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

Gambling Treatment Programs Evaluation Update - 2002

July 1, 2001 Through June 30, 2002

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EXECUTIVE SUMMARY

During the report period, the gambling treatment and prevention programs in Oregon underwent significant change. Under the leadership of a newly appointed gambling services manager, a comprehensive plan was initiated that greatly expanded prevention and outreach efforts while supporting the transition to a more efficient treatment delivery mechanism based on a fee-for-service reimbursement. Due in major part to these changes, the enrollment of gambler clients increased nearly 40% and that for family clients approximately 66% over previous year enrollments. The total number of gambler clients enrolling in the 28 programs in the state was 1380 while 272 family members were enrolled in family specific counseling programs. Nearly 34,000 hours of gambling treatment services were delivered from July 1, 2001 to June 30, 2002.

In addition to the innovative prevention and outreach efforts, two short-term residential respite programs were implemented, a self-paced and home-based intervention program, and significant enhancements to the statewide Helpline.

Approximately 28% of those enrolling accessed the system through the Helpline. Approximately 10% came to the programs through recommendations of a past or current program participant and another 10% upon the recommendation of a family or friend. One of the goals of the treatment system was to ensure that treatment was available in a timely manner. Commendably, the average number of work days between first call to a program and first available appoint was less than four days and the reported average commute time to treatment was only 25.5 minutes.

The average age of gamblers enrolling in treatment was 43.4 years and males were significantly more likely to be younger than females. Males comprised approximately 53.4% of the gambler clients and only 30.5% of the family clients. Slightly over 90% of the clients were White.

The primary gambling activity of both males and females was video poker (74.1%) followed by slot machines (10.0%), cards (5.2%), betting on animals (1.6%), Keno (1.5%), and bingo (1.4%). Approximately 69.5% indicated their primary gambling was at a lottery retailer and 21.8% at a casino or Indian gambling center. The average distance traveled to gamble was 13.3 miles. The average gambling related debt was $22,840 with several clients reporting debts well over $100,000. The average annual household income was $36,246. Males were significantly more likely to report higher annual household incomes, yet the difference in the amount of gambling related debt was not significant between males and females. Over 71% of the gambler clients reported they were employed full-time and approximately 41% reported being married.

On average, problem gambling treatment consisted of 13 individual and/or group counseling sessions that took place over a four month period. The average cost for treating an individual with a gambling problem was $715. For clients classified as "successful completions," on average, treatment consisted of 25 sessions occurring over an eight and a half month period and cost $1439.

It is estimated that problem gambling treatment in Oregon has an approximate efficacy rate of 75%. At the time of discharge for those clients who successfully completed treatment, 98.1% reported either abstinence (71%) or reduced (27.1%) gambling. At six-months post-discharge, 89.9% reported either abstinence (46.2%) or reduced gambling (43.7%) when compared to before treatment. A similar rate of abstinence and reduced gambling was reported at 12 months post-discharge.

Nearly 95.5% of the clients were willing to recommend the programs to others. The most helpful elements of the treatment were gaining a better understanding of themselves and their relation to gambling; learning alternative ways to solve problems; and being able to share the experience with peers under the direction of skilled counselors.

Approximately 70% of those problem gamblers who enroll do not complete their full course of prescribed treatment. Nonetheless, follow-up data indicated that 37% of these clients reported no gambling at 90 days and an additional 29% reported gambling much less than before treatment. Interestingly, those who left treatment before completing the entire program were significantly more likely to report more severe symptomology than those who remained in treatment longer.

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INTRODUCTION

This report has been prepared as an annual update of the activities of the publicly funded gambling treatment programs within the State of Oregon. The report focuses on treatment program activities during the fiscal year with limited comparisons to prior years.[1]

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 26 outpatient programs open and within the past year the State had funded two short-term residential, or respite, programs for pathological gamblers[2] as well as field tested a home-based program with limited telephone access to qualified gambling counselors.

[1] Recent prior year reports are available from the author via email. Earlier reports are also available for a nominal copying fee.
[2] A third respite program was slated for opening in the summer of 2002.

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 below.

Gambling Opportunities

Oregon, like most states, has dealt with illegal and gray gambling[3] 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.

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

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

In 1984, the Oregon State Lottery was created by a vote of the people through the initiative process and passed by a margin of two to one. The Lottery is governed by a five-member governor-appointed Commission that is approved by the State Senate. The Lottery's statutory mandate is to "produce the maximum amount of net revenues to benefit the public purpose …commensurate with the public good."[4] 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.[5] 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 that is based on the outcome of professional sporting events, Keno (1991), Video Poker (1992), Pick 4 (2000), and Win for Life (2001).

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 3% of the Video Lottery net proceeds be used to establish and fund treatment programs for disorder gamblers in the State.[6]

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

[5] To date, over $4 billion has been awarded in prizes and nearly $2 billion returned as profit to the State. The Lottery currently returns approximately 96% of it's net revenue to prizes and the State.

[6] Expansion to video poker was narrowly passed by the legislature and subsequent court challenges inadvertently found that funding of treatment was not legal. This crisis caused many treatment programs to temporarily suspend services until the legislature could enact legislation that would allow for funding of treatment from the general fund although recent legislation has again linked treatment funding to 1% of the Lottery net proceeds.

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 study.

Finally, 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 which 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[7] IGCs were able to offer all gaming customarily associated with "Las Vegas" style casinos.

Estimating Gambling Treatment Utilization 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)[8]

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

[7] The ninth IGC was in the planning stages at the time this report was written.
[8] Copies of all studies sponsored by OGATF can be downloaded from www.gamblingaddiction.org .

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 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[9] to the most recent estimate of the adult population in Oregon[10] the projected enrollments should be between 1175 and 2430.[11]

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

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

and 4.1% were problem gamblers (Carlson, M. and Moore, T., 1998).[12] The study estimated that the numbers of adolescents seeking treatment each year should be between 94 and 272 individuals each year. Nonetheless, subsequent anecdotal investigation[13] 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 the population reported past year gambling and an estimated 1.2% were problem gamblers with an additional 0.3% probable pathological gamblers (Moore, T., 2001b).

DISORDERED GAMBLING TREATMENT IN OREGON

Formal programs for the treatment of disordered gambling in Oregon were first established as pilot programs in 1993. Agencies applying for state funding[14] 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

[12] 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.
[13] 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.
[14] All state funding was directed through the counties. Each agency's contract was with the county in which they operated.

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.[15] 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. Most programs currently follow a cognitive behavioral approach.

As education, training, and counselor certification efforts, led and implemented by the informal gambling treatment providers' association,[16] blossomed within the state, most programs applied an integrated strategy to the treatment of the disordered gamblers and their family members.[17]

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.

[15] This is arguably a generalization.
[16] 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.
[17] Many programs have specialized treatment efforts for family members which are not contingent upon the gambler being also enrolled.

OREGON GAMBLING HELPLINE

In 1995, when program management was consolidated[18] 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[19] as well as placards placed in each of the establishments that had state-regulated video lottery terminals (video poker machines). Even a few of the Indian casinos in the state had 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.

During the period the Helpline reported[20] receiving 4337 calls[21] from which 2334

[18] It should be made clear that, with few exceptions, treatment providers contract directly with their county and only policy development had been centralized.
[19] See discussion below regarding the role of the Oregon Lottery in advertising treatment and prevention.
[20] These statistics were provided to the evaluator by Helpline staff.

referrals were made. The average length of time per call for gambling help was 13.5 minutes.

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:[22]

The state's Department of Human Services'(DHS), Problem Gambling Services develops and maintains policies, provides technical assistance, and coordinates the problem

[21] This includes calls of all types including wrong numbers, requests for Lottery information such as the winning number, etc..
[22] Material for this section of the report was provider by Dr. Jeffery Marotta, Problem Gambling Services Manager.

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 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 is tasked by statute to develop and operate a play responsibly campaign and invests $600,000 a year 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.[23]

Additionally, counties are provided over $600,000 annually to develop and implement regionally specific prevention plans that include measurable goals and objectives. These prevention plans follow a public health model as a foundation.

Community awareness efforts that have been implemented, or plans for their implementation have been approved include the following activities by county:

Radio/television public service announcement (PSA) or written advertisement	• Clackamas • Deschutes • Josephine • Lane	• Lincoln • Multnomah • Tillamook • Washington
Radio feature	• Deschutes • EOHSC • Josephine	• Lane • Linn-Benton • Tillamook
Newspaper/Newsletter article	• Coos-Curry • Deschutes	• Douglas • Jackson

[23] These programs have received national attention.

	• EOHSC	• Lane
Television/public access feature	• Clackamas • Deschutes • Jackson	• Tillamook • Washington
Regionally produced educational materials	• Clackamas • Deschutes • Josephine • Klamath • Lane	• Lincoln • Linn-Benton • Multnomah • Washington
Regional gambling-specific website	• Lane	

Presentations and the dissemination of information to specific targeted audiences that have been implemented, or approved for implementation, include:

Local government (e.g., board of commissioners)	• Lincoln	
Business community / credit counseling programs	• Coos-Curry • Deschutes	• Jackson
Employee assistance programs (EAPs)	• Douglas	• Jackson
Criminal justice	• Coos-Curry • Deschutes • Jackson	• Klamath • Lane • Linn-Benton
Prevention/treatment professionals (e.g., A&D and MH providers)	• Coos-Curry • Deschutes • EOHSC • Douglas • Jackson	• Josephine • Klamath • Lane • Lincoln • Washington
Treatment clients (e.g., A&D, MH)	• Lane	• Washington
Parents/families	• Clackamas	• Linn-Benton

	• Lane	• Marion
College students	• Deschutes • Josephine	• Washington
Senior citizen groups	• Douglas • Josephine • Klamath	• Lincoln • Linn-Benton • Tillamook
Community groups / coalitions / faith community	• Josephine • Lane • Lincoln	• Linn-Benton • Multnomah • Washington
Merchants	• Jackson	• Linn-Benton
Casino outreach (where available)	• Douglas	
Latino community	• Multnomah • Lane	
African-American community	• Multnomah	
Information dissemination at health or community fairs	• Lane • Lincoln	• Multnomah • Washington
Unspecified general population	• Tillamook	

Prevention education, awareness, and outreach to the youth included:

Use/adaptation of video	• Columbia-Clatsop	
Presentations: middle school youth	• Lane	
Presentations: high school youth	• Lane	
Presentations: at-risk youth	• Jackson • Klamath	• Lane • Marion
Prevention education curriculum/integration:	• Clackamas • Josephine	• Lincoln • Linn-Benton

Prevention education curriculum/integration: distributed to local educators	• Jackson

Efforts for early identification and screening for problem and pathological gambling had been initiated, or plans approved as follow:

A&D/DUII clients	• Clackamas • Coos-Curry	• Linn-Benton • Multnomah
Mental health clients	• Clackamas • Douglas • Multnomah	
Youth (survey)	• Columbia-Clatsop • Marion	
Economically disadvantaged	• Columbia-Clatsop	

Training of allied professional staff for the identification and referral of problem and pathological gamblers had been implemented, or plans approved, as follow:

Problem identification & referral training	• Clackamas • Coos-Curry • EOHSC • Douglas • Josephine	• Lane • Linn-Benton • Marion • Multnomah

Other activities that had been implemented, or approved for implementation included:

Community forum	• Douglas	• Josephine
Formation of problem gambling issues committee	• Lane	

EVALUATION METHODOLOGY

A substantial array of data has been collected from gambler and family clients since the consolidation of the statewide gambling treatment programs in 1995. The dataset and data collection protocol have seen three major revisions with the most recent having been implemented system-wide in November 2001. Because not all programs implemented the new protocol immediately upon release, analysis of new data fields for this report is confined to that collected for enrollments on, or after, January 1, 2002. These fields are flagged in the discussion as containing only partial year data and should be viewed with some caution.

Enrollment, termination, and encounter data are collected by treatment provider staff. This data is recorded on record abstracting forms and shipped to the contractor for processing along with self-report surveys that are completed by both gambler and family clients. The self-report survey is the basis for the follow-up.[24] Beginning in October, 2001, follow-up is conducted with non-completers at 90 days and six months post termination and for those who successfully complete their treatment at 6, 12, 18, and 24 months post termination.

UTILIZATION

Enrollment

Since consolidation of the programs in 1995, the number of gamblers seeking

[24] Due to the size of the evaluation documents they are not included with this report. Electronic versions can be obtained from the contractor.

treatment increased at an average annual rate of 18.2% and family clients increased at an average annual rate of 31.8%. Combined enrollments increased at an average annual rate of 19.2%. The total number of gamblers admitted to the programs since 1995 was 6000 and the total number of family members admitted was 1088 for a combined total admissions of 7,088. The current report period saw a spectacular growth in enrollments resulting in a 39.5% increase in gambler enrollments and a 66.3% increase in family enrollments over the previous year. (Table 1. Utilization of Treatment: Total Admissions and Annual Rate of Change)

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

FY	Gambler Admits (n)	Gambler Rate of Increase From Previous Year (%)	Family Admits (n)	Family Rate of Increase From Previous Year (%)	Total Clients (n)	Total Rate of Increase From Previous Year (%)
95-96	523		62		585	
96-97	565	8.0	114	83.9	679	16.1
97-98	725	28.3	136	19.3	861	26.8
98-99	830	14.5	158	16.2	988	14.8
99-00	988	19.0	183	15.8	1171	15.6
00-01	989	0.1	163	(10.9)	1152	(1.6)
01-02	1380	39.5	272	66.3	1652	43.3
Total	**6000**		**1088**		**7088**	
Average Change		**18.2**		**31.8**		**19.2**

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[25] was launched to increase treatment program funding and attach the level of funding to a minimum percent of the lottery proceeds in the state. That effort included actions intended to stabilize the programs by moving the management and coordination function from the temporary contractual situation, established in July of 1995 with the AOCMHP,[26] 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 funding levels, and general loss of statewide coordination of outreach and treatment efforts. Effects of this uncertainty permeated throughout most provider agencies[27] 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. The new campaign was aggressively deployed in the fall of 2001.

The phenomenal growth in FY 01-02 is speculated to have been influenced by four

[25] Senate Bill 118
[26] 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.
[27] This conclusion is based on extensive, informal contact by the evaluator with program managers and counselors throughout the state.

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. 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.

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[28] 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 from 100 to 150 enrollments. Another potential artifact of the more precise reporting[29] was the finding that the annual recidivism rate of gamblers for the current period was 6.1%, up from 2.4% reported during the previous fiscal year.

Since July 1, 1995 the rate for gambler reenrollment was approximately 15.2%. This rate only applies to gamblers that re-enrolled in the same program since there has not been an effective manner to track clients across programs until implementation of the revised evaluation protocol.

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

Table 2. Active Programs *(FY 01-02)*, is a listing of the twenty-eight programs in operation during the year with the number of gambler and family admits for the period. As can be seen, there is a wide variation in the size of the programs throughout the state.

During the report period there were three new programs initiated. Two were the first efforts to establish short-term respite care in the state. The objective of these programs was to provide a brief opportunity for gamblers to gain a foothold in early recovery by being able to go into a therapeutic residential setting for up to one week. The respite program in Columbia County was housed in an residential alcohol and drug treatment center while the respite program in Josephine County was in conjunction with a mental health residential care facility.

Table 2. Active Programs FY 00-01

County / Region	Agency	Gambler Admits	Family Admits	Total Admits
Clackamas	Clackamas County	79	12	91
Columbia	Columbia County	38		38
Columbia	Columbia County Respite Care	4		4
Coos	ADAPT Coos County	31		31
Curry	Curry County	5		5
Deschutes	Deschutes County	37	4	41
Douglas	Douglas County	25	6	31
Douglas	ADAPT	12		12
Hood	Mid-Columbia (Gilliam, Hood, Wasco)	13	4	17
Jackson	Addiction Recovery Center	38	1	39
Jackson	On Track	40	3	43
Josephine	Josephine	19	3	22
Josephine	Josephine County Respite Care	2		2
Klamath	Klamath County	0	0	0
Lake	Lake County	1		1
Lane	Addictions Counseling Services	145	33	178
Lincoln	Lincoln County	19		19
Linn/Benton	Linn/Benton Counties	45	1	46
Marion	Cascadia Behavioral Health	57	12	69
Marion	Serenity Lane	50		50

Multnomah	Center for Community MH	14		14
Multnomah	Cascadia Behavioral Health	295	116	411
Multnomah	OHSU Behavioral Health Clinic	106	15	121
Polk	Polk County	10		10
Tillamook	Tillamook Family Counseling	13	4	17
Umatilla	Umatilla (Baker, Grant, Morrow, Union, Umatilla, Wheeler)	80	16	96
Washington	Tualatin Valley Centers	153	35	188
Yamhill	Yamhill County	31	7	38
Statewide	Minimum Intervention Project	18		18
	TOTAL	**1380**	**272**	**1652**

The third new program initiated during the year was a telephone based minimal intervention program run by Cascadia Behavioral Healthcare in Portland. This program was principally based on the successful model developed by Hodgins and was targeted at two primary audiences. The first intended audience was comprised of individuals who would be classified as sub-clinical problem gamblers (those endorsing less than five of the ten DSM criteria) and would subsequently not require more intense traditional face-to-face intervention. The second intended audience were those individuals that, due to long distances from traditional outpatient programs, would experience difficulty commuting to treatment. Experience during the startup year found more of those with severe problems were accessing the program.

The self-paced program was based on the combination of participants completing readings and exercises in a workbook that was mailed to their home. The workbook consisted of four major sections with the first focusing on self-assessment of gambling and the problems associated with gambling. The second section focused on facilitating and supporting the participant to arrive at a goal to either quit gambling (abstinence) or to attempt

to reduce gambling (harm reduction) and the choice was left to the individual. The third section addressed techniques to achieve the individual's goal and included readings on irrational thoughts, the concept of randomness, thought redirection, strategies to effectively deal with urges to gambling, techniques to avoid gambling venues, controlling access to money, and soliciting help for their plan from others. The final section of the workbook focused on maintaining the goals that were set, understanding relapses (and implementing plans to avoid), making amends, and dealing with other life problems.

Participants were scheduled for four telephone sessions with a qualified gambling counselor. If necessary, the program could extend the number of phone sessions. At the end of the workbook was a list of other resources that the participant could use and these were discussed with the counselor and referrals made according to need.

During the startup year, only 18 individuals elected to participate in the evaluation. These findings are included in a separate report.

Treatment Access

A total of 46 different sources were identified as providing contact information for the treatment programs. By system design, the Helpline was expected to be the largest referral source to state-funded treatment. As can be seen in the following Table 3. Access Source – Gambler, approximately 28.2% of the gambler clients enrolling in treatment during the period identified the Helpline as the source for the provider agency's telephone number. This ratio was consistent with that reported the previous year. The second most frequently cited referral source by the enrolling gamblers was previous or current program clients which represented

10.1% of the distribution.[30] "Family or friends" was the third most frequently cited source for program contact information with 9.9%. The remainder of the sources for program contact information were infrequently reported.

Table 3-A. Access Source Gamblers – FY 01-02

Access Source	(n)	Percent
Helpline	389	28.2
Program Client*	140	10.1
Family/Friends	136	9.9
Self Help Group	49	3.6
Mental Health Agency	38	2.7
Jail – City or County	37	2.6
Yellow Page Ad *	36	2.6
Private Health Professional	31	2.2
Probation	27	2.0
Television Ad/PSA *	27	2.0
All Others	470	34.1
Total	**1380**	**100.0**

It should be noted that Umatilla Region implemented an in-jail program that accounted for 34 of the 37 clients that were reported as receiving contact information about the program from a jail.

Family clients reported significantly[31] different distribution of sources for obtaining the programs' contact information than did the gamblers. Thirty-nine percent reported that they had received the program's contact information from a family member or friend followed by the Helpline (17.3%), a current or past client of the program (14.3%), Web or Internet[32] (3.3%), Yellow Page ad in a telephone directory (3.3%), or self-help group (1.8%). A total of 10 other sources were identified and combined in the "other" category. Although the

[30] The previous data collection protocol allowed individuals to identify themselves as the "access source," or where they obtained the information necessary to contact the program. The new data collection protocol removed this option from the choices since it did not provide specific information as to where the individual actually received the phone number, or contact information. Additionally, it was being anecdotally reported that many of the individuals presenting for treatment had heard of the program from "previous or current clients of the program." This option was added to the new protocol. Since the new protocol was operational on, or about, November 1, 2001, these two fields do not represent full year data. Other fields flagged with an asterisk (*) are also specific to the new protocol and do not represent full year data.

[31] chi square $p < .01$

difference between the gamblers and the family members reported access to the programs' contact information is of interest for future outreach efforts, some caution should be exercised since it may have been influenced by the fact that once gamblers are enrolled in the programs, there is an effort to ensure their families are aware of the family treatment programs.

Table 3-B. Access Source Family Clients – FY 01-02

Access Source	(n)	Percent
Family/Friends	106	39.0
Helpline	47	17.3
Program Client*	39	14.3
Web/Internet	9	3.3
Yellow Page Ad *	9	3.3
Self Help Group	5	1.8
Jail	5	1.8
Other	52	19.2
Total	**272**	**100.0**

One of the new fields added to dataset specifically requested providers to indicate if another agency, or individual, had taken deliberate action to get the client to treatment. Of the 730 records received from January 2002 through June 2002, 131 (19.1%) indicated the client's enrollment had been facilitated by another individual or agency. (Table 4. Referral Source Gambler)

Table 4. Referral Source Gambler – (Partial Year Data)

Referral Source	(n)	Percent
Helpline	65	8.9
Family or Friends	46	6.3
Mental Health Agency	17	2.3
Outpatient A&D Treatment	12	1.6
Private Health Professional	11	1.5
Probation	10	1.5
Other/None	569	77.9
Total	**730**	**100.0**

The primary source for a hands-on referral was the Helpline (8.9%) followed by family or friend (6.3%), mental health agency (2.3%), outpatient alcohol and drug treatment

[32] Both the Oregon Gambling Treatment Foundation and the Oregon Lottery have program contact information including the statewide toll free telephone number.

program (1.6%), private health professional (1.5%), and probation (1.5%). The other/none category was comprised of 21 other identified entities all with less than 1% and those records with no referent indicated. Interestingly, of the 10 clients that were referred by probation only one was from the Umatilla region that had the program within the jail. Two of the five clients referred to treatment by another outpatient gambling treatment program were enrolling for respite care and three of the four that were referred to treatment from jail were in the Umatilla in-jail program (statistics not shown).

Of the 137 family clients admitted after implementation of the new protocol only 19 were indicated as having had another person or agency take deliberate action to facilitate their enrollment. Of these 19, 17 (89.5%) reported a family member or friend, had taken action to get them enrolled, one (5.3%) reported a private health professional, and one a self-help group member.

The need for prompt access to assistance for the gambler has long been recognized as an important mechanism to facilitate client follow through for a first visit. Although this had previously been tracked anecdotally system-wide, the providers and the PGSM felt it essential that prompt access be one of the measurable performance criteria for the gambling treatment contracts between the state and the providers.[33] The criteria was that all callers seeking assistance would either been seen within five work days, or at least offered an appointment within the five work day window.

[33] All contracts are with a single county agency who then might either perform the counseling services as part of a county program or subcontract with a state accredited agency. For the regions, the contract remains between the state and one county and the participating counties in the region are normally governed by intergovernmental agreements.

The date the client first called the program has been in the evaluation protocol since 1998 while the field for the first available appoint was added in current revision of the protocol. As can be seen in Table 5. Lag Time to First Appointment, the average number of days excluding weekends and holidays was 5.3 days with a standard deviation (sd) of 8.0 days. (Table 5. Lag Time to First Appointment)

Table 5. Lag Time to First Appointment
Gamblers – FY 01-02

Number of Records	Average Lag (Days)	sd
1296	5.3	8.0

Table 6. Lag Time to First Available Appointment
Gamblers – (Partial Year Data)

Number of Records	Average Lag (Days)	sd
724	3.9	4.0

Due to personal scheduling conflicts, 164 clients during the second half of the fiscal year did not accept the first available appointment. Had they done so, the average lag time between first call and first appointment would have averaged 3.9 days (sd = 4.0), well under the five work day performance criteria (Table 6. Lag Time to First Available Appointment).

Table 7. Lag Time to First Appointment
Family – FY 01-02

Number of Records	Average Lag (Days)	sd
146	3.8	3.7

Access to care was also readily available for family members as can be seen in Table 7. Lag Time to first Available Appointment. On average, appointments were available for family members with 3.8 days (sd = 3.7).[34] Family clients tended to be as expeditious in coming in for their first

[34] This field has incomplete data for the period.

Table 8. Lag Time to First Appointment Family – (Partial Year Data)		
Number of Records	**Average Lag (Days)**	**sd**
228	5.3	7.7

appointment as were the gambler clients (Table 8. Lag Time to First Appointment Family Clients).

Another factor critical to effective treatment is the proximity of the client to the treatment program. Also in the new protocol, programs were requested to document the amount of time[35] it took the client to commute from their home to the treatment facility.

As can be seen in Table 9. Commute Time to Treatment, the average commute time for the 562 gambler clients for whom data was reported was only 25.5 minutes (sd 20.2). Family members also reported a similar amount of time for the commute to treatment.

Table 9. Commute Time to Treatment Gamblers & Family (Partial Year Data)			
	Number of Records	**Average Commute Time (Minutes)**	**sd**
Gamblers	562	25.5	20.2
Family	95	25.7	14.7

GAMBLER DEMOGRAPHIC CHARACTERISTICS

Age

The average age of gamblers enrolling in treatment has remained relatively constant over the past several years ranging from a high of 43.4 this year to a low of 40.0 years in FY

[35] To simplify this data element, a decision was made to document time as opposed to miles in an effort to compensate for various transportation modalities such as private vehicle, public transportation, walking, etc. without burdening the data collection with additional data points.

95-96. Over all years, female gamblers in treatment have been significantly older[36] than males and remained so during the current report period. The average age of males was 42.0 (sd = 11.2) while the average age of females was 45.0 (sd = 11.1) (Table 10. Average Age of Gamblers).

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

FY	All			Males			Females		
	n	Mean	sd	n	Mean	sd	n	Mean	sd
FY 01-02	1365	43.4	11.2	733	42.0	11.2	626	45.0	11.1

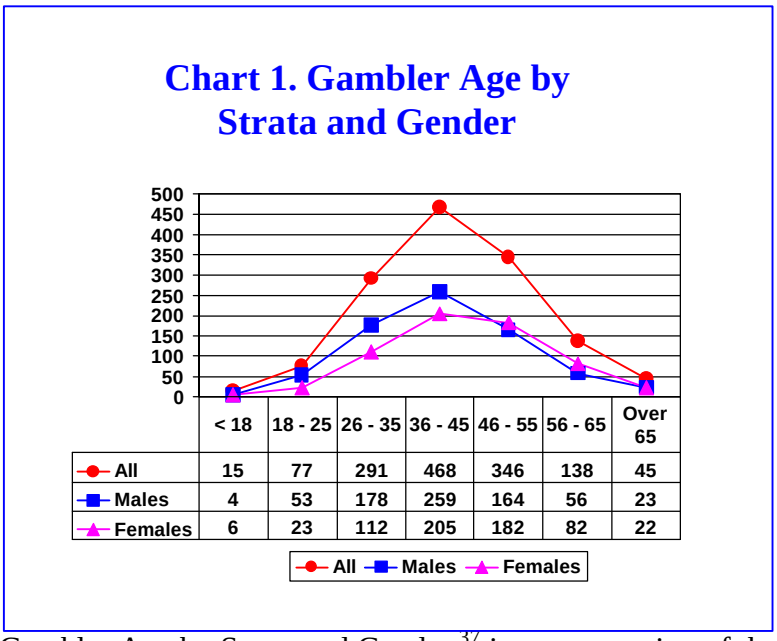


Chart 1. Gambler Age by Strata and Gender,[37] is a presentation of the distribution of gamblers by age strata and gender. During the report period, 15 (1.1% of those with records

[36] t test $p < .01$

[37] Missing gender data accounts for the sum of males and females not equaling "all" in some of the strata.

reporting age) were less than 18 years old (four males and six females)[38] while those over 65 comprised 3.4% of the gamblers being treated.

Males comprised approximately 53.4% of the enrolling gamblers[39] during the current year. This gender mix has been relatively constant over the past several years, demonstrating a higher frequency of females enrolling in treatment than was expected based on the projections of the previously cited prevalence studies. These studies all found that males were more likely to become problem and pathological gamblers than females. This finding would suggest, as has been confirmed in the general healthcare literature, that females are more likely to seek treatment than males.

Race/Ethnicity

A majority of the gamblers (90.3%) reported their race as White (non-Hispanic) followed in order, Black (2.3%), Native American (2.0%), Asian (1.9%), Hispanic (1.5%), Southeast Asian (1.1%) and other (0.9%). The racial mix of gamblers has remained relatively stable over the past several years with some minor shifting of representation. There were essentially no

Table 11. Race/Ethnicity of Gamblers
(In Percent of Distribution)

Race/Ethnicity	Percent
White	90.3
Black	2.3
Native American	2.0
Asian	1.9
Hispanic	1.5
Southeast Asian	1.1
Other	0.9
Total	100.0

[38] The statistics presented in this report are valid percentages based on actual data reported without attempting to estimate data for missing fields.
[39] Gender information was calculated utilizing only the gender field in the database since several records had missing age information.

differences in the distribution between males and females. (Table 11. Race/Ethnicity of Gamblers)

Findings from other research (Moore, T., Jadlos, T, Carlson, M. 2000) suggest that minorities are underrepresented in the treatment population in Oregon. (Current statewide census data suggests that approximately 85% of the population is White.)

Education

The average education level of gamblers at the time of enrollment has also remained consistent over the past several years at approximately 12.7 years of completed schooling. Males reported slightly more years of education (12.8 years) than females (12.7 years) (Table 12. Average Number of Years Education – Gamblers by Gender).

Table 12. Average Number of Years Education Gamblers - By Gender (In Years)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1321	12.7	2.1	711	12.8	2.2	607	12.7	2.1

Marital Status

Approximately 40.8% of the gamblers reported being married at the time of admission, followed by divorced (22.6%), never married (22.0%), separated (5.3%), living as married (5.7%), and widowed (3.6%). Males significantly[40] were more likely than females to

[40] chi square $p < .01$

report never married than married while females were significantly[41] more likely to report being widowed. (Table 13. Marital Status of Gamblers)

Table 13. Marital Status of Gamblers as Reported at Admission - By Gender (In Percent of Distribution)

Marital Status	FY 00-01 All (n = 1339)	Males (n = 737)	Females (n = 613)
Married	40.8	40.7	40.9
Divorced	22.6	21.0	24.5
Never Married	22.0	27.5	15.5
Separated	5.3	4.7	6.1
Living As Married	5.7	4.6	7.0
Widowed	3.6	1.5	6.0
Total	100.0	100.0	100.0

Living Situation

Approximately 50.1% of the gambler clients reported living with their spouse (24.6%) or their spouse and their children (25.5%) at the time of admission. Slightly over 20% reported living alone, 12.7% reported living with parents or other relatives 7.3% living alone with their children, 7.1% with friends, and 2.6% were living in an institution or group home. Although there were differences in the

Table 14. Living Situation of Gamblers as Reported at Admission - By Gender (In Percent of Distribution)

Living Situation	FY 00-01 All (n = 1320)	Males (n = 702)	Females (n = 617)
Spouse with Children	25.5	26.2	25.0
Spouse/SO	24.6	22.6	26.8
Alone	20.2	21.9	18.3
Parents/Relatives	12.7	14.4	10.5
Alone with Children	7.3	3.1	12.0
Friends/Others	7.1	8.7	5.3
Institution/Group	2.6	3.1	2.1
Total	100.0	100.0	100.0

[41] chi square $p < .01$

distribution of living situations between the genders, only living alone with children was significant,[42] where females were more likely to report this situation. (Table 14. Living Situation of Gambler)

Household Size and Dependents Living with Gambler

Partial year data indicated the average number of individuals, including the gambler and dependents, living together was 2.2 (n = 680, sd = 1.3) with a very slight difference between male and females. (Table 15. Household Size)

Table 15. Household Size
Gamblers - By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
680	2.2	1.3	360	2.2	1.4	319	2.2	1.2

Partial year data indicated that approximately 17.8% of the gambler client households had children under the age of six years and 26.5% between the ages of 6 years and 17 years. More than 91% of the households were reported with members between the ages of 18 years and 64 years old while 7.2% were reported with household

Table 16. Household Size by Age Group
By Gender (Partial Year Data)
(n = 680)

	Under 6 Years Old	**6 – 17 Years Old**	**18 – 65 Years Old**	**Over 65 Years Old**
All	121	180	620	49
	1.5 (0.8)	1.6 (0.8)	1.6 (0.7)	1.2 (0.4)
Males	73	92	325	18
	1.5 (0.8)	1.7 (0.9)	1.6 (0.7)	1.3 (0.5)
Females	48	87	294	31
	1.4 (0.7)	1.5 (0.7)	1.6 (0.7)	1.2 (0.4)

[42] chi square $p < .01$

members (dependents or the gambler) 65 years old or older. Table 16. Household Size by Age Group[43] presents the number of household with members in each of the age groups, the average number of members per household in that age group, and the standard deviation (sd).

Housing Type for Gambler Clients

Forty-two percent of the gambler clients were living in a rental unit without rental assistance or rental subsidies, 40.7% were living in a home they owned, 3.7% were living in a rental unit for which they were receiving rental assistance, 2.7% were in an institution (such as prison), 1.7% were homeless at the time of enrollment in the gambling program, and 9.2% were living with friends or families and they were not paying rent. Females were significantly[44] more likely to live in a home they owned than were males. (Table 17. Housing Type)

Table 17. Housing Type By Gender (Partial Year Data) (In Percent of Distribution)

Housing Type	All (n = 698)	Males (372)	Females (n = 325)
Rent – No Subsidies	42.0	44.4	38.8
Own	40.7	35.8	46.5
Rent – With Subsidies	3.7	3.2	4.3
Institution/Group Home	2.7	4.3	0.9
Homeless	1.7	2.7	0.6
Other/Not paying Rent	9.2	9.6	8.9
Total	100.0	100.0	100.0

[43] The data in this table is presented with the number of household members reported in the cell over the average number of member in this age group and the standard deviation in parentheses.
[44] chi square $p < .01$

Employment and Employability

A majority (56.1%) of the gambler clients were working full-time (35 or more hours per week), 10.1% were working part-time (17 to 34 hours per week), and 3.8% were working irregular (averaging less than 17 hours per week). Slightly over 15% were unemployed and looking for employment while the remaining 14.7% were not working and were not looking for employment. Males were significantly[45] more likely to be employed full-time than females and conversely, females were significantly[46] more likely to be employed part-time than males. Females were also significantly[47] more likely to be unemployed and not looking for work.

Table 18. Employment Status By Gender (In Percent of Distribution)

Status	All (n = 1332)	Males (716)	Females (n = 613)
Full-Time	56.1	63.5	47.3
Not Employed – Looking	15.3	15.1	15.5
Not Employed – Not Looking	14.7	12.2	17.7
Part-Time	10.1	5.4	15.7
Irregular	3.8	3.8	3.8
Total	100.0	100.0	100.0

[45] chi square $p < .01$
[46] chi square $p < .01$
[47] chi square $p < .01$

Table 19. Employability
By Gender
(In Percent of Distribution)
(Partial Year Data)

Status	All (n = 679)	Males (364)	Females (n = 314)
Employable/Working	79.1	79.0	79.3
Retired	5.9	5.5	6.4
Disabled	5.6	6.0	5.1
Student	3.5	4.1	2.9
Incarcerated	2.7	3.8	1.3
Homemaker	1.9	0.0	4.1
Temporary Layoff	1.2	1.6	0.6
Seasonal Worker	0.1	0.0	0.3
Total	100.0	100.0	100.0

Another data element introduced with the revised program evaluation protocol was that of employability to augment the understanding of the potential employment situation of the gambling clients. Slightly over 79% of the gambler clients were either working or employable, 5.9% retired, 5.6% disabled, 3.5% students, 2.7% incarcerated,[48] 1.9% homemakers, 1.9% experiencing temporary layoffs (and were employable), and 0.1% seasonal workers. The differences between the distributions for males and females was not significant. (Table 19. Employability)

Income

[48] This distribution of gambler clients that were incarcerated at the time of enrollment is most likely an artifact of the timing of the introduction of the new evaluation protocol and enrollments in the prison program discussed above and will most likely decrease once full-year data is available.

Overall, the average household income was $36,246 (n=1228, sd 40,489). Males' average reported annual household income was $38,403 (n=674, sd 47,650) while females' average income was reported at $33,598 (n=551, sd 29,251). The difference between males and females reported annual household income was statistically significant.[49] (Table 20. Average Income of Gamblers)

Table 20. Average Annual Household Income of Gamblers By Gender (In Dollars)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1228	36,246	40,489	674	38,403	47,650	551	33,598	29,251

Gambler clients were most likely to report their source of income as coming from wages (71.2%), followed by pension or unemployment (5.7%), Social Security (5.5%), Social Security Disability (1.9%), welfare (1.8%), other (5.6%). More than 8% reported no income. (Table 21. Source of Income of Gamblers)

Table 21. Source of Income of Gamblers By Gender (In Percent)

Income Source	**All (n =1322)**	**Males (n = 711)**	**Females (n = 607)**
Wages	71.2	69.5	72.7
Pension/Unemployment	5.7	6.6	4.8
Social Security	5.5	6.4	4.8
SSI - Federal	1.9	1.7	2.1
Welfare	1.8	2.3	1.4
Other	5.6	6.7	4.6
No Income	8.3	6.8	9.6
Total	100.0	100.0	100.0

[49] t test $p < .05$

Gambling Preference

As has been the case since the inception of the pilot treatment efforts in 1993, video poker has been the most frequently identified game of preference as indicated by approximately 80 percent of gamblers in earlier studies. (Moore, T., 2001c) During the report period, gambler clients reported their primary game of choice as video poker (74.1%), followed by slot machines (10.0%), cards (5.2%), and animals (1.6%). With the 1997 revised data collection protocol, an attempt was made to distinguish between video poker, regular slot machines, and video line games. This distinction is believed to not be as clean as originally determined in that the term slot machine is commonly utilized to identify any electronic gambling machine as well as the older mechanical machines.

There are differences noted between the games of choice by males and females. Excluding video poker, males tend slightly to prefer cards, horse and dog (animal) wagering, sports betting, and dice while females tended towards bingo and slot machines. Females were more likely[50] to report video poker or slot machines (combined categories) than were males. (Table 22. Primary Gambling Preferences)

Table 22. Primary Gambling Preferences By Gender (In Percent of Distribution)

Game	All (n = 1319)	Males (n = 707)	Females (n = 608)
Video Poker	74.1	73.4	74.7
Slot Machines	10.0	5.5	15.3

[50] chi square $p < .01$

Cards	5.2	7.9	2.0
Animals	1.6	2.7	0.3
Keno	1.5	2.0	1.0
Bingo	1.4	0.7	2.6
Sports (not Lottery)	1.3	2.4	0.0
Breakopens/Scratch	1.1	0.8	1.3
Dice	0.8	1.6	0.0
Video Line Games	0.4	0.1	0.7
No Preference	0.4	0.3	0.5
Other/None	2.2	2.6	1.6
Total	100.0	100.0	100.0

Slot machines were most often indicated as a secondarily preferred game (17.7%), followed by scratch tickets (15.8%), cards (14.6%), video poker (11.0%), and keno (10.4%).

As would be expected from the preferred game, most gambler clients (69.5%) indicated they primarily did their gambling in a lottery retail establishment where video poker games are found. This was followed by gambling in a casino or Indian gaming center (21.8%); food or convenience store where traditional lottery games are sold (2.5%), and at a track or off-track gambling establishment (1.7%). (Table 23. Primary Location)

Table 23. Primary Location for Gambling By Gender (In Percent of Distribution)

Location	All (n = 1295)	Males (n = 697)	Females (n = 594)
Lottery Retailer (Video)	69.5	69.2	69.9
Casino	21.8	19.8	24.2
Food/Convenience Store	2.5	2.6	2.2
Track/Off Track Wagering	1.7	2.9	0.3
Restaurant/Pub (No VLT)	1.0	1.1	0.8
Bingo Hall (Non Indian)	0.7	0.1	1.3
WWW/Internet/Phone	0.7	0.7	0.7
Family/Friend Home	0.6	1.1	0.0

Card Room - Public	0.5	1.0	0.0
Private Club	0.2	0.3	0.0

Table 24. Distance Traveled to Primary Gambling Activity By Gender (In Miles) (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
534	13.3	30.0	276	13.2	34.9	257	13.5	23.6

Other	0.8	0.2	0.6
Total	100.0	100.0	100.0

Although females tended to report gambling in casinos more frequently than males, this difference was not statistically significant.

Gambler clients reported primarily gambling in Oregon (95.3%), followed by gambling in the state of Washington (1.4%), Nevada (0.9%), and California (0.6%). The average distance traveled to the location of the primary gambling was reported at 13.3 miles (sd = 30.0). There was no significant difference between the distance traveled to gamble for males and females. (Table 24. Distance Traveled)

Gambling Behavior

Males were significantly[51] more likely to report their first gambling experience at an earlier age (20.7 years) than females (27.3 years). (Table 25. Age of First Gambling Experience)

Table 25. Age of First Gambling Experience By Gender (In Years) (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
683	23.8	12.0	361	20.7	11.0	321	27.3	12.1

As well, males were also significantly[52] more likely to report an earlier age of onset for gambling problems (29.1 years) than females (34.8 years). (Table 26. Age of Onset of Gambling Problems)

Table 26. Age of Onset of Gambling Problems By Gender (In Years)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
1189	31.8	13.3	628	29.1	12.9	557	34.8	13.1

Interestingly, male gambler clients were not more likely to report more frequent episodes of problem gambling[53] nor were they more likely to report longer episodes of

[51] t test $p < .01$
[52] t test $p < .01$

[53] Episodes are defined as where problem gambling is preceded by a period of at least 12 months problem free.

problem gambling. (Table 27. Total Problem Gambling Episodes and Table 28. Length of Current Gambling Episode)

Table 27. Total Problem Gambling Episodes By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
478	2.45	4.0	243	2.3	3.2	234	2.4	4.7

Table 28. Length of Current Problem Gambling Episode By Gender (In Months) (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
595	55.9	71.1	306	57.7	65.6	288	54.1	76.4

Of those gambler clients enrolling in treatment after implementation of the revised evaluation data collection protocol, 40.0% reported that the current treatment was their first serious attempt to stop or control their gambling.[54] For those who had made a serious attempt to stop or control their gambling, the average number of previous times was reported as 3.4 (sd = 4.1) with no significant difference between males and females. (Table 29. Serious Attempts to Stop or Control Gambling)

Table 29. Serious Attempts to Stop or Control Gambling By Gender (Partial Year Data)

All	Males	Females

[54] Serious attempts are defined as an attempt that resulted in at least 30 days of success.

n	Mean	sd	n	Mean	sd	n	Mean	sd
323	3.4	4.1	164	3.5	3.4	159	3.3	4.7

Gambler clients were also asked if they had sought assistance from a professional counselor, or GA, in any of their previous serious quit, or control, attempts. The average number of assisted quit attempts was reported as 1.7 (sd = 1.8) and there was no significant difference between males and females. (Table 30. Assisted Serious Attempts to Stop or Control Gambling)

Table 30. Assisted Serious Attempts to Stop or Control Gambling By Gender (Partial Year Data)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
185	1.7	1.8	97	1.9	1.9	88	1.6	1.7

The average debt related to problem gambling was reported at $22,840 (sd = 77,722). One male and one female reported gambling debts in access of $750,000, one male and three females reported gambling debts between $500,000 and $750,000, five males and four females reported debts between $250,000 and $500,000, and fifty gambler clients (29 males and 21 females) reported gambling debts of between $100,000 and $250,000. There were no significant differences between the average gambling related debts of males and females. (Table 31. Average Gambling Related Debt)

Table 31. Average Gambling Related Debt By Gender (In Dollars)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
1,211	22,840	77,722	635	22,572	57,960	573	23,214	95,091

Table 33. Average Gambling Event Time
By Gender (In Hours)
(Partial Year Data)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
541	4.4	5.1	276	4.3	5.6	264	4.5	4.5

The average number of days gambled reported by gambler clients for the 30 days previous to enrolling in treatment was 11.2 days (sd = 8.2). There was no significant difference between males and females in the number of days gambled. (Table 32. Average Number of Days Gambled)

Table 32. Average Number of Days Gambled in Past 30 Days
By Gender (In Days)
(Partial Year Data)

All			Males			Females		
n	Mean	sd	n	Mean	sd	n	Mean	sd
534	11.2	8.2	271	11.1	7.9	262	11.4	8.5

The average amount of time spent during each gambling session was reported as 4.4 hours (sd = 5.1 hrs). There was no significant difference between males and females. (Table 33. Average Gambling Event Time)

The average reported daily expenditure for days gambled for gambling was $329.32 (sd = 852.60). Although females reported a higher daily expenditure than males, the difference was not statistically significant. (Table 34. Average Daily Gambling Expenditure)

Table 34. Average Daily Gambling Expenditure By Gender (In Dollars) (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
546	329.32	852.60	284	285.93	525.52	261	376.44	1102.69

Three primary types of gambling pattern were defined for the evaluation in an effort to further understand the needs of the gamblers entering treatment. The definitions were arbitrarily based on anecdotal experience of clinicians and the evaluator. The first gambling type was defined as a regular gambler who gambled some every month but had not experienced any periods of abstinence during the past 12 months prior to treatment.

The second type was defined as an individual who was able, in the previous 12 months to maintain 30 or more days of abstinence prior to enrollment, but who experienced lapses at irregular intervals and the relapse duration was of 14 to 180 days. The third type of gambling pattern was defined as individuals who maintained abstinence for periods of 30 days or more and relapses were relatively short lasting from one to fourteen days.

As can be seen in Table 35. Gambling Pattern, more than 78% of the

Table 35. Gambling Pattern By Gender (In Percent) (Partial Year Data)

Pattern	All (n = 584)	Males (n =300)	Females (n =283)
Type 1 Regular	78.6	77.6	79.5
Type 2	8.1	7.0	9.2
Type 3	9.9	12.7	7.1
Other	1.0	0.7	1.4
Not Gambling	2.4	2.0	2.8
	100.0	100.0	100.0

gambler clients enrolling in treatment could be defined as "regular" (type 1 in the table) gamblers; 8.1% as those able to maintain periods of abstinence of 30 or more days, but who's relapses were generally long (type 2); and 9.9% who were able to maintain periods of abstinence of 30 days or more and who's relapses were relatively short (type 3). Males were more likely[55] to be classified as exhibiting the third type of gambling pattern than females.

Gambling Related Consequences

All gambler clients are required to be screened utilizing the criteria set forth by American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders for pathological gambling. A brief synopsis of the ten criteria can be seen in Table 36. Diagnostic Criteria for Pathological Gambling. In order for an individual to be formally diagnosed with pathological gambling, they must endorse a minimum of five of the ten criteria. It must be noted that both pathological and problem gamblers are eligible for care within the state-funded programs. Additionally, an occasional client will be enrolled into a program for relapse prevention where there may have been no recent gambling.

[55] chi square $p < .05$

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.

Overall, the average number of items from the DSM screen endorsed was 7.5 (sd = 2.1). Males endorsed, on average, 7.3 items and females endorsed 7.7 items. This difference was statistically significant.[56] (Table 37. Average Number of DSM Criteria Endorsements)

Table 37. Average Number of DSM Criteria Endorsed By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
567	7.5	2.1	296	7.3	2.2	270	7.7	2.0

Although beyond the scope of this report for discussion, there is not universal agreement for the utilization of the DSM criteria as the only vehicle for screening and assessing for pathological gambling. In an effort to better understand the viability of the DSM criteria, the frequency with which each of the criteria are endorsed has been documented. As can be seen in Table 38. Frequency of Endorsement of DSM Items, six of the ten items were endorsed by over 80% of the gambler clients. Although there are

[56] t test $p < .05$

noticeable differences between males and females these differences are not statistically significant.

Table 38. Frequency of Endorsement of DSM Items By Gender (In Percent) (Partial Year Data)

DSM Criteria	All (n = 567)	Males (n = 296)	Females (n = 270)
1. Preoccupation	90.3	88.5	92.2
2. Increasing amounts of money	81.8	79.4	84.4
3. Unsuccessful efforts to control	82.7	80.1	85.6
4. Restless when cutting back	76.4	70.0	83.3
5. Gambles to escape	87.3	84.8	90.0
6. Chasing	85.7	84.5	86.3
7. Lies to conceal gambling	83.1	82.4	93.7
8. Commits illegal acts	39.5	36.1	43.3
9. Jeopardize or lost relationships	60.5	62.8	58.1
10. Relies on others for money	61.4	56.8	66.7

Providers are also required to request gambler clients complete the 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.

The following lengthy table provides the average standardized scores by domain and by gender. (Table 39. BSI Average Standardized Scores at Enrollment)

Table 39. BSI Average Standardized Scores at Enrollment By Domain and Gender (Partial Year Data)

BSI Domain	n	Mean	sd
Somatization			
All	471	48.2	9.0
Males	240	47.5	8.8
Females	231	49.0	9.2
Obsessive Compulsive			
All	469	50.0	8.6
Males	236	50.0	8.2
Females	233	50.0	9.1
Interpersonal Sensitivity			
All	469	49.9	8.9
Males	237	50.7	8.8
Females	232	49.0	8.9
Depression			
All	470	50.2	8.1
Males	237	50.6	8.1
Females	233	49.9	8.2
Anxiety			
All	469	47.4	8.1
Males	236	47.4	8.0
Females	233	47.4	8.2
Hostility			
All	470	50.4	7.3
Males	237	51.5	7.9
Females	233	49.3	6.3
Phobic Anxiety			
All	472	46.4	7.8
Males	239	47.5	7.7
Females	233	45.3	7.7

Paranoid Ideation			
All	468	48.8	8.7
Males	237	49.6	8.9
Females	231	47.9	8.3
Psychoticism			
All	471	50.7	8.9
Males	238	51.3	8.7
Females	233	50.1	9.0
General Severity			
All	476	47.3	9.5
Males	241	47.4	9.7
Females	235	47.5	9.4

The BSI has been standardized on several different populations. For this evaluation, the standardized scores for outpatient mental health are employed. As can be seen, across all domains, clients enrolling in gambling treatment range between the 47th and 51st percentile[57] indicating that they are quite similar in self-reported symptoms to those seeking outpatient mental health services. Males reported statistically more significant symptomology scores than females in the domains of interpersonal sensitivity, hostility, phobic anxiety, and paranoid ideation although the percentile difference in their scores was small.

During enrollment, providers screen prospective clients for suicide ideation, gestures, and suicide attempts. Although this screening has occurred from the initiation of the gambling treatment programs in the state, it has not been formally documented until incorporation of the revised protocol.

[57] The BSI standardized scores are provided for males and females. Therefore, care should be exercised in not misreading this information to suggest that males and females report similar symptomology.

Approximately 9.9% of the clients enrolling reported that they had considered and formulated plans to commit suicide within the six month previous to enrollment. Of these, 16 reported they had experienced, on average, 1.6 non-life-threatening events that had been self-induced (Table 40. Suicide Gestures in Last Six Months).

Table 40. Suicide Gestures in Last Six Months
By Gender
(Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
16	1.6	0.8	7	1.9	0.8	9	1.3	0.7

Table 41. Suicide Attempts in Last Six Months
By Gender
(Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
30	1.5	0.9	14	1.7	1.0	16	1.3	0.8

Thirty individuals (4.1%) reported, on average, 1.5 self-induced, life-threatening events in the six month prior to enrolling in treatment. (Table 41. Suicide Attempts in Last Six Months)

Primary Diagnoses

More than 97.4% of the clients enrolling in treatment were reported with pathological gambling as the primary Axis I diagnosis and another 1.6% were reported as having a substance dependence diagnosis as the primary diagnosis. Approximately 22.0% of gambler clients were reported with a secondary Axis I diagnosis and these were mostly substance

dependence diagnoses. The primary substance use issue was alcohol abuse and dependence which accounted for 52% of the substance use disorders.

Consequences of Gambling

Slightly more than 23.4% of the gambler clients reported being divorced, separated, or otherwise lost a significant relationship as a result of gambling. The average number of lost relationships was 1.4 (sd = 1.0). (Table 42. Average Number of Significant Relationships Lost)

Table 42. Average Number of Significant Relationship Lost Due to Gambling By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
171	1.4	1.0	100	1.4	1.1	71	1.4	0.9

Approximately 14.9% reported losing a job as a result of gambling. The average number of jobs lost was 1.3 (sd = 0.9). (Table 43. Average Number of Jobs Lost Due to Gambling)

Table 43. Average Number of Jobs Lost Due to Gambling By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
109	1.3	0.9	55	1.4	1.1	54	1.2	0.4

Slightly more than 10.7% reported they had been charged with criminal activity that was directly related to their gambling. The average number of charges was 5 (sd = 10.2) with five clients reporting between 10 and 20 charges and three reporting more than 20 charges related to their gambling. Although females reported, on average, more charges, the difference was not significant. (Table 44. Average Number of Criminal Charges Relating to Gambling)

Table 44. Average Number of Criminal Charges Relating Gambling By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
78	5.0	10.2	49	4.0	6.4	29	6.5	14.4

Slightly more than 4.2% of gambling clients were reported as awaiting charges being made at the time of enrollment and less than 1% were either awaiting trial or awaiting sentencing. Approximately 2.9% were on probation at the time of enrollment for gambling related offenses, 1.0% for gambling *and* alcohol or drug related crimes, and less than one percent for gambling and other crimes excluding alcohol or drug crimes.

Approximately 5.5% of gambler clients reported previous jail time for gambling related offenses with an average of 26.1 months (sd = 63.6) being served. Although males reported serving more time than females, this difference was not significant due to the small number of females reporting jail time. (Table 45. Average Number of Months Incarcerated for Gambling Offenses)

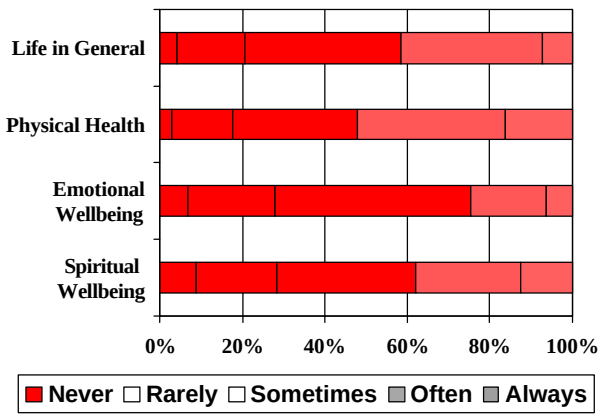
Table 45. Average Number of Months Incarcerated for Gambling Offenses By Gender (Partial Year Data)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
40	26.1	63.6	33	29.7	69.3	7	9.1	11.9

Approximately 2.6% of the gambler clients reported having charges filed against them for violent acts that were related to the gambling. The average number of charges was 1.7 (sd = 2.1) (Table 46. Average Number of Violent Charges Related to Gambling)

Table 46. Average Number of Violent Charges Filed Related to Gambling By Gender (Partial Year Data)								
	All			**Males**			**Females**	
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
19	1.7	2.1	15	1.9	2.3	4	1.0	0.0

The self-report survey, completed by the client at enrollment, discharge, and follow-up contains two quality of life domains with the first addressing general levels of satisfaction with self and others and the second domain addressing activities that have been associated with recovery. The distribution of response to the individual indicators for each

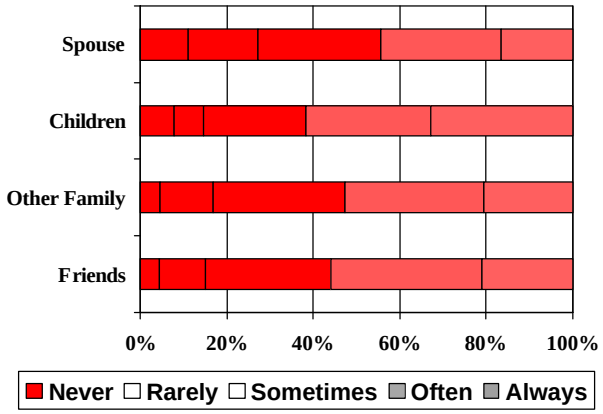
Chart 2. General Life Satisfaction (Gambler at Enrollment) Previous Six Months



of these domains are presented in the next six charts (Charts 2 through 6). The design of the evaluation effort is to track these key wellness and quality of life indicators from enrollment (baseline) through 24 month follow-up. Due to the timing of the implementation of the new protocol and the report, statistical analysis of variance between each of the milestones (enrollment to discharge and follow-up points) was not possible because of the small number clients that were enrolled and discharged during the six-month window. Nonetheless, the responses to these questions present interesting findings.

As can be seen in Chart 2 General Satisfaction, at the time of enrollment (n = 570) in the programs, approximately 18% to 30% of the clients reported never, or rarely having been satisfied with life in general, physical health, emotional wellbeing, or spiritual wellbeing in the six months prior to enrollment. Conversely, 14% to 50% reported being either often or always satisfied with these areas of their lives. This suggests that although many of the clients that are entering treatment are certainly not finding fulfillment in their lives, nearly as many clients are well fulfilled in their lives. These findings should be interpreted with caution since earlier annual reports have suggested that those seeking treatment for gambling problems in the publicly funded programs have much more intact social networks than those seeking care for publicly funded substance dependence or other mental health issues.

Chart 3. Satisfaction with Key Relationships (Gambler at Enrollment) Previous Six Months

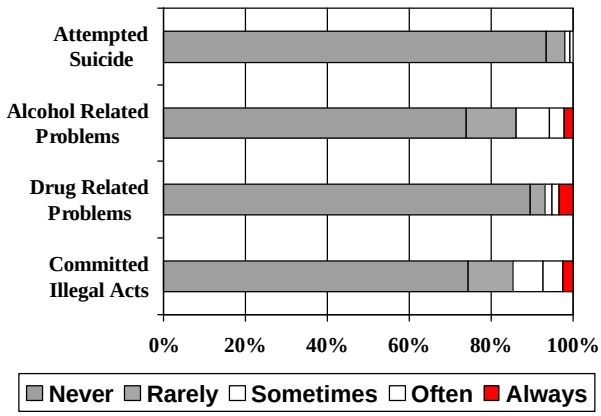


Following this pattern, as can be seen in Chart 3 Relationship Satisfaction, nearly half of the clients reported being satisfied with their relationships with spouse, children, family and friends often or always. Nevertheless, relationships with spouses or significant others appeared to be more compromised when compared with other relationships.

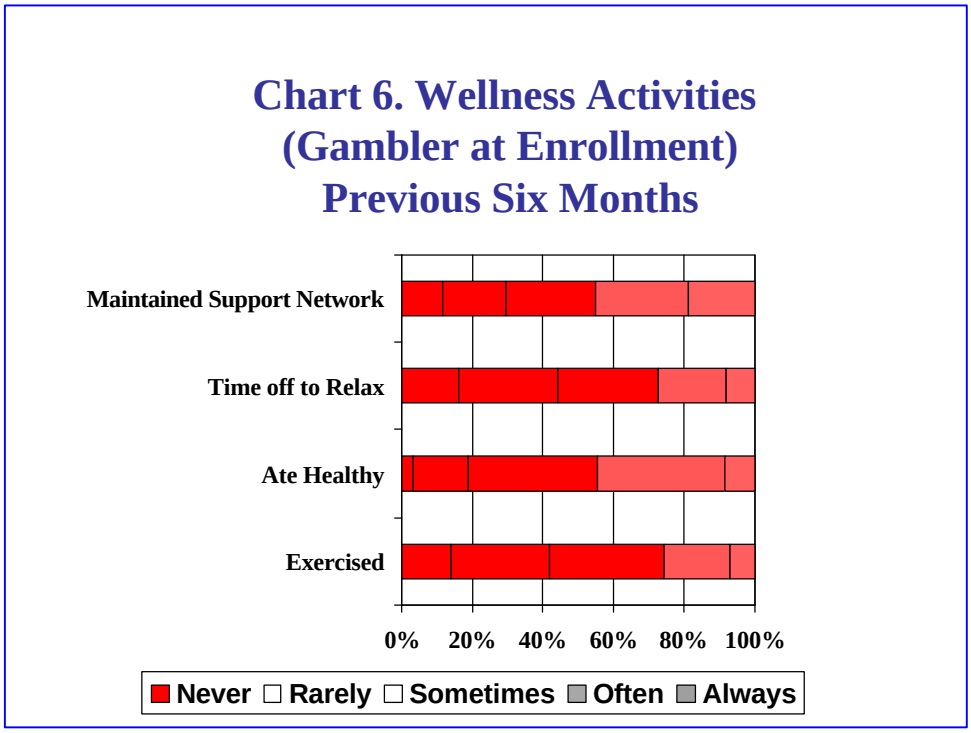
The survey also looks at very general levels of functioning addressing the self-reported frequency of accomplishing responsibilities at home and work and paying bills on time. As can be seen in Chart 4. Critical Activities Completed, a slight majority of 56.5% reported they often or always accomplished their responsibilities at home. Nearly 84% responded they often or always accomplished their responsibilities at work, suggesting what has long been believed that personal problems are less likely to become problematic at work.

Chart 4. Critical Activities Completed (Gambler at Enrollment) Previous Six Months

Chart 5. Other Problems (Gambler at Enrollment) Previous Six Months



A good deal of research that has been conducted in the past few years has suggested a high correlation between pathological gambling and suicide, substance dependence, and the commission of illegal acts to obtain money with which to gamble. Although the client population reports much higher rates of attempted suicide (approximately 7.5%), alcohol related problems (approximately 26.2%), illegal drug related problems (approximately 10.5%), and illegal acts to obtain money (approximately 25.7%) than the general population, the findings from this sample may not be as high as those found in other studies. Although not scientifically testable with the data at hand, it is hypothesized that these rates are more suggestive of individuals seeking treatment earlier. (Chart 5. Other Problems)



The final indicators for general wellbeing look at the clients' perception of the extent to which a supportive network of family and friends is maintained; the extent to which time is taken off to relax; the extent to which the client maintains a healthy diet; and, the extent to which the clients exercise. Although these are arguably subjective indicators, the purpose of this element of the evaluation is to document changes in the self-report from the enrollment

baseline. As can be seen in Chart 6, Wellness Activities, the distribution of responses to these indicators tend, in general, to mirror those of the general satisfaction indicators. As the sample increases in size and longitudinal data becomes available, more meaningful correlational analysis opportunities will be available.

Previous Treatment History

Approximately 22.3% of enrolling gambler clients reported that had received formal outpatient or inpatient treatment prior to the current enrollment. The average number of prior treatments was 1.4% (sd = 0.8). (Table 47. Average Number of Prior Formal Gambling Treatment Episodes)

Table 47. Average Number of Prior Formal Gambling Treatment Episodes By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
163	1.4	0.8	87	1.5	0.9	76	1.3	0.7

Slightly more than 18.3% reported receiving formal outpatient or inpatient treatment for alcohol and drug problems. The average number of treatments was 1.5 (sd = 1.1). (Table 48. Average Number of Prior Formal Alcohol/Drug Treatment Episodes)

Table 48. Average Number of Prior Formal Alcohol/Drug Treatment Episodes By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
134	1.5	1.1	82	1.5	0.8	51	1.6	1.4

Slightly more than 19.3% reported receiving formal outpatient or inpatient treatment for mental health problems and the average number of treatments was 1.9 (sd = 1.9). (Table 49. Average Number of Prior Formal Mental Health Treatment Episodes)

Table 49. Average Number of Prior Formal Mental Health Treatment Episodes By Gender (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
141	1.9	1.9	61	1.9	1.7	79	1.9	2.1

Nearly 41% of the gambler clients had previously accessed some form of formal outpatient or inpatient treatment prior to the current enrollment including either gambling, substance abuse, or mental health treatment. Of these, approximately 13.7% had accessed both gambling and mental health treatment, 10.4% both gambling and substance abuse treatment, 12.7% both substance abuse and mental health treatment, and 3.4% had previously accessed all three types of treatment.

FAMILY CLIENT DEMOGRAPHICS

Age and Gender

The average age of family clients at the time of enrollment was 44.4 years (sd = 12.4) and the gender mix was 69.5% female. (Table 50. Average Age of Family Clients)

Table 50. Average Age of Family Clients (Partial Year Data)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
270	44.4	12.4	81	44.9	11.9	186	44.3	12.4

Race/Ethnicity

As can be seen in Table 51. Race/Ethnicity of Family Clients, 88.9% were reported as White, 3.1% Hispanic, 1.9% Asian, 1.5% Black, 1.1% Native American, 0.8% Southeast Asian, and 2.7% other.

Table 51. Race/Ethnicity of Family Clients (In Percent of Distribution)

Race/Ethnicity	Percent
White	88.9
Hispanic	3.1
Asian	1.9
Black	1.5
Native American	1.1
Southeast Asian	0.8
Other	2.7
Total	100.0

Relationship to Gambler Client

The most common relationship to the gambler client was reported as spouse or significant other (60.9%), followed by parent (14.0%), child (12.3%), sibling (3.9%), other family member (5.0%), and friend or co-worker (3.9%). It is interesting to note the differences that children attending family treatment are more likely to be male and that gambler clients are less likely to have a female friend or co-worker attend treatment although these differences are not significant. (Table 52. Relationship of Family Client to Gambler Client)

Table 52. Relationship of Family Client to Gambler Client By Gender (In Percent)

Relationship	All (n = 182)	Males (n =54)	Females (n = 122)
Spouse/Significant Other	60.9	51.8	64.7
Parent/Step Parent/Guardian	14.0	11.1	15.6
Child/Step Child	12.3	16.6	9.9
Sibling	3.9	1.9	4.9
Other Family Relation	5.0	5.6	4.9
Friend or Co-worker	3.9	13.0	0.0
Total	100.0	100.0	100.0

Family Diagnosis

With implementation of the revised evaluation data collection protocol, providers were requested to document DSM Axis I and Axis II diagnostic codes. Preliminary data provided for this report indicates that 84.0% of the coding has been the "V" codes for relationship problems with the remaining 16% distributed over a variety of codes from adjustment to depressive disorders. It was also found that a few counselors were inappropriately coding this field with the code for pathological gambling.

TREATMENT

The following information is based on gambler clients whose cases were closed during the report period. The total number of case closings during the period was 1189.

Treatment Type

As discussed above, there are three primary treatment venues with the state-funded system including outpatient, respite, and the home-based minimal intervention program. With the

Table 53. Treatment Type – Gambler Clients (In Percent) (Partial Year Data)

Relationship	All (n = 657)
Outpatient	85.8
Intensive Outpatient/Partial Hospitalization	12.9
Minimal Intervention	1.1
Residential/Inpatient	0.2
Medically-Managed Inpatient	0.0
Long-term Residential	0.0
Total	100.0

introduction of the revised evaluation data collection protocol, providers were requested to document the type of treatment received from a list of six choices.

As can be seen in Table 53. Treatment Type – Gambler Clients, the majority of care is provided in an outpatient setting (85.8%), followed by intensive outpatient/partial hospitalization (or day care) (12.9%), minimal intervention (1.1%), and residential/inpatient (0.2%). There was no formal medically-managed inpatient nor long-term residential care in Oregon. Since this is partial year data, it should be viewed with caution since it does not reflect current utilization of respite care.

Gambler Length of Enrollment

The average length of enrollment for all gambler clients was 124.2 days (sd = 160.9) .(Table 54. Average Length of Enrollment All Gambler Clients) and for those gambler clients that were recorded as successfully completing their course of treatment, the average length of enrollment was 260.4 days (sd = 212.3) which was significantly[58] longer than non-completers. (Table 55. Average Length of Enrollment Successful Completing Gambler Clients). There

Table 54. Average Length of Enrollment All Gambler Clients By Gender (In Days)

FY	All			Males			Females		
	n	Mean	sd	n	Mean	sd	n	Mean	sd
FY 95-96	400	100.6	118.2	232	94.5	112.6	125	105.2	120.0
FY 96-97	532	123.5	131.3	311	116.0	120.0	194	126.6	122.9
FY 97-98	620	143.3	175.2	342	148.1	183.3	244	150.1	169.7
FY 98-99	707	175.7	198.5	413	170.4	193.1	274	183.0	202.5
FY 99-00	876	156.2	169.6	516	147.4	154.6	344	169.7	185.1
FY 00-01	1043	184.9	209.9	551	172.5	197.6	461	207.9	223.5
FY 01-02	1188	124.2	160.9	647	116.7	163.4	529	134.8	158.6

[58] t test $p < .01$

were no statistically significant difference between males and females average length of enrollment.

As can be seen in the table above, the average length of enrolment dropped significantly[59] from previous years. This is most likely partially an artifact of the more timely closure of inactive cases as required by the new contracts. The average length of enrollment also dipped for those successfully completing the programs, but the difference between the report year and the previous year was not statistically significant.

Table 55. Average Length of Enrollment Successful Completing Gambler Clients By Gender (In Days)

FY	All			Males			Females		
	n	Mean	sd	n	Mean	sd	n	Mean	sd
FY 95-96	47	194.2	128.6	28	178.1	140.9	14	241.7	105.3
FY 96-97	107	233.6	156.8	67	230.2	146.1	34	202.9	99.9
FY 97-98	144	263.9	242.0	71	311.1	274.3	62	238.5	201.7
FY 98-99	228	267.8	186.6	122	243.7	168.8	97	295.1	189.8
FY 99-00	233	262.9	196.1	142	254.0	192.8	86	271.0	188.7
FY 00-01	330	283.2	230.5	169	266.9	285.0	150	318.4	251.3
FY 01-02	296	260.4	212.3	157	260.3	226.8	137	262.8	194.9

Gambler Client Successful Treatment Completion Rate

The criteria for successful completion of treatment includes the completion of at least 75% of the short-term treatment goals, completion of a continued wellness plan (i.e., relapse prevention plan), and lack of engagement in problem gambling behaviors for a least 30 days prior to discharge.

[59] t test $p < .01$

As can be seen in Table 56. Treatment Termination Status – Gambler Clients, the adjusted[60] successful program completion rate was 27.9%. Approximately 49.0% stopped attending treatment against staff advice after engagement and 16.4% failed to engage in treatment following the initial face-to-face assessment. The administrative case closures were due to a concerted effort by the providers to ensure the evaluation efforts had an accurate and timely database. Although most of the administrative case closures were for old records that had been "open" for long periods of time, they were coded as closed on the same day they had been opened so as to not skew the length of enrollment reported above.

Table 56. Treatment Termination Status – Gambler Clients By Gender (In Percent)

Case Status at Termination	All (n = 1177)	Males (n = 640)	Females (n= 525)
Successfully Completed Treatment*	***27.9***	***27.2***	***28.7***
Stopped Attending – Against Staff Advice*	49.0	47.8	50.5
No Show for Initial Appointments *	16.4	17.7	15.2
Non-Compliance with Rules*	1.3	0.8	1.7
(Neutral Reasons)	0		
Moved from Catchment Area	2.8	2.3	3.4
Further Services Not Appropriate at Provider	2.5	3.8	1.0
Incarcerated	0.8	0.5	1.1
Conflicting Hours	0.6	0.9	0.2
Physical or Mental Illness	0.4	0.6	0.2
Program Cuts	0.3	0.3	0.4
No Transportation	0.2	0.2	0.2
Administrative Case Closure	0.6	0.6	0

[60] The adjusted successful completion rate omits "neutral" discharges as delineated in the table.

There were no significant differences between males and females in regards to the case status at closing.

Table 57. Successful Program Completion Rates - Adjusted (In Percent of Distribution)

FY	Gamblers	Family
FY 95-96	15.9	20.6
FY 96-97	24.2	36.0
FY 97-98	28.9	39.5
FY 98-99	36.9	45.8
FY 99-00	29.8	35.1
FY 00-01	35.7	38.5
FY 01-02	27.9	43.4

As can be seen in Table 57. Successful Program Completion Rates, the overall adjusted gambler client successful completion rate dropped from 35.7% in FY 00-01 to 27.9% in the current report year. Again, this apparent dip in the successful program rates is most likely attributable to the increased vigilance to the reporting requirements associated with a fee-for-service reimbursement.

Referral After Treatment

With the implementation of the revised evaluation data collection protocol, providers were requested to document where they were referring gambler clients after they left the treatment program. In analyzing the data, especially for those clients who failed to show for their initial appointments, and to a somewhat lesser extent, those who simply stopped coming, it became apparent that it was unclear how these referrals were being made.

For example, of those who were coded as “no show for initial appointments,” 70.8% were coded as being given a referral to Gamblers Anonymous (GA), 1.1% were referred to the minimal intervention program, and 2.2% to outpatient treatment. Similarly, for gambler clients who were coded as “stopped coming against staff advice,” 22.5% were coded as being referred to GA, 24.7% to outpatient treatment, 22.5% to the minimal intervention program, 3.4% to a therapist not associated with a formal program, and 4.5% to residential care. The

program evaluation question that needs to be answered before this information can be of use is how were these referrals were made since most of these individuals who do not complete treatment simply disappear without a termination, or closing, session.

For those gambler clients that successfully completed treatment, 59.5% were referred to GA, 10.2% to other gambling treatment venues, and 3.3% to other resources. Approximately 27% were reported as not receiving referrals for aftercare.

Again, the data for this element is based on partial year data and should be viewed with caution.

Family Treatment

The family treatment programs are stand-alone programs where family members[61] and friends can attend also free of charge. One of the unique facets of these treatment efforts is that participation by a family member is not contingent on the gambler's attendance. In many situations, it has been anecdotally reported to the evaluator that the family's engagement in the program has been the precipitating event that led to the gambler's eventual enrollment.

One of the difficulties in attempting to evaluate the family treatment component of the statewide system is the variety of potential treatment goals. Unlike the treatment of pathological gambling where there are only two viable goals, reducing problems associated with the gambling (harm reduction) or abstinence, family treatment goals cover a wide spectrum. These goals can range from improving the emotional, mental, and physical

[61] Eligibility as a "family member" is flexible and, in practice, has included extended family members and friends who are involved in the gambler's life.

wellbeing of the family member who has been living in, and trying to survive, the turmoil of living with a person with a mental illness to encouraging the gambler to access treatment, to protecting the family assets.

With this in mind, reporting and discussing the average length of enrollment and successful program completion rates become convoluted when it is impossible to link such factors to specific goals. Nonetheless, they are reported in hopes of increasing the understanding of family treatment for pathological gambling.

Family Length of Enrollment

The average length of enrollment for all family clients was 120.0 days (sd = 154.6). Females were significantly[62] more likely to remain enrolled longer than male family clients. (Table 58. Average Length of Enrollment All Family Clients)

Table 58. Average Length of Enrollment All Family Clients By Gender (In Days)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
229	120.0	154.6	70	91.0	126.4	157	134.2	164.4

For family clients that were reported as successfully completing their course of

Table 59. Average Length of Enrollment Successful Completing Family Clients By Gender (In Days)

All			Males			Females		
n	**Mean**	**sd**	**n**	**Mean**	**sd**	**n**	**Mean**	**sd**
88	186.7	186.3	22	136.2	126.2	66	203.5	199.5

[62] t test $p < .05$

treatment, the average length of enrollment was 186.7 days (sd = 186.3). The difference between genders was not significant; however, those successful completing their course of treatment remained significantly[63] longer than those that did not. (Table 59. Average Length of Enrollment Successful Completing Family Clients)

Family Client Successful Program Completion Rate

The adjusted successful program completion for family clients was 43.4%.[64] Slightly over 29% of the family clients' cases were closed after they failed to return following an initial visit, 23.8% stopped coming against staff advice following engagement in treatment, and 4.0% were closed as the provider determined that further services at that program were not appropriate. Although there are some differences in the distribution of responses between males and females, none were significant. (Table 60. Treatment Termination Status – Family Clients)

Table 60. Treatment Termination Status – Family Clients By Gender (In Percent)

Case Status at Termination	All (n = 227)	Males (n = 69)	Females (n = 156)
Successfully Completed Treatment (Adjusted)	***43.4***	***39.3***	***45.6***
No Show for Initial Appointments	29.1	27.5	30.1
Stopped Attending – Against Staff Advice	23.8	27.5	21.2
Non-Compliance with Rules (Neutral Reasons)	0.4	1.5	0.0
Further Services Not Appropriate at Provider	4.0	7.3	2.6
Physical or Mental Illness	1.8	0.0	2.6
Program Cuts	0.9	1.5	0.6
Non-Compliance with Rules	0.4	1.5	0.0
Moved from Catchment Area	0.4	1.5	0.0

[63] t test $p < .01$

[64] There are no defined standards for successful family client completion as there are for the gambler client.

Conflicting Hours	0.4	0.0	0.6
Incarcerated	0.4	1.5	0.0
No Transportation	0.0	0.0	0.0

Services Provided

As discussed above, the statewide system began its transition to a fee-for-service funding basis at the beginning of the report period. Providers were required to submit encounter data on a monthly basis to the evaluator[65] for processing. [66]

The were no caps on the total amount of services that could be provided to clients although there were caps placed on the number of assessment hours that could be provided per treatment episode (2 hours); the number of individual face-to-face individual counseling hours per day (2 hours) and per month (8 hours); the number of group hours per day (3 hours) and per week (6.25 hours). The reimbursement rates from July 1, 2001 through September 30, 2001 were $81.08 for assessment and individual session hours and $27.04 per hour for group counseling. These rates were increased on October 1, 2001 to $82.52 and $27.52 per hour.

Previous to this funding change, providers reported a summary of hours of service provided to each client at the time of discharge. Due to the administrative burden that would

[65] The external evaluator contractor, Herbert & Louis LLC, was experienced with insurance claims processing including system design; process and database management; as well as reporting and was able to quickly blend the evaluation data management with the claims data management in a consolidated, streamlined manner. It is outside the scope of this report to discuss this system. However, technical system information can be provided upon request from the report author, or general system information, including policy, from Dr. Jeffrey Marotta, the state's Gambling Services Manager.

[66] Although the first year was not truly a fee-for-service reimbursement, grant funding was reviewed and reallocated from programs where utilization, based on encounter data reporting, was below expected levels, to programs that were providing more services than planned.

have been placed on providers to report a summary of services provided to all clients in their programs as of June 30, 2001, a decision was made to forego having complete individual case encounter data until the system could "catch up" with clients that were both enrolled and closed under the new encounter reporting structure.

As can be seen in Table 61. Utilization, 23,196 sessions were reported during the year for a total of 33,823 hours of service. The direct fee-for-service cost of these services was approximately $1.5 million and the actual cost, including a 5% administrative fee to the counties was $1,574,634. This information includes services to both gambler and family clients and is for services delivered during FY 01-02.

Table 61. Overall Utilization FY 01-02

Service Type	Hours	Sessions	Total Cost
Individual Counseling/Assessment	10,540	9,954	$861,176
Group Counseling	23,283	13,242	638,475
Total	33,823	23,196	$1,499,651

Looking more specifically at service utilization by client, it was necessary to include services that were delivered after the end of FY 01-02. To accomplish this, encounter data for clients that were enrolled during the report year, and subsequently closed either during the report year, or the six months following the report year are included in the following tables to provide an overview of the level of effort expended by case.

Table 61a. Gambler Client Service Utilization – All Discharge Types shows that the average number of encounter per gambler client case was 12.4 (sd = 14.9). The total number of hours delivered was approximately 18.9 hours per case (sd = 24.8) while the average case reimbursement was $715.29 (sd = 884.22).[67]

Table 61a. Gambler Client Service Utilization All Discharge Types

Service Type	n	Average Hours	sd
Encounters	799	12.4 sessions	14.9
Hours	799	18.9 hours	24.8
Case Reimbursement	799	$715.29	884.22

For gambler clients who successfully completed the program, the average number of encounters was 25.3 (sd = 19.5), the average number of service hours expended was 39.5 hours (sd = 34.2), and the average case reimbursement was $1439.40 (sd = 1176.76). (Table 61b. Gambler Client Successful Completers Service Utilization)

Table 61b. Gambler Client Successful Completers Service Utilization

Service Type	n	Average	sd
Encounters	210	25.3 sessions	19.5
Hours	210	39.5 hours	34.2
Case Reimbursement	210	$1439.40	1176.76

Gambler clients who did not successfully compete treatment averaged only 7.8 sessions (sd = 9.4) for

Table 61c. Gambler Client Non-Completers Service Utilization

Service Type	n	Average	sd
Encounters	589	7.8 sessions	9.4
Hours	589	11.5 hours	14.5
Case Reimbursement	589	$456.04	559.12

[67] This is without the 5% administrative overhead provided to counties and discussed above.

an average of 11.5 hours (sd = 14.5) per case at an average case reimbursement of $456.04 (sd = 559.12). (Table 61c. Gambler Clients Non-Completers Service Utilization)

Table 61d. Family Client Service Utilization All Discharge Types

Service Type	n	Average Hours	sd
Encounters	170	8.5 sessions	9.3
Hours	170	12.3 hours	14.1
Case Reimbursement	170	$545.30	624.90

Overall, family clients attended, on average, 8.5 sessions (sd = 9.3) for an average of 12.3 hours per case (sd = 14.1) at an average case reimbursement of $545.30 (sd = 624.90). (Table 61d. Family Client Service Utilization All Discharge Types)

The average number of sessions for family clients who successfully completed the programs was 14.2 times (sd = 11.2), the average number of service hours per case was 20.6 hours (sd = 17.4), and the average case reimbursement was $922.25 (sd = 740.01). (Table 61e. Family Client Successful Completers Service Utilization)

Table 61e. Family Client Successful Completers Service Utilization

Service Type	n	Average	sd
Encounters	71	14.2 sessions	11.2
Hours	71	20.6 hours	17.4
Case Reimbursement	71	$922.25	740.01

Non-successful family clients averaged 4.4 sessions (sd = 4.4) per case, for an average of 6.3 hours (sd = 6.5) per case, at an average case reimbursement of $274.90 (sd = 320.55).

Table 61f. Family Client Non-Completers Service Utilization

Service Type	n	Average	sd
Encounters	99	4.4 sessions	4.4
Hours	99	6.3 hours	6.5
Case Reimbursement	99	$274.90	320.55

The differences between successful and non-successful program completers are statistically significant for each of the three measures.[68]

OUTCOMES

The revised evaluation data collection protocol included, in addition to the pre/post administration of the BSI, a modified self-report survey that replaced the HLGI discussed in previous reports. This survey contains the core questions from the HLGI plus demographic questions which mirrored central items on the record abstracting forms in an effort to provide consistent date points across enrollment, discharge, and follow-up.[69] The gambler client enrollment form contains 54 questions comprised of eight general demographic questions, ten questions regarding general satisfaction with life, 16 questions regarding general activities related to the results of problem gambling, 10 questions of the DSM screen for pathological gambling,[70] four questions directly related to gambling behavior, and six questions relating to treatment utilization. The discharge version of the gambler client survey includes an additional 11 satisfaction questions, eight of which utilize a Likert-type rating scale and three that are open-ended. The follow-up instrument is the same as the discharge version except it omits five of the service related satisfaction questions which only provide information that is useful at discharge. The 90-day follow-up survey for clients who did not complete treatment contains one additional question regarding reasons the client did not remain in treatment longer.

[68] t test $p < .05$
[69] Copies of these instruments are available electronically by emailing a request to admin@herblou.com
[70] These questions are the same that have been used in previous prevalence studies.

A separate survey was developed for family clients that includes the same questions as found in the gambler client survey except those questions that apply directly to ones gambling.

Follow-up was undertaken for successful program completers at six and twelve months and for those who left the program for reasons other than successful completion, the follow-up is at 90 and 180 days.[71]

Discharge Outcomes

One of the difficulties, discussed above, has been the collection of the survey data at discharge. This is due to the fact that a majority of the clients simply stop coming to treatment.

Improved Symptoms

Information discussed in the previous section regarding utilization, length of enrollment, and termination status are considered outcomes of the system. More specifically, the revised evaluation data collection protocol incorporated the use of the BSI (discussed above) as the primary measurement for short-term changes in symptomology.

One of the difficulties, mentioned above, was the low participation rates at discharge. Many of the gambler clients would simply stop attending treatment and consequently it was not possible for the providers to collect representative comparative BSI data at termination. That data which was collected and matched by client (n = 75) with enrollment responses to

[71] The revised protocol calls for follow-up also at 18 and 24 months.

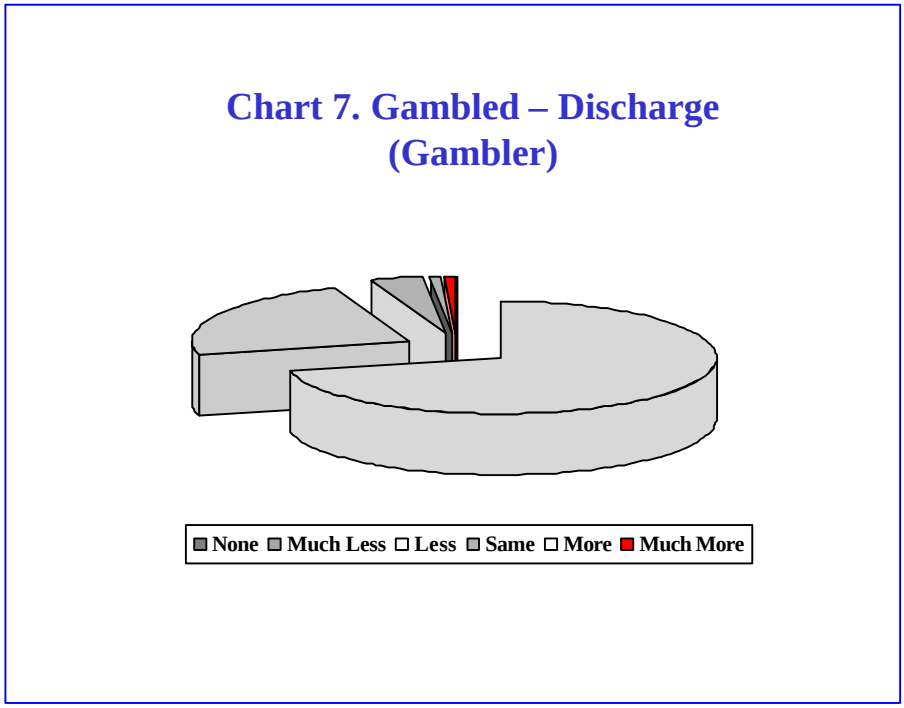
the BSI indicated statistically significant[72] improvement only in the domain of interpersonal sensitivity.[73] Nonetheless, the value of using the BSI was supported when comparison of enrollment symptomology of those completing treatment was compared to those who left treatment against staff advice.

In previous reports, (Moore, T., 2001c) using the Herbert Louis Gambling Index reported that clients leaving treatment before successful completion reported higher levels of symptomology at admission than those that remained in treatment and successfully completed. These earlier finding were supported with successful program completers scoring significantly lower symptomology in the domains of depression ($p < .01$), anxiety ($p < .05$), hostility ($p < .01$), paranoid ideation ($p < .01$), psychoticism ($p < .01$), and the general severity index ($p < .05$) of the BSI.

This finding suggests that gambler clients with higher levels of symptomology are either finding short-term relief from the brief exposure to the program and leaving or they are simply returning to the community finding no value in the programs. This is further discussed in the non-completer follow-up section below.

[72] Friedman two-way ANOVA
[73] This domain is comprised of questions relating to self-worth when around others.

Respondents are asked to indicate the frequency with which they gambled since entering treatment. The response choices include did not gamble, much less than before treatment, less than before treatment, about the same as before treatment, more than before enrolling in treatment, and much more than before treatment.[74] "in the past six months." Seventy-one percent reported no gambling, 23.4% much less than before treatment, 3.7% less than before treatment, 0.9 about the same, and only 0.9% indicated they were gambling more than before enrolling in treatment. (Chart 7. Gambled – Discharge)

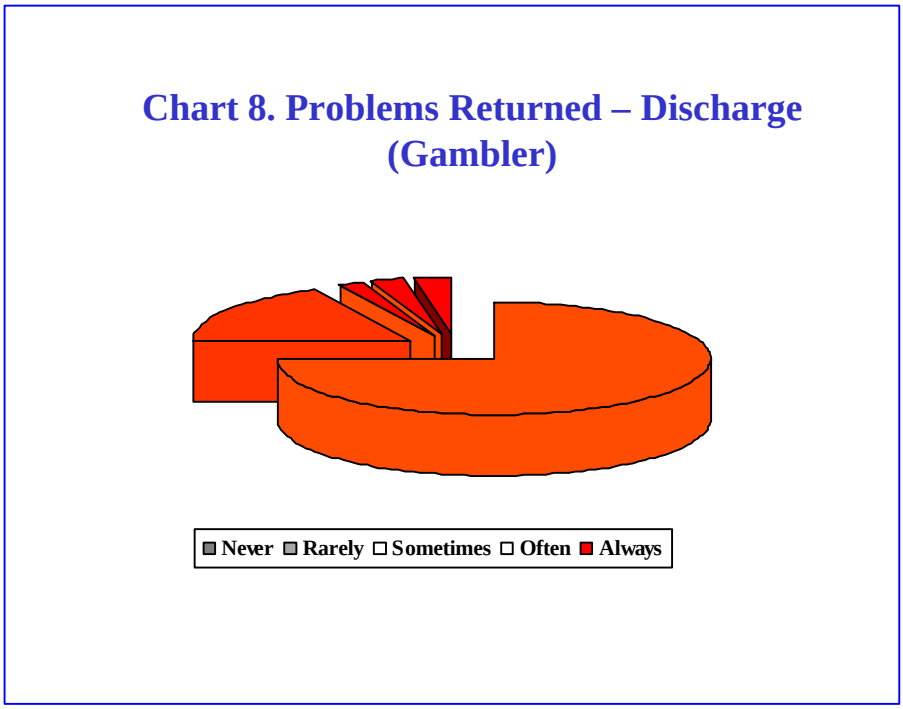


Following a similar pattern, the gambler clients at discharge responded never 75.2% to the question if the problems that had brought them to treatment had returned. Nearly 18% responded rarely, 1.8% sometimes, 2.7% often, and another 2.7% always. This distribution is presented in Chart 8. Problems Returned – Discharge.

[74] The old survey utilized the Liker-type scale.

Satisfaction

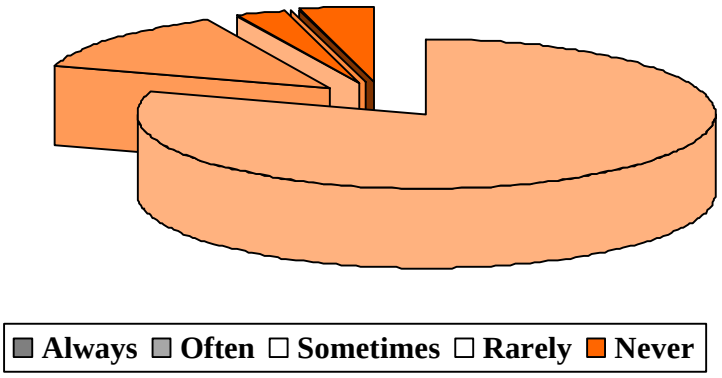
Of the 116 gambler client discharge surveys that were collected by the providers, 93.7% indicated that the care they received was helpful. This question is scored utilizing a five point Likert-type scale with the categories of always, often, sometimes, rarely, and never to indicate the respondent's level of agreement with the statement.



As would be expected at the end of treatment, a large segment of the sample (57.1%) indicated they had not gambled since enrolling in treatment, another third (33.3%) indicated that their gambling was much less than before treatment, 7.1% responded their gambling was less than treatment, and only 2.4% indicated their gambling was about the same as before treatment.

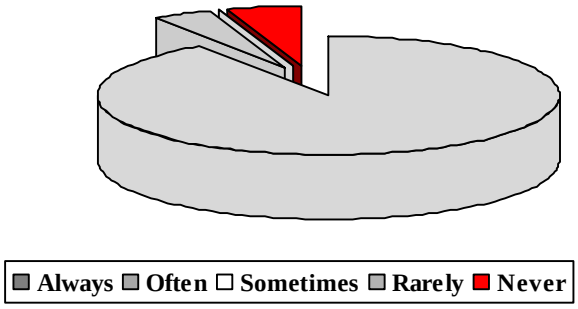
As can be seen in Chart 9. Care Helpful – Discharge (Gamblers), the positive scores were comprised of 80.0% always, 13.0% often, 2.6% sometimes, and 4.3% never.

Chart 9. Care Helpful – Discharge (Gambler)



Approximately 90.4% of the gambler clients were willing to recommend the program to others always, 4.3% often, and only 5.2% responded never. (Chart 10. Would Recommend – Discharge). These satisfaction distributions are very consistent with those reported in previous years.

Chart 10. Would Recommend – Discharge (Gambler)



Five central themes continue to be present in the gambler clients' response to the open-ended question regarding the most helpful part of treatment. These themes include: 1) understanding self and in respect to gambling; 2) understanding pathological gambling; 3) learning ways to support alternative behaviors to solve problems; 4) discussions with peers with the same problems; and, 5) having counselors to facilitate the process. As expected, comments supported the notion that individuals place different value on the helpfulness of one-on-one sessions versus groups sessions.

There were no themes that emerged from the gambler clients' response to the open-ended question regarding the least helpful aspects of treatment. Of the few comments that were provided, all primarily pertained to specific incidences that did not suggest any trends.

Suggestions to improve treatment consistently have included the need to better "advertise" the availability of the treatment programs, more session availability, and the desire for smaller groups. Except for the first suggestion, these comments are relatively program specific where participants from smaller programs express desire for more availability of counseling and those from larger programs occasionally suggest smaller group sizes.

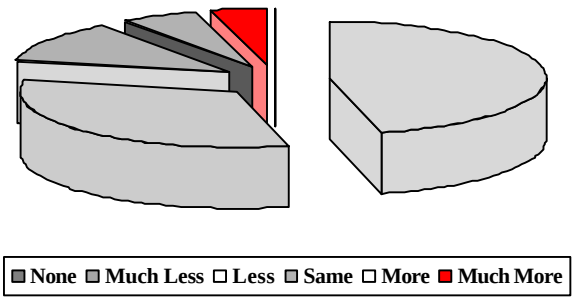
Family Client Outcomes & Satisfaction – Discharge

Only 26 family client discharge satisfaction surveys were received during the report period and consequently the following comments should be viewed with caution.

Approximately 81% of the family clients indicated that the problems that had brought them to treatment had not returned and approximately 85% indicated that the care had been helpful and that they would refer others to the program.

Follow-Up Outcomes & Satisfaction

Chart 11. Gambled – Six Month Follow-Up (Gambler – Successful Treatment Completers)

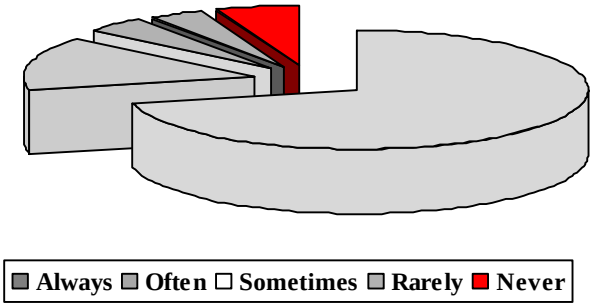


At six-month follow-up 46.2% (n = 140) of the gambler clients who had successfully completed treatment reported no gambling since enrolling in treatment. Approximately 31.9% reported some gambling but much less than before enrolling in treatment, 11.8% reported gambling less; 5.9% gambled about the same as before treatment, 4.2% reported gambling more than before enrollment, and none reported gambling much more than before enrollment. (Chart 11. Gambled – Six-Month Follow-Up: Gambler - Success Treatment Completers)

Of these respondents, 57.0% reported they felt the care was always helpful, 24.4% often helpful, 8.1% sometimes helpful, 4.4% rarely helpful, and 5.9% never helpful. Experience suggests that consumer satisfaction ratings tend to drop off the longer the time between receipt of service and survey. Nonetheless, their willingness to recommend the program to others remained strong with 71.3% indicating always, 14.6% often, 4.4%

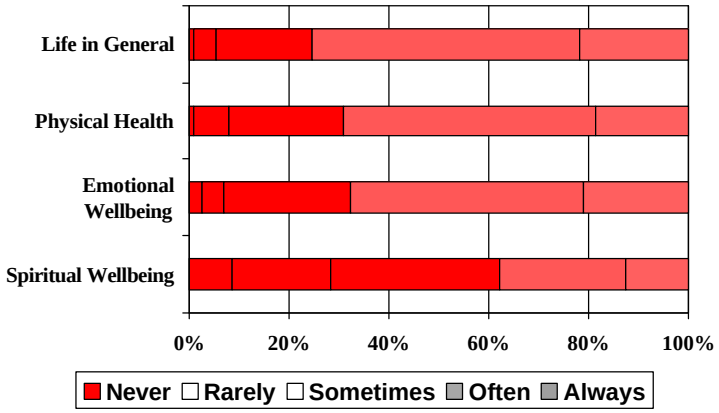
sometimes, 3.7% rarely, and 5.9% indicating they would never recommend the program to others with similar problems. (Chart 12. Would Recommend – Six-Month Follow-Up: Successful Program Completers)

Chart 12. Would Recommend
Six-Month Follow-Up
(Gambler – Successful Program Completers)



Although the data presented in Chart 13, General Life Satisfaction – Six Months, is not for the same clients as reported above as baseline[75] enrollment, the difference are nonetheless remarkable. At six months, slightly over 75% of the 118 successful program

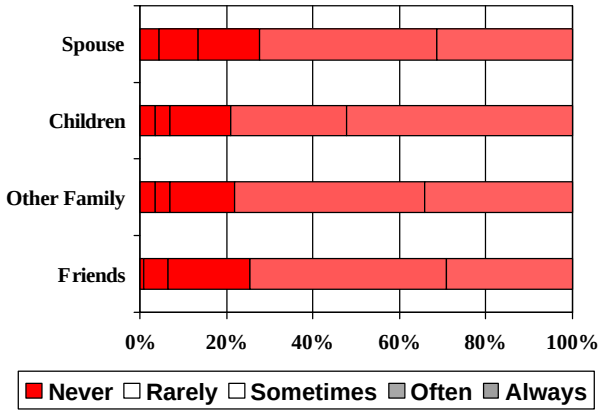
Chart 13. General Life Satisfaction
(Gambler at Six Months)
Previous Six Months



[75] This, again, is due to the timing of the new protocol and the reporting period.

completers participating with the new protocol reported they were satisfied with life in general often or always (compared to approximately 42% of those enrolling during the period). (Chart 13. General Life Satisfaction)

Chart 14. Satisfaction with Key Relationships (Gambler at Six Months) Previous Six Months



Similarly, the six-month follow-up sample also reported much improved levels of satisfaction than their cohort that enrolled during the period. For example, 72.6% of the follow-up sample reported being often or always satisfied with their spouse or significant other compared to the enrollment sample where only 44.3% responded similarly. (Chart 14. Satisfaction with Key Relationships)

At six-month follow-up, the sample also reported marked improvement in the accomplishment of responsibilities at home and at work as well as paying bills on time (Chart 15. Critical Activities Completed) as well as in problems related to the use of alcohol, illegal drugs, criminal activities, and suicidality (Chart 16. Other Problems).

Chart 15. Critical Activities Completed (Gambler at Six Months) Previous Six Months

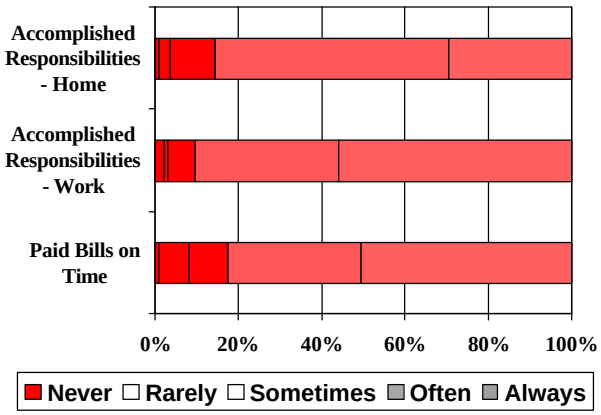
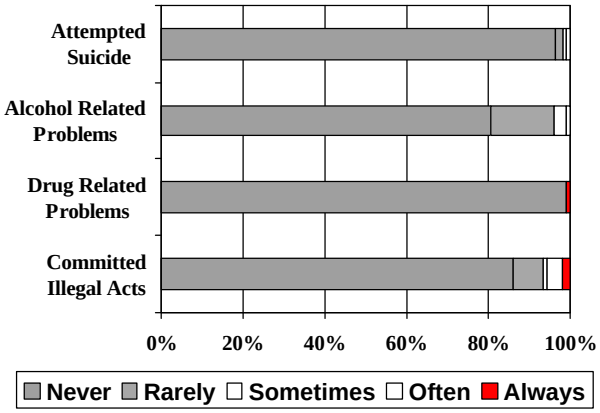
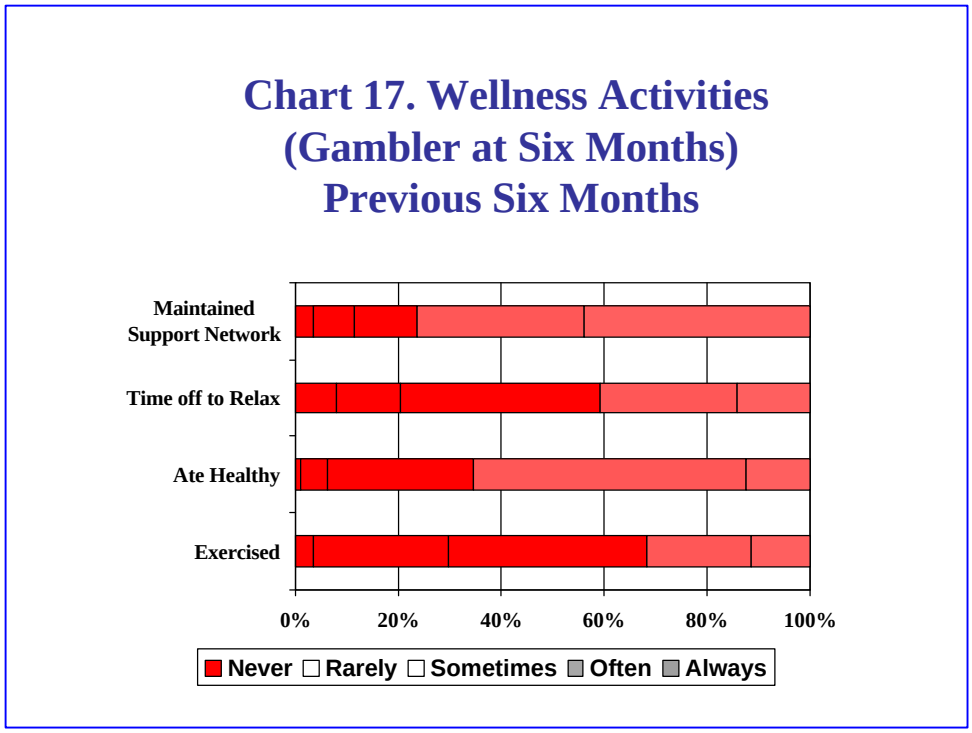


Chart 16. Other Problems (Gambler at Six Months) Previous Six Months

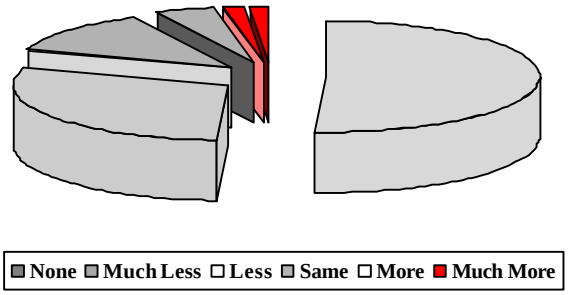


As would be expected, successful clients at six-months post discharge also were more likely to maintain a supportive network with family and friends, to take time off to relax, and ate healthy. Their responses to exercise were interestingly quite similar to their cohorts at discharge. (Chart 17. Wellness Activities)



Although it is tempting to conclude from the information presented above that improvement continues after treatment, it should be kept in mind that this is not longitudinal data for the same clients but is from two different samples. (Baseline data was not available for those in the six-month follow-up because the survey questions were not in place when they enrolled.)

Chart 18. Gambled – 12-Month Follow-Up (Gambler – Successful Treatment Completers)

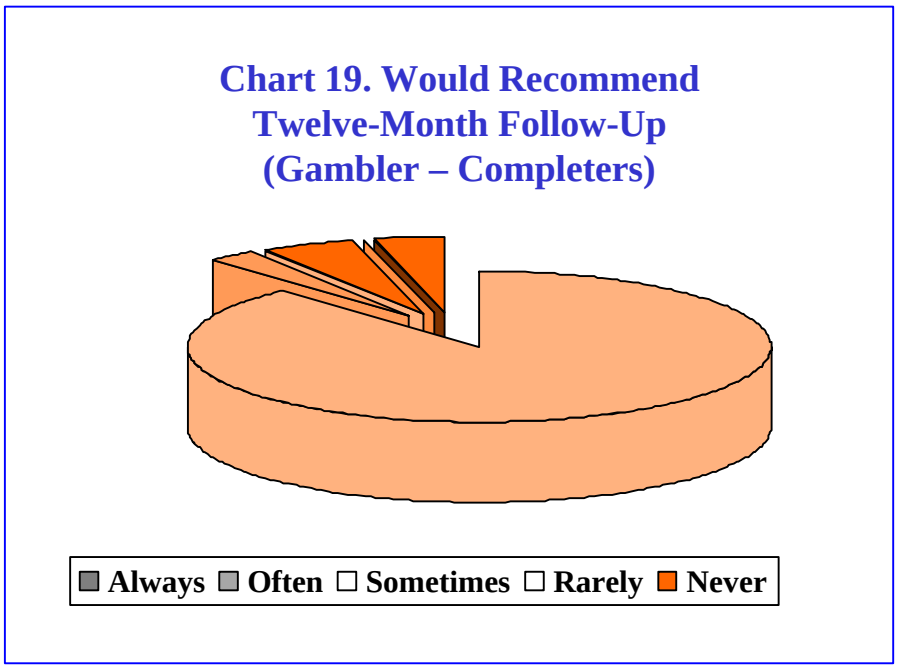


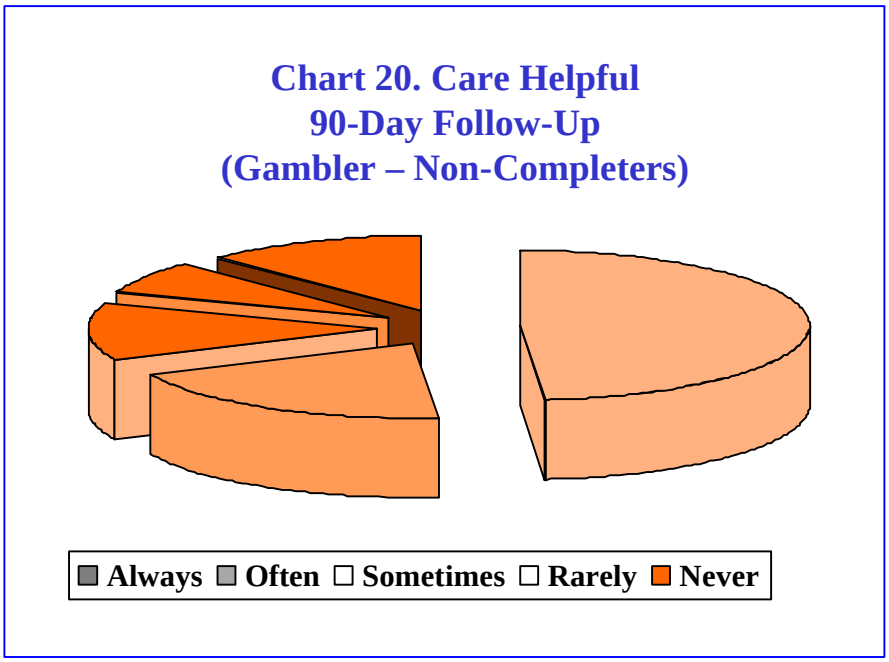
At 12-month follow-up, 50.8% of the 77 respondents,[76] indicated that they had not gambled since enrolling in treatment. Slightly over 29% reported that they had gambled but much less than before treatment, 12.3% reported less gambling, 4.6% about the same, 1.5% more, and 1.5% reported much more gambling than before they had enrolled in treatment.[77] (Chart 18. Gambled – 12-Month Follow-Up: Gambler – Successful Treatment Completers)

At 12-month follow-up, gambler clients' willingness to recommend the program to others remained very positive with 88.2% indicating always, 2.6% often, 5.3% sometimes, and only 3.9% responding never. (Chart 19. Would Recommend Twelve-Month Follow-Up)

[76] The revised protocol called for providers to submit additional client tracking (locator) information for those clients who volunteered to participate in the follow-up. These 12-month follow-ups were with the older protocol.

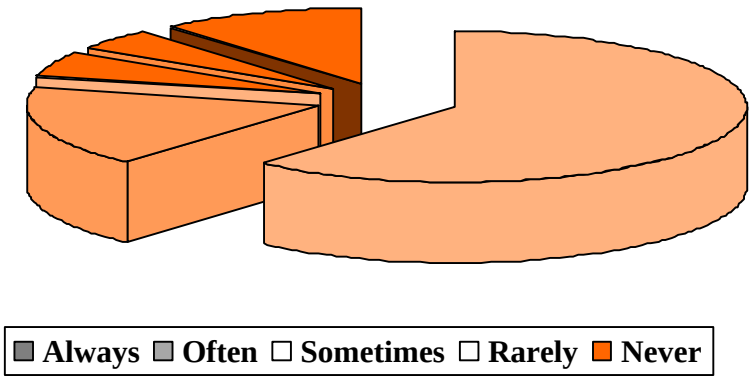
[77] During follow-up, respondents are referred back to their treatment program, to another program in their area, or to the minimal intervention program as appropriate if they indicate they are having problems.





Of the 104 gambler clients that did not successfully complete treatment and were contacted for 90-day follow-up, 48.6% indicated that the care was always helpful, 19.4% often helpful, 12.5% sometimes helpful, 6.9% rarely helpful, and only 12.5% indicated that the care received was never helpful. Although this is not what would be considered great levels of satisfaction, it is important to note that 68.0% of those that simply walked away from

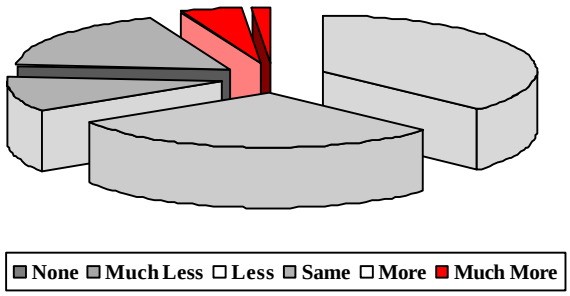
Chart 21. Would Recommend
90-Day Follow-Up
(Gambler – Non-Completers)



treatment found it helpful. (Chart 20. Care Helpful – 90-Day Follow-Up: Gambler Non-Completers)

Confirming this, 78.5% of the non-completers indicated they would be positive in recommending the program to others (61.4% always, 17.1% often), 5.7% sometimes, 5.3% rarely, and 11.4% never. (Chart 21. Would Recommend – 90-Day Follow-Up: Gambler Non-Completers)

Chart 22. Gambled
90-Day Follow-Up
(Gambler – Non-Completers)



Importantly, 37.3% of the gambler clients who dropped from treatment reported no gambling at 90 days. Nearly 28.5% reported gambling much less than before treatment,

10.4% less, 4.5% more, and only 1.5% reported gambling much more than before they enrolled in treatment. (Chart 22. Gambled – 90-Day Follow-Up: Gambler Non-Completers)

Findings that support the notion that non-completers are obtaining value from treatment has been previously reported (Moore, T., 2001, 1999). Also, from the non-completer response to the open-ended question regarding what was most helpful, it appeared that similar themes emerged as those for program completers including: 1) understanding self and in relation of self and 2) understanding pathological gambling; 3) learning ways to support alternative behaviors to solve problems; 4) discussions with peers with the same problems; and, 5) having counselors to facilitate the process.

Least helpful themes grouped around availability of services (times and location), dislike of group setting, not connecting with counselor (including questioning of counselor skills), and a variety of other reasons.

Reasons given for not remaining in the program longer tended to blend with the themes found in the responses to the least helpful question. Gambler clients appeared to be surprisingly frank when answering this question. For example, comments were given to the effect that "my marijuana use was challenged and I was not ready to let go of that." I wasn't ready to quit gambling – I felt I deserved all the misery and shame that gambling causes." "I wanted help, but I wasn't at the right point to accept it." "It seemed I had the tools to leave treatment."

Suggestions for improvement included more availability (both time and location), more intensity at the beginning of the program and doing more to engage the client early on (one suggested having mentors).

Follow-Up Completion Rates

Previous reports have stressed the need to view the follow-up findings with some caution due to the relatively low rates of client responses. With the implementation of the revised evaluation protocol, the state's gambling services manager strengthen the follow-up by enhancing the evaluation contract as well as requiring providers to submit expanded locator information. These changes were introduced to the field in November 2001 but were not fully implemented until early 2002. Even with the changes only being in effect for less than six months system wide, some improvement for the year was realized although the overall rate of contact was approximately 30%. Only participants that signed a consent to participate were in the follow-up pool. During the report period, approximately 65% of all enrollees agreed to participate in the follow-up. The major weakness in increasing completion rates is ensuring treatment provider personnel collect adequate locator information which has historically been problematic.

SUMMARY

Even with phenomenal growth in enrollments of more that 43% over the previous year, the statewide gambling treatment system continued to provide effective care. This growth appears to be the result of a combination of factors including the initiation of formal prevention and outreach efforts, updated Lottery sponsored media campaign, increased attention to business under the direction of a highly visible problem gambling services manager, and expanded word of mouth referrals.

Although successful program completion rates and average length of enrollments decreased, these are most likely artifacts of the increase in emphasis on record keeping stemming from the transition to fee-for-service coupled with contractual requirements for the timely submission of data reinforced by a monthly reporting process of the providers performance to goals.

Client satisfaction remained very high with nearly 95% of the clients indicating they would recommend the program to others. Nearly 50% reported abstinent from gambling across six and twelve months post discharge for those who successfully completed the programs and at 90-days for those who left the programs against staff advice. In addition to those reporting abstinence, approximately 40% of all groups reported that if they had gambled since enrolling in treatment, it was to a lesser extent.

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