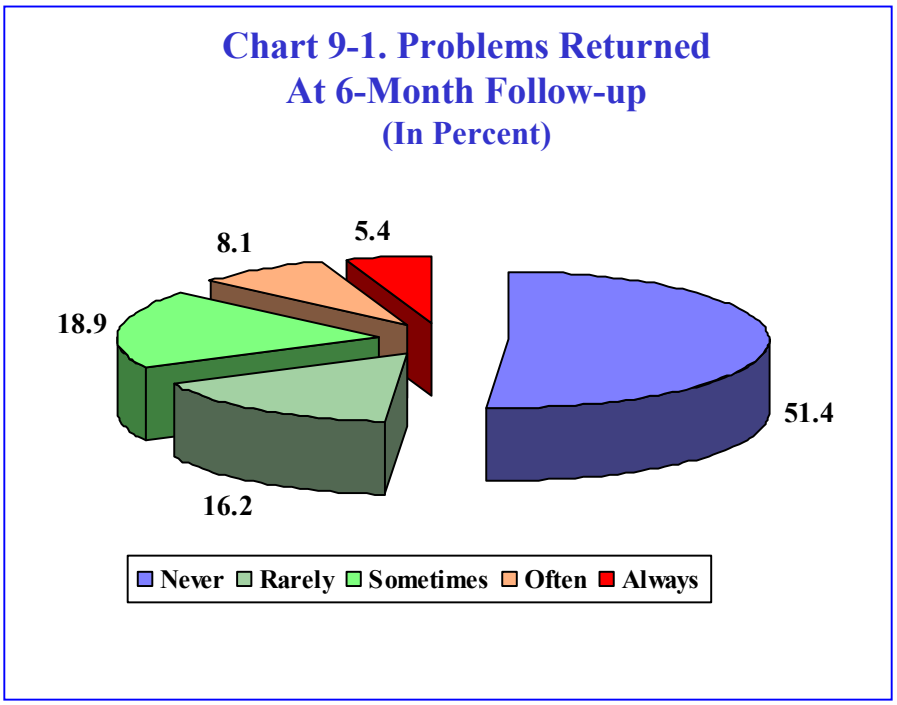


Chart 9-1. Problems Returned
At 6-Month Follow-up
(In Percent)
8.1
5.4
18.9
51.4
16.2
Never
Rarely
Sometimes
Often
Always

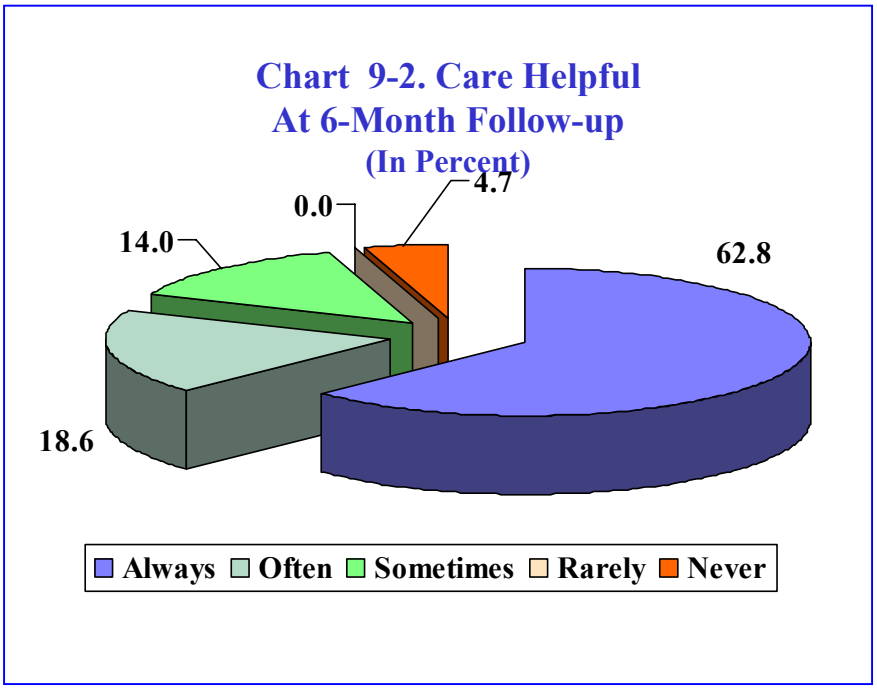


Chart 9-2. Care Helpful
At 6-Month Follow-up
(In Percent)
4.7
0.0
14.0
62.8
18.6
Always
Often
Sometimes
Rarely
Never

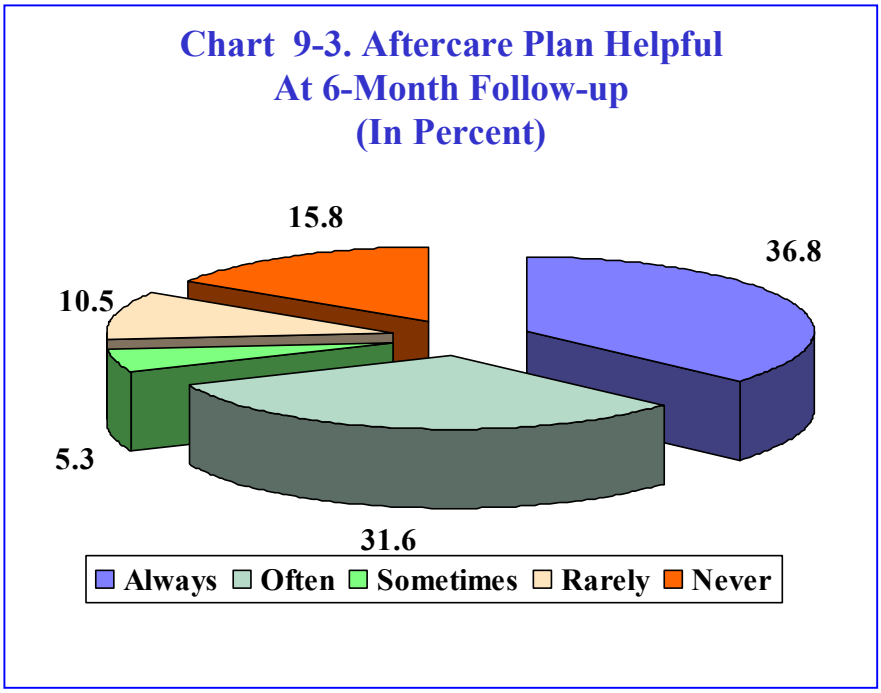


Chart 9-3. Aftercare Plan Helpful
At 6-Month Follow-up
(In Percent)
15.8
36.8
10.5
5.3
31.6
Always
Often
Sometimes
Rarely
Never

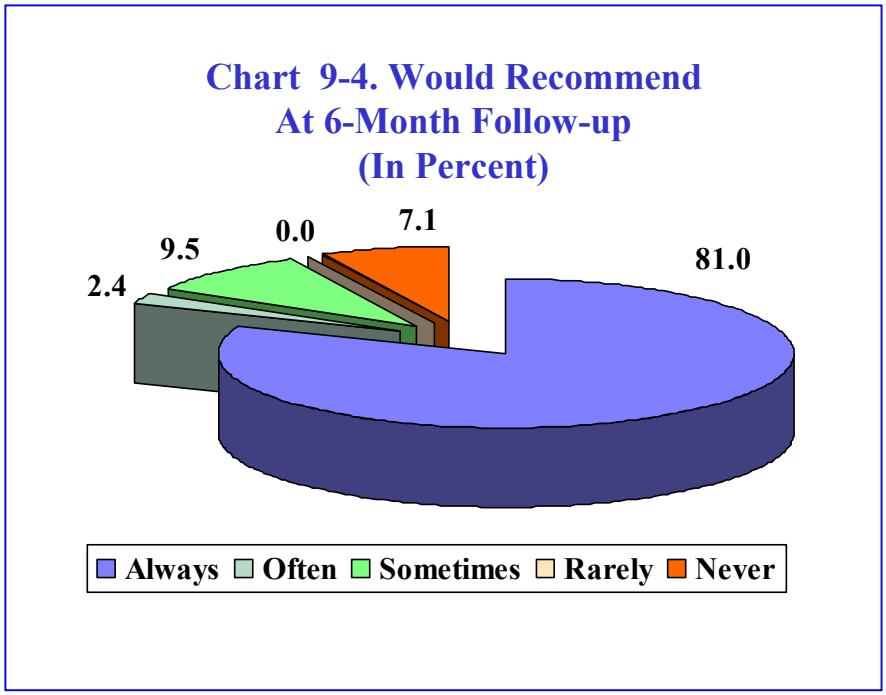


Chart 9-4. Would Recommend
At 6-Month Follow-up
(In Percent)
7.1
0.0
9.5
2.4
81.0
Always
Often
Sometimes
Rarely
Never

TAB 10. MINIMAL INTERVENTION PROGRAM

Key questions addressed in this section:

What are the demographic characteristics of participants?
What are the gambling activities of participants?
What are the outcomes of the minimal intervention program?

Synopsis

The minimal intervention program was developed to focus on two specific populations. First, were those individuals who were problem gamblers, but who's gambling situation would not be clinically classified as pathological gambling. The second group the program was intended to serve were those problem and pathological gamblers who were either home-bound or lived in such rural areas of the state that attending traditional brick and mortar outpatient programs was not practical. Levels of participation in the program were less than expected and exposure of the availability of the program was viewed to be limited. On average, the number of diagnostic criteria reported for participants in this program was lower than that for clients in the regular programs. Nonetheless, findings at 12-months revealed good success rates and positive participant satisfaction.

Key Findings

- ❑ Primary gambling activities are video poker and slot machines
- ❑ Primary gambling takes place at lottery retailer and IGCs
- ❑ Demographic and gambling problem severity are similar to those of clients entering the traditional programs
- ❑ 66.7% reported either no, or less, gambling 12-months post enrollment
- ❑ Participant satisfaction with the program was positive

*** Findings based on***
34 Gambler Enrollments
29 Gambler Discharges
24 12-Month Follow-up

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).

GEAR utilizes 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 is strongly aligned with that of Motivational Interviewing, and is derived from the research of Dr. David Hodgins of Calgary, Canada.

The program is operated under a separate contract with the State by Cascadia Behavioral Healthcare, Inc. located in Portland Oregon. Historically, the program has not

received as many referrals as expected and those who have been referred to the program, by-in-large, have had serious problems with gambling and have been diagnosed as pathological gamblers.

Demographically, the clients enrolling in GEAR have been quite similar to those enrolling in the regular programs in respect to age, education, ethnicity, and other measures. Although the number of participants reported to the contractor as enrolled during the period was small (n=34), there were some differences.

Females were significantly[79] more likely to enroll in GEAR than males when compared to the gender mix of clients enrolling in the traditional outpatient programs. A greater portion of the females enrolling in GEAR reported being married than those in traditional programs, and also reported a higher frequency of having children at home. Conversely, males were more likely to report living alone than their cohorts in the traditional programs.[80]

There was a tendency for the GEAR clients to report a higher frequency of slot machine gambling than those in the traditional programs along with a corresponding tendency to report gambling in IGCs or casinos. Although the distance traveled to gamble was further, it was not significantly different than that for those in the traditional programs.

The number of DSM diagnostic items endorsed was 6.1, that was slightly lower than then number endorsed by the clients in the regular programs.

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[79] chi square < .05

[80] Due to the small n, the statistical significance of these differences should be approached with caution.

At 12-month follow-up, approximately one-quarter of the participants reported no gambling, 57.2% reported less gambling, 14.3% were gambling at about the same rate, and 14.3% were gambling more than before enrollment.

At follow-up, 68.2% reported that the goals they had set for themselves regarding gambling were appropriate, and 68.2% also felt the program was helpful.

These findings are very encouraging when viewed in the context that the severity of the problems reported by the participants was greater than initially expected. The most helpful elements of the program, as reported at 12-months by clients, were quite similar to those found for the traditional outpatient programs and included having the counselor to talk with during the process and having the workbook increased awareness of the extent of the problem and was useful for review.

TAB 10. GEAR GAMBLER CLIENT DEMOGRAPHICS - TABLES & CHARTS

Table 10-1. Average Age of Gamblers By Gender (In Years)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
34	44.5	8.4	12	46.9	7.0	22	43.1	8.8

Table 10-2. Race/Ethnicity of Gamblers (In Percent of Distribution)

Race/Ethnicity	All	Males	Females
White	91.2	91.7	90.9
Native American	5.9	0	9.1
Hispanic	2.9	8.3	0
Black	0	0	0
Asian	0	0	0
Southeast Asian	0	0	0
Other	0	0	0
Total	100.0	100.0	100.0

Table 10-3. Average Number of Years Education Gamblers - By Gender (In Years)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
32	12.7	2.7	12	13.3	3.0	20	12.3	2.4

Table 10-4. Marital Status of Gamblers - By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Married	50.0	41.7	54.4
Divorced	17.6	16.7	18.2
Separated	8.8	25.0	0
Never Married	11.8	8.3	13.6
Living As Married	5.9	0	9.1
Widowed	2.9	0	4.5
Missing Data	2.9	8.3	0.2
Total	100.0	100.0	100.0

Table 10-5. Living Situation of Gamblers - By Gender (In Percent of Distribution)			
Living Situation	**All**	**Males**	**Females**
Spouse with Children	32.4	16.7	40.9
Spouse/SO	32.4	33.3	31.8
Alone	20.6	41.7	9.1
Alone with Children	5.9	0	9.1
Parents/Relatives	2.9	8.3	0
Friends/Others	0	0	0
Institution/Group	0	0	0
Foster Parents	0	0	0
Missing Data	5.8		9.1
Total	100.0	100.0	100.0

Table 10-6. Household Size by Age Group By Gender				
	Under 6 Years Old	**6 – 17 Years Old**	**18 – 65 Years Old**	**Over 65 Years Old**
	n	**n**	**n**	**n**
	mean sd	**mean sd**	**mean sd**	**mean sd**
All	6	12	31	2
	1.5 0.5	2.0 0.7	1.7 0.7	1.0 0.8
Males	0	3	12	0
	0.0 0.0	2.3 0.5	1.4 0.5	0.0 0.0
Females	6	9	19	2
	1.5 0.5	1.9 0.7	1.9 0.8	1.0 0.0

Table 10-7. Housing Type By Gender (In Percent of Distribution)			
Housing Type	**All**	**Males**	**Females**
Own	55.9	41.7	63.6
Rent – No Subsidies	29.4	50.0	18.2
Other Situation/Not paying Rent	5.9	8.3	4.5
Rent – With Subsidies	2.9	0	4.5
Institution/Group Home	0	0	0
Homeless/Shelter	0	0	0
Unknown/Not Coded	5.9	0	9.2
Total	100.0	100.0	100.0

Table 10-8. Employment Status By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Full-Time	52.9	58.3	50.0
Not Employed – Looking	17.6	16.7	18.2
Not Employed – Not Looking	8.8	8.3	9.1
Part-Time	5.9	0	9.1
Irregular	5.9	8.3	4.5
Unknown/Not Coded	8.9	8.4	9.1
Total	100.0	100.0	100.0

Table 10-9. Employability By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Employable/Working	61.8	58.3	63.6
Temporary Layoff	8.8	8.3	9.1
Homemaker	5.9	0	9.1
Disabled	5.9	8.3	4.5
Student	2.9	0	4.5
Retired	2.9	0	4.5
Seasonal Worker	2.9	8.3	0
Incarcerated	0	0	0
Unknown/Not Coded	8.9	16.8	4.7
Total	100.0	100.0	100.0

Table 10-10. Average Annual Household Income of Gamblers By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
29	40627.60	22699.4	11	37727.30	14238.80	18	42400.00	26419.00

Table 10-11. Source of Income of Gamblers By Gender (In Percent)			
Income Source	**All**	**Males**	**Females**
Wages	64.7	66.7	63.6
Pension/Unemployment	14.7	16.7	13.6
Social Security	8.8	8.3	9.1
Alimony/Child Support	2.9	0	4.5
SSI - Federal	0	0	0
Welfare	0	0	0
Dividends/Interest	0	0	0
OSP State	0	0	0
Other	2.9	0	4.5
No Income	0	0	0
Unknown/Not Coded	6.0	8.3	4.7
Total	100.0	100.0	100.0

Table 10-12. Health Insurance By Gender (In Percent of Distribution)			
Status	**All**	**Males**	**Females**
Other Private	38.2	33.3	40.9
None	23.5	25.0	22.7
Blue Cross/Shield	23.5	25.0	22.7
MEDICARE	2.9	0	4.5
Other Public	2.9	8.3	0
OHP	2.9	0	4.5
VA	0	0	0
MEDICAID	0	0	0
CHAMPUS	0	0	0
Unknown/Not Coded	6.1	8.4	4.7
Total	100.0	100.0	100.0

GEAR Gambling Characteristics Tables & Charts

Table 10-13. Primary Gambling Preferences By Gender (In Percent of Distribution)			
Game	**All**	**Males**	**Females**
Video Poker	58.8	50.0	63.6
Slot Machines	20.6	16.7	22.7
Bingo	8.8	8.3	9.1
Video Line Games	5.9	8.3	4.5
Cards	0	0	0
Animals	0	0	0
Keno	0	0	0
Sports (not Lottery)	0	0	0
Breakopens/Scratch	0	0	0
Power Ball /Daily 4 /Mega Bucks	0	0	0
Dice	0	0	0
No Preference	5.9	16.7	0
Other/None	0	0	0
Total	100.0	100.0	100.0

Table 10-14. Primary Location for Gambling By Gender (In Percent of Distribution)			
Location	**All**	**Males**	**Females**
Lottery Retailer (Video)	64.7	66.7	63.6
Casino	23.5	16.7	27.3
Bingo Hall (Non Indian)	8.8	8.3	9.1
WWW/Internet/Phone	2.9	8.3	0
Food/Convenience Store	0	0	0
Track/Off Track Wagering	0	0	0
Restaurant/Pub (No VLT)	0	0	0
Family/Friend Home	0	0	0
Card Room - Public	0	0	0
Private Club	0	0	0
Other	0	0	0
Unknown	0	0	0
Total	100.0	100.0	100.0

Table 10-15. Distance Traveled to Primary Gambling Activity By Gender (In Miles)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
31	29.6	45.9	10	18.5	28.4	21	35.0	51.3

Table 10-16. Age of First Gambling Experience By Gender (In Years)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
34	26.2	9.3	12	21.8	10.0	22	28.6	7.9

Table 10-17. Age of Onset of Gambling Problems By Gender (In Years)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
32	38.2	8.4	10	39.8	6.3	22	37.5	9.1

Table 10-18. Total Problem Gambling Episodes By Gender								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
24	1.5	1.4	8	1.8	2.0	16	1.4	1.1

Table 10-19. Length of Current Problem Gambling Episode By Gender (In Months)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
32	4.7	4.5	12	6.2	4.8	20	3.8	4.0

Table 10-20. Average Number of Days Gambled in Past 30 Days By Gender At Admission (In Days)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
30	9.8	8.1	10	9.5	9.1	20	10.0	7.6

Table 10-21. Average Gambling Event Time By Gender (In Hours)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
31	4.1	2.2	11	3.5	1.5	20	4.4	2.4

Table 10-22. Average Daily Gambling Expenditure By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
28	559.8	819.3	9	335.0	329.3	19	666.3	950.1

Table 10-23. Gambling Pattern By Gender (In Percent)			
Pattern	**All**	**Males**	**Females**
Type 1 Regular	82.4	66.7	90.9
Type 2	0	0	0
Type 3	14.7	33.3	4.5
Other	0	0	0
Not Gambling	2.9	0	4.5

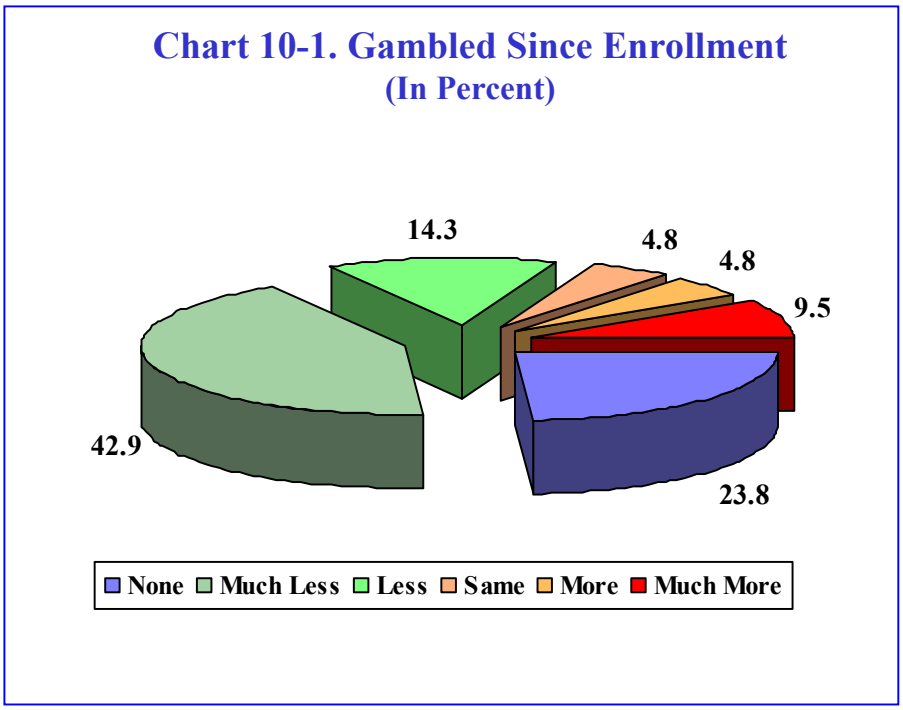
GEAR Gambling Consequences - Tables & Charts

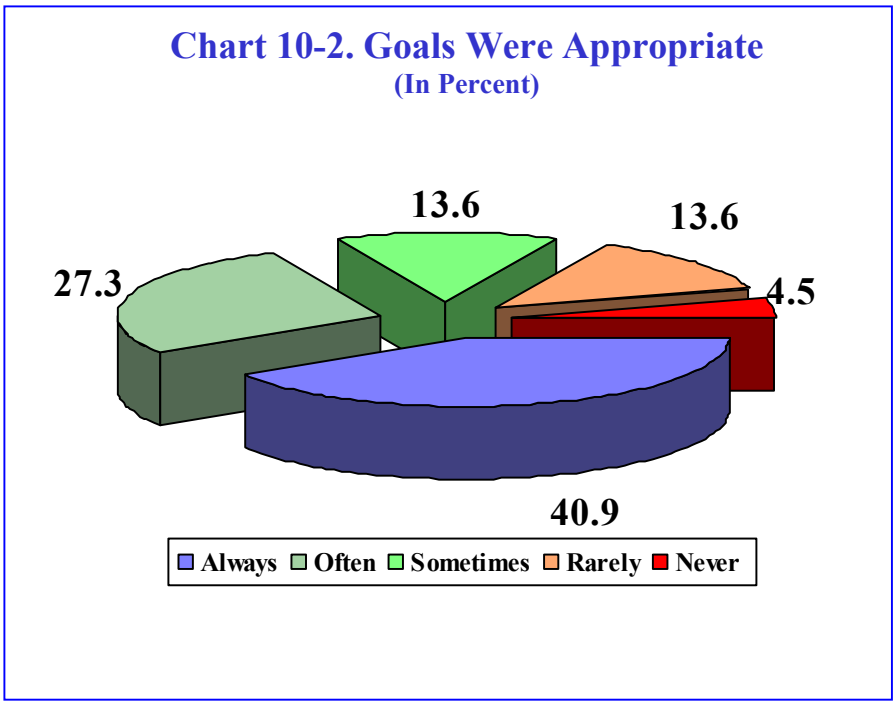
Table 10-24. Average Gambling Related Debt By Gender (In Dollars)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
27	19979.6	21955.2	9	17038.9	233495.2	18	21450.0	20989.2

Table 10-25. Frequency of Endorsement of DSM Items By Gender (In Percent)			
DSM Criteria	**All**	**Males**	**Females**
1. Preoccupation	86.7	80.0	90.0
2. Increasing amounts of money *	66.7	80.0	60.0
3. Unsuccessful efforts to control	93.3	100.0	90.0
4. Restless when cutting back *	66.7	80.0	60.0
5. Gambles to escape *	60.0	40.0	70.0
6. Chasing	86.7	100.0	80.0
7. Lies to conceal gambling	73.3	80.0	70.0
8. Commits illegal acts	13.3	20.0	10.0
9. Jeopardize or lost relationships *	26.7	40.0	20.0
10. Relies on others for money **	40.0	20.0	50.0

* p < .01 ** O < .05

GEAR Outcomes Reported at Twelve Months





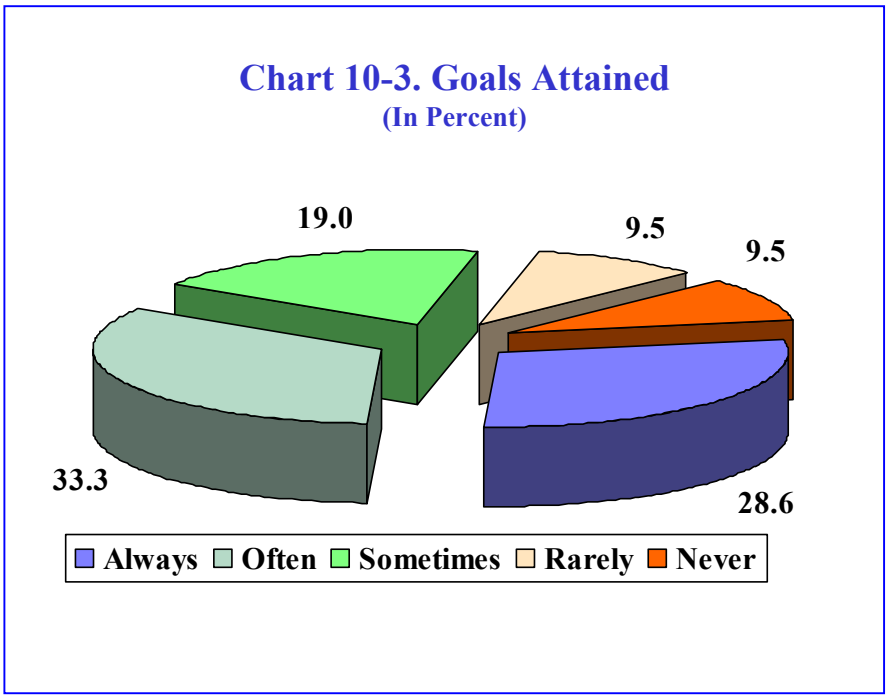


Chart 10-3. Goals Attained
(In Percent)
19.0
9.5
9.5
33.3
28.6
Always
Often
Sometimes
Rarely
Never

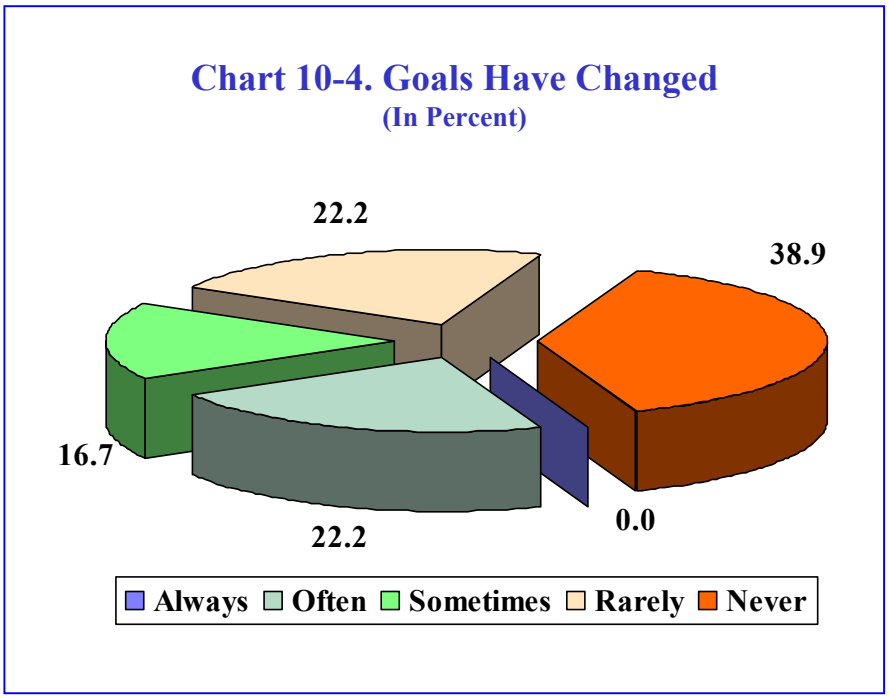


Chart 10-4. Goals Have Changed
(In Percent)
22.2
38.9
16.7
22.2
0.0
Always
Often
Sometimes
Rarely
Never

Chart 10-5. Program Was Helpful
(In Percent)

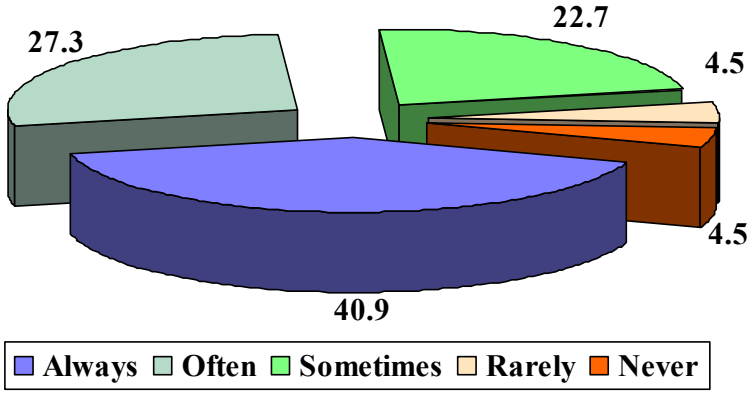
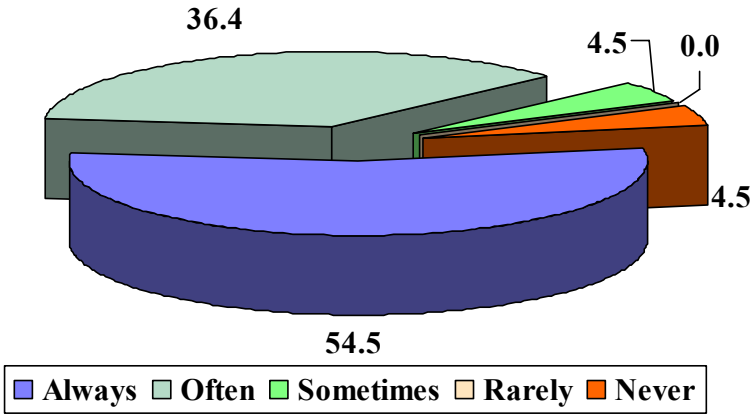


Chart 10-6. Would Recommend
(In Percent)



Tab 11. Prevention

Questions addressed in this section:

What was the design rationale for prevention services?
To what extent were prevention services funded?
What specific activities were undertaken?

Synopsis

DHS Problem Gambling Services orchestrated actions to prevent gambling-related problems, promote informed and balanced attitudes, and protect vulnerable groups. These actions included promoting healthy public policy and developing collaborative relationships between various stakeholder groups. Part of this activity included providing local governments with over $650,000 to develop and implement regionally specific prevention plans that included measurable goals and objectives. The prevention plans follow a public health model as a foundation. As a supplement to regional efforts, the Oregon Lottery developed and delivered a $600,000 statewide public awareness and educational campaign designed to provide clear and consistent messages regarding healthy and unhealthy gambling behavior. The combined efforts between state and local agencies generated thousands of calls to the Problem Gambling Help-Line, that produce approximately 2,500 referrals to problem gambling treatment programs per year (Oregon had a population of 3.42 million in 2003).

Funding

The State of Oregon invested approximately $1,300,000 into problem gambling prevention efforts during the 2002-2003 fiscal year. The Department of Human Services contracted with local county governments to provide $677,577 in regional problem gambling prevention services (20% of the DHS administered Gambling Treatment Funds). Additionally, the Oregon Lottery allocated approximately 10 percent of their marketing budget ($600,000) toward the production and purchasing of ads and educational materials addressing problem gambling.

Prevention and Outreach Overview

Problem gambling prevention programs are directed at avoiding or reducing the 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) six core prevention strategies (see Appendix A of this section for definitions).

Oregon Problem Gambling Services delivers prevention and outreach services by three separate, yet related administrative bodies:

Department of Human Services'(DHS) Problem Gambling Services orchestrates actions to prevent gambling-related problems, promote informed and balanced attitudes, and protect vulnerable groups. These actions include promoting healthy public policy and developing collaborative relationships between various stakeholder groups.

County Governments. Local governments develop and implement regionally specific prevention plans that include measurable goals and objectives. The prevention plans follow a public health model as a foundation. The activities described below under

“regional efforts”, offer an expanded description of the county government efforts that took place during the 2003 fiscal year.

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 "Play Responsibly" campaigns along with problem gambling awareness campaigns uses TV, radio, and print media.

Outreach

County governments' "gambling prevention funds" were used for either prevention or for outreach activities. Outreach activities include case finding among high-risk populations. Common outreach actions included screening for gambling problems within mental health programs, alcohol and drug abuse programs, corrections departments, and at-risk youth programs. Additionally, the Oregon State Lottery's "Play Responsibly" campaigns generate thousands of calls to the Problem Gambling Help-Line, that produce approximately 2,500 referrals to problem gambling treatment programs per year (Oregon has a population of 3.42 million).

Regional Efforts

Reports were collected from Oregon regions that provided problem gambling prevention or outreach activities from July 1, 2002 to June 30, 2003. This overview outlines gambling prevention and outreach activities that were described in reports to the State provided from the following regional service providers (usually county governments):

- Central Oregon (includes Deschutes, Jefferson, & Crook Counties)
- Clackamas
- Columbia-Clatsop
- Curry
- Douglas
- EOHSC (includes Hood River, Wasco, Sherman, & Gilliam Counties)
- Jackson
- Josephine
- Klamath
- Lane
- Lincoln
- Linn-Benton
- Marion
- Multnomah
- Washington
- Yamhill

Analysis of Accomplishments

Prevention:

The information collected for this section was from a review of the 2003 annual problem gambling prevention reports from the above 16 service providers. Because these reports had different authors, the level of service description varied greatly and created limitations in developing a comprehensive program description. One limitation was the ability to confidently classify activities into CSAP prevention strategies (for a detailed list of prevention efforts by CSAP strategy, please refer to Appendix B of this section). An attempt to group the activities into CSAP strategies yielded the description that follows.

The most popular CSAP strategy that appears to have been used is "information dissemination", comprising approximately 87% of all 163 prevention activities (Chart 11-1). Each of the 16 regions provided some type of information dissemination, including media efforts, presentations, youth awareness efforts, and materials provided for specified purposes/populations. Many of the information dissemination efforts involved developing or adapting information for specific population sets (youth, college students, senior citizens, and ethnic groups).

The second most utilized CSAP strategy appears to have been "community-based processes". Community needs assessments were conducted in two regions, and community forums were held in three regions. The most popular community-based process, used in seven regions, involved collaboration with partners or stakeholders; the efforts occurred by forming or participating in committees, and consulting or partnering with other providers. It is likely that additional regions conducted community-based processes in some form, but they did not account for such activities in their annual prevention reports.

Prevention education efforts were conducted in at least three Oregon regions. Many Oregon regions reported providing prevention education, however the information provided in their narrative suggested that many of these efforts were better classified as information dissemination. It is important to distinguish these two strategies; prevention education is two-way communication that aims to "affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities" while information dissemination is usually one-way communication aimed at increasing knowledge and awareness (Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies, 2002). The types of prevention education conducted in Oregon included folding gambling prevention into currently existing ATOD (alcohol, tobacco, and other drugs) curriculum, providing gambling education within the context of an ongoing family education effort, and a high school senior seminar experience.

There were two regions that provided gambling-free alternative activities; both regions offered a poster search activity for the 2003 Oregon Problem Gambling

Awareness Week. Since alternative activities are often expensive and are not proven effective as a stand-alone prevention strategy, it appears appropriate for regional providers use this type of strategy less often in their gambling prevention efforts.

Most of the six CSAP strategies in some way target individuals, families, and communities, and are primarily focused with changing attitudes, knowledge, skills, and/or behavior. Less well known are environmental strategies, that are different than the other CSAP strategies in that environmental strategies function to change the overall *context* in which gambling occurs.

The use of environmental strategies is widely held as a very effective means of prevention that has a far-reaching potential. This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the problem. There are many ways in which environmental strategies could successfully be conducted in Oregon to prevent problem gambling. Some environmental strategies that occurred in Oregon include: working with casinos to implement/change responsible gambling policies; working with regional Lottery retailers to enforce ID checks in preventing underage purchases; and informing law makers about the possible negative consequences of increasing gambling's availability (e.g., adding video slots or creating state operated casinos).

Other Activities:

It is important to recognize other efforts to reduce gambling related harm that were conducted throughout Oregon during the 2003 fiscal year. These activities included identification and referral, and the development or adaptation of evaluation components (for a detailed list of these efforts, please refer to Appendix C of this section).

One area of outreach that deserves to be recognized is that of problem identification and treatment referral. Eleven out of the 16 regions reported using some form of problem identification and referral to problem gambling treatment; many regions have successfully included a gambling screening tool to allied providers' intake process. Populations included in problem identification included: clients enrolled in alcohol and drug programs or mental health programs, corrections clients, economically disadvantaged individuals seeking public assistance, and family members of clients. Eight regions provided some form of problem identification and referral training in their areas.

Half of the regions reported having developed or adapted some form of evaluation component for their programs. Surveys were used to assess community knowledge and awareness, pre- and post-tests were used for youth to assess regional problem gambling activities, and various other evaluations were employed to assess knowledge, awareness, or program efficacy.

Future Directions

At present time there are no reported "best practices" in the field of gambling prevention. However, there are alcohol and drug abuse prevention programs whose efficacy is well documented. A strong case can be made that many of the practices and strategies proved effective for alcohol and drug abuse prevention could be successfully applied to the area of problem gambling.

In 2003, problem gambling prevention experts, under the guidance of Oregon Problem Gambling Services Manager Dr. Jeffrey Marotta, began to formulate a three-year strategic plan for Oregon problem gambling prevention efforts. This strategic plan

focuses on achieving prevention outcomes in each of the following areas: 1) service improvement and support; 2) research and data collection; 3) collaboration; and 4) skill and knowledge enhancement.

While recent budgetary shifts have slowed progress in implementing this plan, some parts of the strategic plan have already been implemented. For instance, in the "research and data collection" component, the 2003-2005 regional reporting forms have been modified to present a straight-forward categorization of efforts provided by CSAP strategy, in many ways similar to Appendix B of this report. Additionally, in the "collaboration" component, a team of regional providers and Jeffrey Marotta have been working with the Oregon Lottery on such topics as statewide responsible gambling efforts and National Problem Gambling Awareness Week. Finally, under "skill and knowledge enhancement" component, DHS has already organized thorough prevention training for regional providers so they may improve understanding and enhance prevention efforts in their areas.

While Oregon's problem gambling services is faced with continued budget uncertainty, all three of the administrative bodies addressing problem gambling (DHS, Lottery, and county governments) will maintain efforts to address problem gambling. Oregon hopes to establish itself as a nationwide leader in promoting healthy communities through programs aimed at reducing the harm caused by gambling.

Tab 11. - APPENDIX A

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) STRATEGIES

Information Dissemination
This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. [Note: Information dissemination alone has not been shown to be effective at preventing substance abuse.]

Education
This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Alternatives
This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to--or otherwise meet the needs usually filled by--alcohol and drugs and would, therefore, minimize or obviate resort to the latter. [Note: Alternative activities alone have not been shown to be effective at preventing substance abuse.]

Problem Identification and Referral
This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based Process
This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Environmental
This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

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

Tab 11. - APPENDIX B

Prevention Activities by CSAP Strategy and Oregon Region: July 1, 2002 – June 30, 2003

PREVENTION ACTIVITIES BY CSAP STRATEGY	REGION (S) PROVIDED	
INFORMATION DISSEMINATION		
Media Efforts		
Public service announcement (PSA) or advertisement (radio)	• Curry • Josephine • Washington	• Central Oregon • Lane
Public service announcement (PSA) or advertisement (print, billboards, bus, etc.)	• Curry • Multnomah	• Lane
Public service announcement (PSA) or advertisement (television)	• Central Oregon • Washington	• Josephine
Radio feature	• Central Oregon • Lane • Washington	• Jackson • Lincoln
Newspaper/Newsletter article	• Curry • EOHSC • Josephine • Lincoln	• Central Oregon • Jackson • Lane
Television/public access feature	• Douglas • Lincoln	• Lane • Washington
Regional website information	• Lane	• Lincoln
Presentations		
Local government (e.g., board of commissioners)	• Douglas • Lane • Washington	• Josephine • Lincoln
Business / credit counseling programs	• Douglas	• Jackson
Employee assistance programs (EAPs)	• Douglas • Multnomah	• Jackson
Corrections / legal professionals (P&P, drug court, judges, attorneys, etc.)	• Central Oregon • Jackson • Multnomah	• Douglas • Klamath
Social service agencies (AFS, etc.)	• Jackson • Lincoln	• Lane • Multnomah

Prevention/treatment professionals (e.g., A&D and MH providers)	• Central Oregon • Jackson • Klamath • Lincoln • Multnomah	• Douglas • Josephine • Lane • Marion • Washington
Treatment clients (A&D, MH)	• Douglas • Lane	• Josephine • Washington
School & youth educators/counselors/ administrators	• Lane • Washington	• Marion • Yamhill
College students	• Central Oregon • Josephine • Multnomah	• EOHSC • Linn-Benton • Washington
Senior citizen groups	• Jackson	
Community groups / coalitions	• Douglas • Lincoln	• Lane • Washington
Faith community	• EOHSC	
Medical community	• Douglas	
Native American community / casino	• Central Oregon • Lane	• Klamath • Lincoln
Parents/families	• Lincoln • Yamhill	• Linn-Benton
Latino community	• Lane	• Multnomah
African-American community	• Multnomah	
Community event/rally: Oregon Problem Gambling Awareness Week	• Lane	
Unspecified population	• Clackamas	• Curry
Youth: Outreach, Presentations (knowledge/awareness)		
Use/adaptation of video	• Columbia-Clatsop	
Presentations: middle school youth	• Lane	• Lincoln
Presentations: high school youth	• Lane • Multnomah	• Marion • Yamhill
Presentations: at-risk youth	• Jackson • Lane • Yamhill	• Klamath • Marion
School conference or fair	• Lane • Washington	• Linn-Benton
Other/Unidentified youth efforts	• EOHSC • Yamhill (to Boy Scouts)	• Josephine
Materials Developed/Provided for Specified Purposes or Populations		
Regionally specific informational materials developed	• Jackson • Lane	• Klamath • Linn-Benton

	• Washington
Materials designed by gambling clients	• Curry (poster)
Targeted educational packets produced	• Central Oregon
Education notebook developed for Lottery retailers	• Linn-Benton
Materials produced or distributed for Oregon Problem Gambling Awareness Week	• Josephine • Multnomah • Lane • Washington
Local government proclamation developed	• Josephine • Lane
Information and materials provided at gambling-related movie screening	• Multnomah
Materials developed for business community / credit counseling programs	• Curry
Materials developed for school educators	• Lane
Criminal justice / public safety	• Central Oregon
Materials developed for prevention/ treatment professionals	• Lane
Materials developed for youth	• Lane
Medical community	• Lincoln
Materials developed/adapted in Spanish (Latino community)	• Lane • Multnomah • Linn-Benton • Washington
African-American community	• Multnomah
Information distributed at community event/fair	• EOHSC • Lane • Linn-Benton • Josephine • Lincoln • Washington
PREVENTION EDUCATION (changes skills, decision-making, judgment)	
Prevention education ATOD integration/curriculum	• Linn-Benton
Ongoing parenting classes/family education with gambling component(s)	• Linn-Benton • Marion
High school senior seminar experience	• Clackamas
ALTERNATIVE ACTIVITIES	
OPGAW poster search	• Clackamas • Lane
PROBLEM IDENTIFICATION & REFERRAL (to education)	
At-risk youth	• Marion
COMMUNITY-BASED PROCESSES	
Community needs assessment	• Central Oregon • Clackamas
Community forum	• Central Oregon • Lane • Josephine
Collaboration with prevention	• Clackamas • Jackson

partners/stakeholders	• Lane • Marion • Washington • Linn-Benton • Multnomah
Collaboration with Latino service providers	• Lane • Multnomah
Problem gambling issues committee	• Lane
SOCIAL POLICY & ENVIRONMENTAL APPROACHES	
None reported by regions. State efforts only.	

Tab 11. - APPENDIX C

OTHER PREVENTION/AWARENESS ACTIVITIES BY REGION PROVIDED

ACTIVITIES	REGION (S) PROVIDED	
Outreach: Identification & Referral to Treatment		
A&D/MH clients	• Curry • EOHSC • Lincoln • Multnomah	• Douglas • Jackson • Linn-Benton
Corrections / legal system clients	• Jackson	• Lincoln
Economically disadvantaged	• Columbia-Clatsop	
Family members of clients	• Douglas	
Problem identification & referral training	• Curry • EOHSC • Lane • Multnomah	• Douglas • Josephine • Linn-Benton • Yamhill
Evaluation: Component Developed/Adapted for Specified Populations		
Community surveys	• Lane	• Lincoln
Professionals/clinicians	• Josephine	• Lane
Lottery retailers	• Linn-Benton	
Educators	• Columbia-Clatsop • Lincoln	• Lane • Yamhill
Parents/families	• Lincoln • Yamhill	• Linn-Benton
Youth pretests/posttests	• Columbia-Clatsop • Lincoln • Yamhill	• Lane • Linn-Benton • Marion
Collective population or unidentified	• Josephine	• Washington
Services Targeting Special Populations (also listed in prevention table above)		
Youth		
College students	• Central Oregon • Josephine • Multnomah	• EOHSC • Linn-Benton • Washington
Senior citizens	• Jackson	
African-American community	• Multnomah	
Latino community	• Lane • Linn-Benton	• Multnomah • Washington
Native American community		

TAB 12. HELPLINE

Questions addressed in this section:

What was the design rationale for Helpline?
To what extent was the Helpline accessed by callers?
What was the level of referrals made from the Helpline to treatment programs?

Synopsis

The Helpline is a critical element of the problem gambling services system in Oregon. Staffed by qualified gambling counselors and co-located with one of the largest outpatient gambling treatment programs in the US, the service provides a highly unique set of features and benefits. Operating 24 hours per day, counselors at the Helpline provide crisis counseling, information, and referral. Those seeking treatment are provided with information about treatment along with the contact information for the closest treatment facility, or the GEAR project as appropriate. In addition to simply providing referral information, positive transfer of calls are made to the treatment center, and counselors conduct short-term follow-up with the caller to ensure they were able to make contact with the treatment center.

Key Findings[81]

- 4403 calls received
- 2292 referrals made
- 1561 referrals with consent to share critical information with treatment
- 749 confirmations by agencies of screening/assessment
- 203 three-way direct connect referrals
- 1163 referrals to Gamblers Anonymous

The Helpline is staffed by qualified gambling counselors who have hands-on experience within the problem gambling treatment setting. The Helpline is operational 24-hours per day, although the highest frequency of calls do come in during normal business hours. During the report period the Helpline reported 4,403 total calls received.

Helpline staff instituted a series of procedures to facilitate the positive referral of callers seeking treatment. These procedures consist of establishing a direct connection with the treatment agency that is most convenient to the caller by establishing a three-way connection with the caller, the Helpline counselor, and the treating agency. During the report period there were 203 such calls connected.

If the calls are received outside the normal operating hours of the preferred treating agency, the counselor requests and documents permission to transmit, by facsimile, pertinent caller information so the treating agency can establish contact with the caller during normal business hours. During the report period, 1,561 such referrals were initiated and 749 confirmations of callers making contact with the treating agency were confirmed.

The Helpline takes a final step in attempting to ensure the caller is connected smoothly with a local treating agency. This is done by first securing permission at the time of the initial

[81] *The information for this section was provided by ACES Meridian Gambling Helpline*

call for the counselor to call the caller back within approximately 72 hours. Approximately 78.6% of those requesting treatment (gamblers and family members) provide permission for the call back and of these, nearly 68% are contacted.

The Helpline also provides a large number (1,163) of referrals to Gamblers Anonymous or GamAnon.

As reported elsewhere in this report, the Helpline is the primary referral source for the treatment program, providing a critical, an indispensable link, between the statewide problem gambling services and responsible gambling advertising sponsored by the Oregon Lottery and the treatment programs. It also provides essential help for callers who are in crisis and suicidal, having made nine such saves during the report period.

TAB 12. HELPLINE – TABLES AND CHARTS

Table 12-1. Call Types

Category	Total
Gambler seeking treatment	1439
Family/friend seeking treatment	271
Inquiry about GA/GamAnon	243
Inquiry about lottery outcomes	139
Gambler seeking info-not treatment	356
Family/friend seeking info only	298
Caller "just wants to talk"	159
Suicidal	9
Agency contacting	179
GA contacting	10
Wrong number/hang-up	1127
Other	173
TOTAL	4403

Table 12-2. Referrals

Activity	Total
Referrals given to callers	2292
Direct (faxed) referrals to treatment	1561
Confirmation of referral by agency	749
Directly connected with agency	203
Permission to call back 72 hours	1344
Successful 72 hour call back	910
GA referrals	1163

Table 12-3. Incoming Calls by Month/Time									
Hours	**0-3**	**3-6**	**6-9**	**9-12**	**12-15**	**15-18**	**18-21**	**21-24**	
Month									**Total**
July	9	2	20	75	69	73	54	18	320
August	8	9	14	73	65	78	69	9	325
September	6	4	22	71	89	73	73	17	355
October	9	1	17	100	95	86	47	15	370
November	7	3	23	92	73	63	46	21	328
December	6	5	21	89	71	54	50	17	313
January	14	2	13	109	101	104	65	21	432
February	5	1	11	63	78	68	53	18	297
March	6	4	31	89	104	82	68	11	395
April	8	6	23	123	127	92	65	17	461
May	8	4	28	116	108	114	78	17	473
June	5	5	20	78	89	70	47	20	334
Total Calls	91	46	243	1078	1069	957	715	201	4403

Table 12-4. Referrals to Treatment by County					
Baker	6	Hood River	5	Polk	26
Benton	22	Jackson	141	Sherman	1
Clackamas	185	Jefferson	12	Tillamook	6
Clatsop	26	Josephine	35	Umatilla	37
Columbia	17	Klamath	24	Union	8
Coos	53	Lake	0	Wallowa	4
Crook	2	Lane	154	Wasco	6
Curry	7	Lincoln	28	Washington	245
Deschutes	71	Linn	65	Wheeler	0
Douglas	81	Malheur	3	Yamhill	32
Gilliam	0	Marion	311	G.E.A.R.	80
Grant	2	Morrow	2		
Harney	1	Multnomah	594		

TAB 13. RESPITE CARE

Questions addressed by this section:

What were the demographic characteristics of respite care clients?
What was the extent of utilization of respite care services?
What were the short-term outcomes of respite care?

Synopsis

Respite care facilities were located in Columbia and Josephine counties and were available to clients throughout the state. Clients enrolling in the respite care reported significantly greater symptomology relative to gambling problems than those clients in the outpatient programs. Nonetheless, demographic characteristics, including choices of gambling games and venues were quite similar to the general outpatient population. Although the small sample size precluded full statistical analysis, there was a finding that suggested respite clients were not returning to engage in a local outpatient treatment program or the statewide GEAR project.

Key Findings

- Respite clients reported significantly greater severity of gambling problems
- Demographic characteristic of respite clients were quite similar to other clients enrolled in outpatient programs.
- Average length of stay was 7.6 days
- Successful program completion rate was 85.7%

Findings based on
30 Client Enrollments
29 Client Discharges

Respite care was established in Columbia and Josephine Counties as regional short-term residential care for clients of the traditional outpatient treatment programs who were unable to achieve necessary stabilization within the outpatient setting for that level of care to be effective. Respite care is not viewed as being the same as residential care that is customarily viewed as being of longer duration.

In order for individuals to be eligible for 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 the short stay in respite care. During the period, 30 individuals were enrolled in respite - 23 from Columbia County and seven from Josephine. Of these 30, 46.7% were reported as being enrolled in an outpatient program during, or following their respite care. Of these 14, who were reported as being enrolled in an outpatient program, six were regular clients of the Columbia County outpatient program.

Eight of the 14 respite clients who were enrolled in outpatient care were discharged from that outpatient program. Of those, two (25.0%) were reported as

successfully completing their outpatient program following the respite care. Although these finding do not support the theory that individuals engaging in respite care will successfully engage in longer-term outpatient care and successfully complete that care, any conclusions should be view with a great deal of caution due to the very small sample size. Nonetheless, the respite programs reported that approximately 71.4% were referred to outpatient treatment, 10.7% to the GEAR program, and 7.1% to residential care.[82]

Demographically, clients enrolling in respite care were quite similar to those enrolling in the outpatient programs.[83] [84] Nonetheless, the average number of DSM criteria endorsed by the clients enrolling in respite care was 9.1 that was significantly higher [85] than the average reported in Tab 7 for the general outpatient population that was 7.6.

Lag time from initial call to first availability of a bed was 6.0 days while the lag between first call and enrollment was 7.0 calendar days (5.9 work days).

The average length of stay (LOS) was slightly higher than expected at 7.6 days (sd = 6.8 days). Eleven of the clients remained in respite care longer than 6 days with the longest reported LOS of 29 days. Nearly 86% of the clients enrolling in respite care successfully completed that treatment effort.

Due to the very small sample size, no tables or charts are provided in support of this section of the report.

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[82] These referrals may have been to an out-of-state facility or possibly to in-state facilities for co-occurring mental health or substance abuse problems.
[83] The small sample size precluded statistical comparison between respite and outpatient clients for most of the demographic data points.
[84] Unfortunately, the Josephine County respite program data contained a large number of missing fields that further precluded meaningful statistical analysis of the demographic information.
[85] t test $p < .01$

TAB 14. EVALUATION METHODS & DATA CAPTURE RATES

Questions addressed by this section:

What was the evaluation protocol?
How successful was the protocol in collecting data?

Synopsis

The same basic evaluation protocol has been in place since 1993 when the first gambling treatment pilot projects were evaluated by the contractor, although the survey/interview schedule has progressively become more sophisticated as the available knowledge base regarding the treatment of pathological gambling has grown. Follow-up of those who successfully complete their treatment program is conducted at six and twelve months post discharge for both gambler and family clients. Follow-up for non-completers is conducted at 90 and 180 days post discharge. Although adjusted completion rates have increased during the report period, there are yet problems with the treatment programs collecting sufficient contact information for follow-up. Nonetheless, data collected at follow-up is considered to be representative of the treatment population since there are no apparent characteristics that would suggest differences between those who provide consent for follow-up and those who do not.

Key Findings

- 65.2% of gamblers provide consent to participate in follow-up
- 53.7% of family clients provide consent to participate in follow-up
- The rate of consent for follow-up is no different among those who complete and those who do not complete their course of treatment.
- Successful follow-up rates are less for non-completers
- Adjusted treatment completer follow-up rates are above 70%

The datasets for the program evaluation are discussed in more detail in the preceding sections of this report. At admission, the dataset consists of a records abstracting form, a self-report survey, and a locator form. At discharge, only a self-report survey is to be administered by the treatment agency. The follow-up dataset consists of a modified survey/interview that encompasses both the basic demographic questions abstracted at enrollment and the key outcomes indicators recorded at admission by the self-report.

Follow-up is conducted at 90 and 180 days for those gamblers and family clients who do not complete their planned course of treatment. For those who successfully complete treatment, follow-up is conducted by the evaluator at six and twelve months post discharge. Follow-up is only conducted with clients who have provided written, informed consent at enrollment.

Follow-up consists of a minimum of two first class mailings to the client followed by a minimum of five telephone calls on different days and during differing time blocks (morning, afternoon, evening, and weekends). Failure of the mailings or phone calls[86] to achieve a response from the client results in calls being made to family members or close

[86] If the client can be contacted by telephone the survey is conducted as an interview.

associates whom the client has identified for the locator form. These locator sources are exhausted before the case is considered a failure to contact within the scope of the protocol.

The locator form was first introduced during FY 01-02 and was shortened at the request of the treatment providers during the current report period. Nonetheless, attaining completed locator forms from the treatment agencies has been problematic as can be seen in the following tables. Without adequate locator information, follow-up can be difficult at best, and in some situations, nearly impossible with limited information.

Tracking those who do not complete their prescribed treatment plan has several pitfalls. First, many of the clients only show up at the treatment program for one or possibly two sessions and when follow-up contact is made they report that they either never enrolled in the program, or they never received services from the program and refuse to participate in the interview. The second problem is that often it is difficult for the programs to provide the evaluator with discharge information until well after the 90-day follow-up window has passed. Finally, for these individuals, who may show only one or two times, completing all the necessary paperwork, including the locator form, is not accomplished and once the individual has left against staff advice it is usually extremely difficult to collect any information.

The minimum target rate for follow-up completion for all categories (completers, non-completers, gamblers, and family clients) is 70%. Due to the difficulty associated with obtaining meaningful locator information from treatment agencies, the successful program completion rates are shown in the accompanying tables by two percentages. The first percentage is the adjusted follow-up completion rate which removes cases from the formula

that are represented by no locator information, or when the information is received too late for the follow-up. This rate more aptly addresses the contractor's efforts in attaining follow-up.

The second rate provided, is the "raw" rate calculated by dividing the number of completed surveys/interviews by the total number of clients in the follow-up (excluding those still actively being tracked within the window).

Aggressive attempts are made to track clients for whom adequate locator information has not been provided. This includes written and follow-up verbal request to the treating agencies for locator information when no, or incomplete, locator forms have been received with the enrollment packages. For the most part, agencies do share what contact information they have on record (with the signed consent), but in most situations, the agencies do not have complete contact information.

Regardless, mailings and calls are made to the last known addresses of clients for whom locator information is not received. Although this greatly increases the level of activity for the contractor it occasionally results in a completed interview/survey.

Due to these problems, a revision to the protocol has been implemented for FY 03-04 that focus on a randomized sample for follow-up so that more rigorous activity can be targeted at a smaller number of clients.

TAB 14. EVALUATION PROTOCOL – TABLES AND CHARTS

Table 14-1. Program Completion Status vs. Informed Consent for Follow-UP

Client and Status	n	Percent
Enrollment		
Gamblers With Consent	983	65.2
Gamblers Without Consent	525	34.8
Family With Consent	157	53.0
Family Without Consent	139	47.0
Discharge Status		
Gambler Completers With Consent	144	62.6
Gambler Completers Without Consent	86	37.4
Gambler Non-Completers With Consent	500	62.9
Gambler Non-Completers Without Consent	295	37.1
Family Completers With Consent	30	57.7
Family Completers Without Consent	22	42.3
Family Non-Completers With Consent	70	52.2
Family Non-Completers Without Consent	64	47.8

Table 14-2. Gambler Non-Completers 90 Day Data Capture Rates		
Case Status at Closing of Tracking Window	**n**[87]	**Percent**
Adjusted Follow-Up Completion Rate[88]		48.7
Successfully Completed	116	12.4
Failed as per protocol (no contact)	65	6.9
Data received too late for tracking	362	38.6
No locator information received from program	259	27.6
Re-enrolled, not tracked	44	4.7
Client claims no services received – unable to respond	35	3.7
Consent for follow-up retracted	27	2.9
Individual claims never enrolled – unable to respond	15	1.6
Phone bad – no returned mail	12	1.3
Client refused to provide locator information	2	0.2
Mentally/physically unable to complete survey	1	0.1
Family contacted – client location unknown	1	0.1
Total cases within 90-day window	939	

[87] The numbers presented in this column of all the tables in this section will not equal the numbers for discharges reported in the first table due to the extended time frame of the data collection window.

[88] Calculation of this rate removes cases from the equation for which the evaluator had little, or no, control. Includes the categories of "Data received too late for tracking," "No locator information received," "Client claims no services received – unable to respond to survey/interview," "Individual claims never enrolled – unable to respond to survey/interview," "Consent retracted," "Client refused to provide locator information," "Re-enrolled – same episode of care – not tracked."

Table 14-3. Family Non-Completers 90 Day Data Capture Rates		
Case Status at Closing of Tracking Window	**N**	**Percent**
Adjusted Follow-Up Completion Rate		50.0
Successfully Completed	12	8.8
Failed as per protocol	8	5.9
No locator information received from program	70	51.5
Data received too late for tracking	35	25.7
Individual claims never enrolled – unable to respond	5	3.7
Consent for follow-up retracted	4	2.9
Client claims no services received – unable to respond	2	1.5
Total cases within 90-day window	136	

Table 14-4. Gambler Non-Completers 6-Month Capture Rates		
Case Status at Closing of Tracking Window	**n**	**Percent**
Adjusted Follow-Up Completion Rate		61.0
Successfully Completed	213	22.7
Failed as per protocol	55	5.9
No locator information received from program	252	26.9
Data received too late for tracking	216	23.0
Consent for follow-up retracted	61	6.5
Re-enrolled, not tracked	44	4.7
Client claims no services received – unable to respond	43	4.6
Individual claims never enrolled – unable to respond	22	2.3
Phone bad – no returned mail	13	1.4
Client refused to complete locator	7	0.7
Mentally/physically unable to complete survey	7	0.7
Family contacted – client location unknown	3	0.3
Deceased	1	0.1
Other	1	0.1
Total cases within 6-month window	938	

Table 14-5. Gambler Completers
6-Month Capture Rates

Case Status at Closing of Tracking Window	n	Percent
Adjusted Follow-Up Completion Rate		86.0
Successfully Completed	178	44.3
Failed as per protocol	2	0.5
No locator information received from program	127	31.6
Data received too late for tracking	49	12.2
Re-enrolled, not tracked	15	3.7
Consent for follow-up retracted	15	3.7
Family contacted – client location unknown	7	1.7
Phone bad – no returned mail	5	1.2
Mentally/physically unable to complete survey	2	0.5
Individual claims never enrolled – unable to respond	1	0.2
Deceased	1	0.2
Total cases within 6-month window	402	

Table 14-6. Family Non-Completers
6-Month Capture Rates

Case Status at Closing of Tracking Window	n	Percent
Adjusted Follow-Up Completion Rate		60.3
Successfully Completed	35	25.5
Failed as per protocol	5	3.6
Data received too late for tracking	24	17.5
Phone bad – no returned mail	1	0.7
No locator information received from program	48	35.0
Consent for follow-up retracted	16	11.7
Individual claims never enrolled – unable to respond	5	3.6
Client claims no services received – unable to respond	2	1.5
Mentally/physically unable to complete survey	1	0.7
Total cases within 6-month window	137	

Table 14-7. Family Completers 6-Month Capture Rates		
Case Status at Closing of Tracking Window	**n**	**Percent**
Adjusted Follow-Up Completion Rate		90.7
Successfully Completed	39	39.8
Failed as per protocol	0	0
Data received too late for tracking	15	15.3
No locator information received from program	39	39.8
Consent for follow-up retracted	3	3.1
Re-enrollment – not tracked	1	1.0
Mentally/physically unable to complete survey	1	1.0
Total cases within 6-month window	98	

Table 14-8. Gambler Completers 12-Month Capture Rates		
Case Status at Closing of Tracking Window	**n**	**Percent**
Adjusted Follow-Up Completion Rate		77.7
Successfully Completed	139	36.5
Failed as per protocol	6	1.6
No locator information received from program	161	42.3
Data received too late for tracking	25	6.6
Consent for follow-up retracted	25	6.6
Re-enrolled, not tracked	14	3.7
Individual claims never enrolled – unable to respond	1	0.3
Phone bad – no returned mail	4	0.1
Mentally/physically unable to complete survey	2	0.5
Family contacted – client location unknown	2	0.5
Deceased	2	0.5
Total cases within 6-month window	381	

Table 14-9. Family Completers
12-Month Capture Rates

Case Status at Closing of Tracking Window	n	Percent
Adjusted Follow-Up Completion Rate		82.6
Successfully Completed	38	39.6
Failed as per protocol	1	1.0
No locator information received from program	43	44.8
Data received too late for tracking	7	7.3
Consent for follow-up retracted	4	4.2
Individual claims never enrolled	1	1.0
Re-enrollment – not tracked	1	1.0
Mentally/physically unable to complete survey	1	1.0
Total cases within 6-month window	96	

TAB 15. ORS FOR FUNDING & PROGRAM

This section includes a brief summary of the Oregon Revised Statutes (ORS) that enacts the problem gambling treatment services (ORS 461.549) and the funding source for the services (ORS 409.435). The actual ORS are available at http://landru.leg.state.or.us/ ors/409.html and http://landru.leg.state.or.us/ ors/461.html.

Chapter 409 — Department of Human Services — 2003 EDITION

GAMBLING ADDICTION PROGRAMS

409.430 Gambling addiction programs; advisory committee.

(1) The Department of Human Services, in collaboration with county representatives, prior to January 1, 2000, shall develop a plan for the administration of the statewide gambling addiction programs and delivery of program services.

(2) The Department of Human Services may appoint an advisory committee or designate an existing advisory committee to make recommendations to the department concerning:

(a) Performance standards and evaluation methodology;

(b) Fiscal reporting and accountability;

(c) Delivery of services; and

(d) A distribution plan for use of available funds.

(3) The distribution plan for the moneys available in the Problem Gambling Treatment Fund shall be based on performance standards.

(4) The Department of Human Services may enter into an intergovernmental agreement or other contract for the delivery of services related to programs for the prevention and treatment of gambling addiction and other emotional and behavioral problems related to gambling.

(5) Before entering into an agreement or contract under subsection (4) of this section, the Department of Human Services must consider the experience, performance and program capacity of those organizations currently providing services. [1999 c.985 §3]

409.435 Problem Gambling Treatment Fund.

(1) There is established in the State Treasury, separate and distinct from the General Fund, the Problem Gambling Treatment Fund. All moneys in the Problem Gambling Treatment Fund are continuously appropriated to the Department of Human Services to be expended for programs for the prevention and treatment of gambling addiction and other emotional and behavioral problems related to gambling and for the administration of the programs.

(2) The Problem Gambling Treatment Fund shall consist of:

(a) The net proceeds from the Oregon State Lottery allocated to the fund under ORS 461.549;

(b) Moneys appropriated to the fund by the Legislative Assembly; and

(c) Interest earnings on moneys in the fund. [1999 c.985 §2]

Chapter 461 — Oregon State Lottery

2003 EDITION

461.549 Use of video lottery proceeds for treatment of gambling-related behavioral problems.

(1) The Legislative Assembly finds that emotional and behavioral problems related to gambling may impose additional costs on state government and on the state economy, such as additional mental health expenditures, increased law enforcement costs and lost economic output. The use of a portion of the net receipts from video lottery games to pay the costs of preventing and treating emotional and behavioral problems related to gambling promotes the creation of jobs and this state's economic development by offsetting and treating the negative economic consequences of such behavior.

(2) In each fiscal quarter, commencing with the fiscal quarter beginning July 1, 2001, there is allocated from the Administrative Services Economic Development Fund to the Problem Gambling Treatment Fund established by ORS 409.435 an amount of not less than one percent of the moneys transferred from the State Lottery Fund to the Administrative Services Economic Development Fund during that fiscal quarter. [1995 c.814 §1; 1999 c.985 §1]

Note: See note under 461.544.

Note: Section 6, chapter 732, Oregon Laws 2003, provides:

Sec. 6. Notwithstanding ORS 461.549, there is allocated for the biennium beginning July 1, 2003, from the Problem Gambling Treatment Fund, to the Department of Human Services, for distribution to counties for treatment of gambling addiction, the amount of $5,600,000. [2003 c.732 §6]

TAB 16. SUMMARY

Reports for the state-wide problem gambling services system have been prepared since 1995 in an effort to document both the level of effort expended as well as the outcomes of the programs. These reports have chronicled both the development of the system, and the challenges faced. Since 1995 the problem gambling services have faced closure due to lack of funding three times. As discussed in Tab 1, these were due to the initial Oregon Supreme Court Ruling, a simple short-fall of funding, and as this report is being written, a complete loss of funding due to legislative acts associated with a severe economic situation.

Taking the funding issue aside, the increase in utilization of the problem gambling treatment services over the past eight years has been nothing short of phenomenal. Looking at this increase in utilization could be interpreted as an increase in the incidence of problem and pathological gambling. However, replicated prevalence studies suggest that the prevalence has not increased, but most likely the ongoing efforts of the Oregon Lottery to effectively advertise the availability and effectiveness of treatment, coupled with the prevention and outreach efforts of the problem gambling services are most responsible for these increases. In fact, the earliest empirically based projections for target enrollment levels made in 1997 and revised in 2001 in concert with the prevalence studies suggest that enrollments are mid-range with the projections and should be expected to continue to increase for the next several years.

Nonetheless, common sense would suggest that expansion of gambling activities including more IGCs, more Lottery VLTs, and a potential shift to line games on the Lottery VLTs will increase the incidence of problem and pathological gambling. From a public

policy perspective, the consistent and uninterrupted deployment of an effective statewide treatment and prevention system should be a paramount importance. Utilizing recent national estimates[89] and the most recent prevalence rates in Oregon,[90] it is estimated that the total social costs of problem and pathological gamblers is approximately $361 million[91] for Oregonians.

Findings presented in this report strongly indicate a problem gambling services system that is successful in both encouraging problem and pathological gamblers to seek treatment as well as efficiently providing effective services. With a very low average per case costs, strong successful outpatient completion rates, and very good abstinence rates at follow-up, the system certainly supports sound public policy in keeping the social-economic and personal emotional costs of problem and pathological gambling in check.

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[89] See Grinols, E., (2004). Gambling in America: costs and benefits. Cambridge University Press. p176 that estimates the social cost per pathological gambler at $11,304 and that per problem gambler at $3,222.

[90] See Volberg, R. (2001). Changes in gambling and problem gambling in Oregon.; Moore, T. (2001). The prevalence of disordered gambling among adults in Oregon: a secondary analysis of data. Both published by the Oregon Gambling Addiction Treatment Foundation and available on web at www.gamblingaddiction.org. Based on current population estimates by the Bureau of Census, the approximate number of adult problem gamblers in Oregon is 35,800 and the number of pathological gamblers are estimated at 23,000.

[91] This is derived by multiplying the estimated number of problem gamblers by $3,000 and the estimated number of pathological gamblers by $11,000.