A Plan for the Assessment of Problem Gambling in Wood County, Ohio
The ADAMHS Board of Wood County

Prepared by William J. Ivoska, Ph.D.

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Introduction

Ohio law requires the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to promote, assist in the development of, and coordinate or conduct programs for gambling addiction. The constitutional amendment that brought casinos to Ohio also includes OhioMHAS as the authority expected to address problem and pathological gambling. This amendment includes a requirement that two percent of the tax on the casinos' gross revenue go to the State Problem Casino Gambling and Addictions Fund to support efforts to alleviate problem gambling and substance abuse and related research in Ohio.

To date, OhioMHAS collaborates the Wood County Alcohol and Drug Addiction Services Board (ADAMHS) and with the Ohio Lottery Commission, local communities, alcohol and other drug treatment providers, faith-based entities, and others to reduce problem gambling and to establish and improve gambling treatment and prevention services for Ohioans.

Using funds provided by OhioMHAS, the Wood County ADAMHS board commissioned this research so that a data driven prevention plan would be developed for the residents of Wood County.

Population Assessment of Problem Gambling

The study of gambling addiction is a relatively new field of study. Epidemiological studies of gambling addictions first appeared in the 1970's (Kallick, et.al, 1976) and the creation of taxonomies and characterization of gambling followed (Kipnis, 1997). The 1980's had a rapid expansion in the availability of legal gambling in North America and state governments began to establish services for those with gambling problems.   Soon after came the need for a better understanding of gambling behaviors and the need for studies in population prevalence about problem gambling.

The purposes of conducting population prevalence studies of gambling are varied. Population prevalence studies determine current overall prevalence of gambling in a community; they describe the prevalence of each type of gambling; they can be used to calculate personal expenditures on each form of gambling; and they establish the prevalence of those with gambling disorders. In turn, this information is useful in understanding the overall recreational value of gambling to society versus the negative social impacts. Studies of gambling help calculate the actual number of problem gamblers in need of treatment and the types of gambling most associated with gambling disorders. Changes in the

prevalence of problem gambling from one time period to the next, or between communities, provides important information about the incidence of problem gambling and the potential effectiveness of programs and policies designed to reduce gambling's harm (Volberg, 2007; Williams & Volberg, 2012)

However, there has been some question about the accuracy of the prevalence rates obtained in these surveys. These questions concern whether non-gamblers are under-represented in 'gambling' surveys due to lack of interest/participation; whether different administration formats (telephone; face-to-face) produce equivalent results; the true status of the many instrument-identified problem gamblers (especially for those who do not report any corroborating gambling behavior); and the weak correspondence between problem gamblers identified in population surveys and their subsequent assessment in clinical interviews (Williams & Volberg, 2012).

The Measurement of Problem Gambling

The accuracy of the measurement of Problem Gambling has been equally difficult. Mental health agencies, such as those funded by the Wood County ADAMHS Board, need to be able to accurately screen for and diagnose pathological gambling in order to provide appropriate treatment services. In 1990, a published critical review of existing instruments used to measure problem gambling included only two instruments (Volberg & Banks, 1990). Today there are over a dozen problem gambling instruments that have been developed for a variety of purposes, including screening assessment, diagnosis, epidemiological surveys, research, treatment planning, and treatment outcome monitoring. These instruments range in length from as few as two items to more than one hundred items.

Some of the more commonly used instruments designed for adults that are in current use and have supportive research on instrument reliability and validity include the following: Gamblers Anonymous 20 Questions (GA-20), The South Oaks Gambling Screen (SOGS), the Massachusetts Gambling Screen (MAGS), the DSM-IV-MR, The Gambling Treatment Outcomes Monitoring System (GAMTOMS), the Lie/Bet, the Canadian Problem Gambling Index (CPGI), the Gambling Behavior Interview (GBI), the Clinical Global Impression (CGI), the Pathological Gambling adaptation of the Yale-Brown Obsessive-Compulsive Scale (PG-YBOCS), the Gambling Symptom Assessment Scale (G-DAS), and others. The Alberta Gambling Research Institute provides an overview of gambling prevalence in Australia, Canada, The United States, and in other countries. Their site shows the wide variety of instruments chosen throughout the United States and elsewhere (http://www.abgamblinginstitute.ualberta.ca/LibraryResources/ReferenceSources/PrevalenceUnitedStates.aspx).

The newest iteration of the Diagnostic and Statistical Manual, DSM-5, continues to encourage the study of gambling through its addiction syndrome taxonomy (Shaffer, LaPlante, & Nelson, 2012a). We now view gambling from a public health perspective (Richard & Humphrey, 2014).

Current diagnosis of disordered gambling is described in the revised DSM-5. The DSM-5 recommends that clinicians identify four of the following 9 criteria be present for a diagnosis:

1. A need to gamble with increased amounts of money in order to achieve same level of excitement;

2. Restlessness or irritability when attempting to cut down or stop gambling;
3. Repeated efforts to control, cut back, or stop gambling have not been successful;
4. Often preoccupied with gambling (e.g. reliving past gambling experiences, planning one's next gambling experience, thinking of ways to raise funds to gamble);
5. Often gambles when feeling distressed (e.g. helpless, guilty, anxious, or depressed);
6. Chases one's losses – after losing money, returns the next day to win losses back;
7. Lying to conceal the extent of the gambling problem;
8. Has jeopardized or lost a significant relationship job, or other opportunity (educational/career) because of gambling;
9. Relies on others (e.g., family, friends, acquaintances) to provide money to relieve a desperate financial situation.

The DSM-5 reclassifies disordered gambling from an impulse control disorder to a behavioral addiction. As such, this paper has used the term 'disordered gambling' or 'gambling disorder' rather than pathological gambling, at-risk gambling or other terms.

Identification of the diagnostic presence of a gambling disorder has been challenging for researchers in gambling addiction. Questions that are sensitive to the presence of the diagnosis often produce many false positive diagnoses (type I error), while questions that are highly specific to symptoms have a higher rate of missing the diagnosis (type II error). Most researchers regard some symptoms as better than other symptoms as predicting the presence of the disorder. As such, a variety of measurement scales exist.

The empirical investigation of the classification accuracy of disordered gambling remains an imprecise science. Multiple scales exist, most of which offer construct validity, and i.e. they correlate well to other instruments that measure a gambling disorder. This is especially true of brief disordered gambling screens. Current research segments the population gambling characteristics between youth, elderly, minorities; between the types of games people play; and, the context within which games are played (Anthony, 2012).

The Ohio Study

In October, 2012, The Ohio Department of Alcohol and Drug Addiction Services released the findings of their first population study of problem gambling in the state of Ohio. The study provided prevalence rates for at-risk and problem gambling in 4 Ohio Counties, selected demographics and gambling status, type and frequency of gambling including dollars spent, family and individual correlates of gambling, and community perceptions and attitudes about gambling. The purpose of the study was to establish baseline prevalence of at risk and problem gambling in Ohio prior to the openings of casinos in the four counties. Additionally, the data obtained could be used for planning for gambling prevention treatment and recovery services.

The Ohio study chose a household telephone survey as their method of data collection. About 3,600 Ohioans, aged 18 and older, completed surveys using a multistage random area probability sample for the state of Ohio, including the four counties of Cuyahoga, Lucas, Franklin, and Hamilton. There were 600 residents surveyed in each county where a new casino will operate and another 1200

surveys overall statewide. The problems of an over-representation of females and older adults and an under-representation of youth and minorities occurred.

The 9 item Canadian Problem Gambling Index (CPGI) was chosen as Ohio's measurement instrument. Ferris and Wynne (2001) reported that the CPGI correlated well with both the South Oaks Gambling Screen (SOGS) and the DSM-IV scales. Two items that measure community attitudes and perceptions of gambling problems were borrowed from the Community Readiness Survey developed by the Minnesota Institute of Public Health. Following recommendations from the CPGI, respondents were categorized as low risk (scoring a 1 or 2 on the index), moderate risk (scoring a 3 through 7), or problem (scoring 8 or 9).

Overall, Ohioans reported that 43.3 percent do not gamble and that 53.8 percent gamble, but report having no problems with gambling. Those at-risk were 2.2 percent reporting low risk, .3 percent reporting moderate risk, and .3 percent reporting problem gambling. Closer to home, Lucas County, which included portions of Ottawa, Fulton, Henry, and Wood Counties, reported that 30.7 percent do not gamble and that 54.5 percent gamble, but report having no problems with gambling. Those at-risk were 11.9 percent reporting low risk, 2.7 percent reporting moderate risk, and .2 percent reporting problem gambling. Within the Lucas County cluster, Black/African Americans were significantly more likely to be in the at-risk/problem gambling group compared to White or Other races. Statewide, males were significantly more likely to have at-risk gambling status than females, but no such difference existed in Lucas County. Lucas County reported that 18-24 year olds were significantly more likely to be at-risk, a difference that did not exist in the statewide sample.

Ohio Gambling Study Implications for Wood County

The Ohio Gambling Study included four geographic clusters, each cluster sampling counties surrounding the new Ohio casinos. Relatively wide variances occurred between the four Ohio clusters and between state averages.

	Don't Gamble	Gamble – no problems	Low Risk	Moderate Risk	Problem Gambling
Ohio	43.4%	53.8%	2.2%	.3%	.3%
Cuyahoga	28.8%	59.6%	9.5%	2.0%	.1%
Lucas	30.75	43.5%	11.9%	2.7%	.2%
Franklin	37.6%	48.2%	9.25	4.8%	.2%
Hamilton	31.6%	55.7%	7.8%	3.5%	1.4%

The Lucas County cluster sampled approximately 750 persons. Only 20 respondents were sampled from Wood County.   With a sample size of only 20, we cannot make inferences to the Wood County population using data obtained from the Lucas County cluster with any more accuracy than we could by using inferences from any other cluster or from the state average.

Using only the state averages, rather than averages from any of the four geographic clusters, estimates of the numbers of Wood County residents who fall into the various categories can be made. The 2010 US census reported that Wood County has 125,488 residents, of which 100,364 are 18 years of age or older. If 43.3 percent of adult Wood County residents did not gamble, similar to the state

average, then 43,558 Wood County residents do not gamble, and the remaining 53, 996 do gamble in some fashion. Those who do gamble can be divided into those who gamble, but have no problems, those at low risk for problem gambling, those at moderate risk for problem gambling, and those who are problem gamblers. An estimate of the number of Wood County residents who do gamble, broken down by the 4 Ohio gambling statuses, adjusted for unique racial/ethnic differences between Ohio and Wood County, is as follows:

	Gamble – no problems	Low Risk	Moderate Risk	Problem Gambling
Wood County	54,153	2,163	295	295
	53.96%	3.8%	.293%	.293%

OhioMHAS plans to replicate the Ohio Gambling Study every two years. The next administration is scheduled for SFY 2015 with results in SFY 2017.

Brief Gambling Assessment Instruments

There are many settings, particularly where time and money for screening are limited, such as in a community health survey or in a clinicians office, where only a brief screen for problem gambling can be administered, such as in 5 items or less. Five items or less is considered brief because it can be administered in a brief period of time, such as a minute or two, and because this number of items is a common number of items for brief screens of other disorders such a substance use disorders.

However, there has been limited empirical research of the classification accuracy of brief problem gambling screens and few investigations beyond that reported for the development of the screens. Therefore, there is little empirical data on which brief screen to select for a given sample or setting. Worse yet, many of the new instruments in the literature are comprised largely of the same items borrowed from existing instruments. The fact that the same items from existing instruments keep appearing in the new instruments suggest that the items are good items, but that refinement is needed.

Since accuracy of brief screens is in question, then the purpose of a brief screen is to identify a person that is likely to have a disorder, and then to follow-up on that identification with a more comprehensive clinical assessment, using a diagnostic interview.

Brief Gambling Assessment Instruments for Adults and Recommendations for Wood County

Six brief problem gambling screens that are commonly used include 1. The two-item Lie-Bet Screen (Johnson et al., 1997); 2. The three-item National Opinion Research Center Diagnostic Screen for Gambling Disorders, Loss of Control, Lying, and Preoccupation screen (NODS-CliP) (Toce-Gerstein, Gerstein, & Volberg (2009); 3. The four-item NODS-PERC (Volberg, Munck, & Petry, 2011); 4. The three-item Brief Biosocial Gambling Screen (BBGS) (Gerbauer, LaBrie, & Shaffer, 2010); 5. The five-item Short SOGS (Room, Turner, & Ialomiteanu, 1999); and 6. One-item screen for problem gambling (Rockloff, Ehrich, Themessl-Huber, & Evans, 2011). Four of these scales were derived from DSM-IV diagnostic criteria for problem gambling, but each uses a different combination of items.

The NODS-CLiP is a three-item screen derived from the NODS, a longer 17 measure of the 10 DSM-IV criteria. The 17 item NODS was used as the 'gold standard' to determine the categorization of problem gambler (Toce-Gerstein, Gerstein, & Volberg, 2009). The three NODS items, best identified to reveal problem gambling, include the following:

a. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?
b. Have you ever tried to stop, cut down, or control your gambling?
c. Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?

Each gambling frequency requires a dichotomous answer (i.e. yes or no). If the respondent answers yes to one or more questions, further assessment is advised.

The NODS-PERC is a four-item screen derived from the full NODS, a longer 17-item measure of the 10 DSM-IV diagnostic criteria. The four NODS items, best identified to reveal problem gambling, include the following:

a. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?
b. Have you ever gambled as a way to escape from personal problems?
c. Has there ever been a period when, if you lost money gambling on day, you would return another day to get even?
d. Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends?

Each gambling frequency requires a dichotomous answer (i.e. yes or no). If the respondent answers yes to one or more questions, further assessment is advised.

The Brief Biosocial Gambling Screen (BBGS) is a three-item screen derived from DSM-IV diagnostic criteria for problem gambling as measured in the National Epidemiological Survey on Alcohol and Related Conditions that used the Alcohol Use Disorder and Associated Disabilities Interview Schedule to measure DSM-IV diagnostic criteria for problem gambling (Gerbauer, LaBrie, & Shaffer, 2010). The three-items best identified to reveal problem gambling include the following:

a. During the past 12 months, have you become restless, irritable, or anxious when trying to stop and (or) cut down on gambling?
b. During the past 12 months, have you tried to keep your family or friends from know how much you gambled?
c. During the past 12 months, did you have such financial trouble as a result of gambling that you had to get help with living expenses from family, friends, or welfare?

Each gambling frequency requires a dichotomous answer (i.e. yes or no). If the respondent answers yes to one or more questions, further assessment is advised.

In response to the growing need to measure problem gambling, a number of instruments have been developed. The most commonly used assessment had been the SOGS, and therefore it has the greatest amount of research to support it. However, recent instrument development has been based on

DSM-IV diagnostic criteria and they too are generating research. The DSM-5 is likely to generate even more research on diagnostic criteria.

Gambino (2006a) demonstrated that instrument classification accuracy is affected by the base rate of a disorder in the population of interest. As such a brief screen for problem gambling in the clinical population with a high base rate will may be more or less accurate when applied to the general population (low base rate). And given the paucity of research comparing differing populations by instrument, it is difficult to select an instrument for a specific purpose or a specific population.

Which brief screen to use, such as the NODS-Clip, the NODS-PERC, or the BBGS, to assess the level of disordered gambling in Wood County among the clinical population, should be determined in a collaborative meeting between representatives from the ADAMHS Board of Wood County and the clinical providers in Wood County, including Behavioral Connections, Family Services of Northwest Ohio, and the Zepf Center. The choice of a brief screen to assess the level of disordered gambling in Wood County among the general population, should be made in a collaborative meeting between representatives of the Wood County ADAMHS Board, the Wood County Health Department, and the Hospital Council of Northwest Ohio.

In all cases, efforts to improve the efficiency of efforts require at least one additional question. In conjunction with the use of a brief scale, Willams and Volberg (2012) recommend that brief scales not be answered unless the person indicates they have gambled at least once a month on some form of gambling in the past year. While this question is not essential, it will minimize the number of false positives that might have been captured in the assessment. This question, used in conjunction with a well validated brief scale that minimized false negatives, will help to ensure a more accurate estimate to problem gambling prevalence.

Brief Gambling Assessment Instruments for Youth and Recommendations for Wood County

Large-scale international prevalence studies report that between 66 percent and 86 percent of youth reported gambling in the past year (Hardoon, Gupta, & Derevensky, 2004), and while there is disagreement about the prevalence of disordered gambling among youth, there is agreement that many youth gamble excessively, and that they are at-risk of becoming disordered gamblers (Derevensky & Gupta, 2006).

There are significant differences in gambling behavior between populations, such as youth, and this requires instruments designed specifically for youth, or at a minimum, adapting existing instruments and/or developing specific norms with existing instruments for youth. Two commonly used screen for youth gambling are the South Oaks gambling screen, revised for adolescents (SOGS-RA; Winters, Stinchfield, & Fulkerson, 1993) and the Massachusetts Adolescent Gambling Screen (MAGS: Shaffer, LaBrie, Scanlan, & Cummings, 1994). These instruments focus on the behavioral indicators of problem gambling (lying, chasing), the emotional and psychological correlates of disordered gambling (withdrawal, guilt, preoccupation, loss of control), the adverse consequences of excessive gambling (illegal acts, school or work problems), and the economic and social problems directly associated with gambling (excessive losses, family problems).

The SOGS-RA has been criticized for over diagnosing problem gambling and studies have shown it to provide higher estimates of problem gambling (Derevensky & Gupta, 2004). However, recent studies (Chiesi, Donati, Gallii & Primi, 2012) report that the SOGS-RA adequately measures youth problem gambling and identifies those who are at risk of developing disordered gambling behaviors.

No brief scale for the identification of problem gambling among youth currently exists. Stinchfield (2011) uses the Minnesota Student Survey (MSS) to measure participation in gambling activities and to measure changes in gambling behaviors over time. The gambling frequency items in the Minnesota Student Survey are not measures of problem gambling, although the greater the involvement in gambling participation the higher the association with problem gambling. Regarding a brief scale for identifying problem gambling among youth, Stinchfield has identified 9 items from the Canadian Adolescent Gambling Inventory (CAGI) that may be used as a gambling problem severity scale for youth. Cheisa (2014) has identified three items from the SOGS-RA that she would suggest as a brief scale for adolescent problem gambling.

The Minnesota (MSS) participation survey asks the following six items:

The preface for all six items is: "During the last 12 months, how often have you done these activities?"

a. Played cards for money;
b. Bet money on games of personal skill like pool, golf, or bowling;
c. Bet money on sports teams or horse racing;
d. Bought lottery tickets or scratch offs;
e. Gambled in a casino;
f. Gambled for money online.

Each gambling frequency item has the following five response options: (1) Not at all; (b) Less than once a month; (c) About once a month; (d) About once a week; and (e) Daily.

The brief SOGS_RA suggested by Chiesi (2014) include the following questions:

a. In the past 12 months, have you ever gambled more than you had planned to?
b. In the past 12 months, have you ever felt bad about the amount you bet, or about what happens when you bet money?
c. In the last 12 months, have you ever hidden from family or friends any betting slips, I.O.U.s, lottery tickets, money that you've won, or other signs of gambling?

Each gambling frequency requires a dichotomous answer (i.e. yes or no).

The decision to use a participation survey, such as the MSS, or a brief screen for disordered gambling will be determined in a collaborative meeting between representatives from the ADAMHS Board funded mental health agencies, ADAMHS Board of Wood County and the Wood County Educational Service Center

Data Collection Methods for Wood County

There has been some question about the accuracy of the prevalence rates obtained in gambling surveys. Williams and Volberg (2012) have found that prevalence rates vary because gamblers are oftentimes overrepresented due to their interest or participation in surveys, because different types of survey administration formats (i.e. telephone, paper and pencil, face-to-face, on-line) produce different results, because the type of measuring instrument varies by study, and because there is a general lack of corroborative gambling behaviors with those identified as problem gamblers.

When studies describe themselves as gambling studies, versus health or recreation studies, prevalence rates are higher, oftentimes twice as high (Williams & Volberg, 2012).   This may be because gamblers are more interested in gambling surveys and are more likely to participate. Problem gambling prevalence is also higher in face-to-face surveys when compared to phone surveys. This may be because face-to-face surveys have two advantages over phone surveys: first, they typically recruit higher rates of the demographic groups where gambling occurs (younger males), and second, face-to-face interviewing appears to result in more honest responses.

As such, gambling prevalence rates obtained from a gambling survey may be determined as much by the methodology and procedural differences in the survey administration as by the actual rates in the population. These problems can be minimized within a community if that community uses the same procedures over time, especially if the primary interest is to compare changes relative to prior studies. Survey administration procedures, including sampling procedures, response rates, survey descriptions and other relevant procedural details should be recorded for comparison over time.

In Wood County, there are three established data collection mechanisms that could be utilized in the systematic collection of information on gambling behaviors and on problem gambling prevalence. These three mechanisms are 1. The biennial ADAMHS Youth Survey, 2. The biennial Wood County Health Survey, and 3. The systematic collection of data from those who present themselves for treatment at ADAMHS sponsored clinical agencies, including COMPASS, Behavioral Connections, The Zepf Center, and Family Services of Northwest Ohio. Collecting data from three different populations, youth, adult, and clinical, would provide three estimates of gambling behaviors in Wood County.

For the ADAMHS Youth Survey, this research recommends a gambling participation survey rather than a brief survey of problem gambling. This is because we have no data that describes how Wood County youth engage in gambling activities. We do not know if Wood County youth bet on poker games conducted on-line or in neighboring homes; we do not know the extent of participation in scratch offs or lottery play; nor do we know how often youth gamble at the Hollywood Casino. A participation survey would provide much needed data on the types and frequency of youth gambling behaviors. Additionally, there is no consensus in the literature regarding a brief survey of youth gambling. While more comprehensive scales to measure youth survey do exist (SOGS-RA), they are too large to incorporate into the existing ADAMHS Youth Survey.

For the Wood County Health Survey, this research recommends adding the three-item NODS-CliP or the four-item NODS-PERC into the Health Survey. The systematic collection of problem gambling behaviors, using the same instrument, following the same survey administration procedures, will

provide consistent trend data. This trend data could be used for the creation and delivery of gambling prevention messaging in Wood County.

For the ADAMHS sponsored providers of clinical services in Wood County, this research also recommends adding the three-item NODS-CliP or the four-item NODS-PERC brief screen. One of these brief screens should be added to the information collected at intake by those who present themselves for treatment. The purpose of a brief screen is to identify a person that is likely to have a disorder, and then to follow-up on that identification with a more comprehensive clinical assessment, using a diagnostic interview. The systematic collection of intake and diagnostic data will give another estimate of the extent of problem gambling in Wood County

Meeting with Providers of Clinical Services in Wood County

On Friday, June 6, 2014, the providers of clinical services met to review the plan for data collection in Wood County. Present at the meeting were the following:

William J Ivoska, Ph.D., Researcher, ADAMHS Board, Wood County
Lorrie Lewandowski, LISW-S, OCPSII, LICDCIII, Associate Director, ADAMHS Board
Scott Acus, Director, Clinical Services Behavioral Connections Wood County
Chris Streidl, Director, Wood County Family Services of Northwest Ohio
Aimee Coe, Program Manager, Zepf/Compass
Janelle LaFond, Executive Director, Children's Resource Center

After much discussion, it was resolved that all clinical providers will include the systematic collection of diagnostic information on disordered gambling at intake. The providers of adult services (Behavioral Connections, Zepf/Compass, and Family Services of Northwest Ohio) will use the three-item NODS-CliP with one addition: a statement preceding the three-items that defines gambling for the client. It was felt that most clients participate in lottery/scratch-offs, but that most clients do not regard that participation as gambling. As such, the NODS-CLiP will be preceded with the statement "We define gambling as participation in things such as bingo, lottery/scratch-offs, casino gambling, dice/craps/poker non-casino, horse/dog racing, sports betting/office sports pools, stock market/day trading, internet gambling, etc. With that in mind, during the past 12 months….."

a. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?
b. Have you ever tried to stop, cut down, or control your gambling?
c. Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?

Each gambling frequency requires a dichotomous answer (i.e. yes or no). If the respondent answers yes to one or more questions, further assessment, through a diagnostic interview, is advised.

For the lone provider of services to you, the Children's Resource Center, the intake process will include the brief version of the SOGS-RA (Chiesi, 2014). The preceding statement to define gambling behavior (and the brief scale) will read as follows: "We define gambling as participation in things such as bingo, lottery/scratch-offs, casino gambling, dice/craps/poker non-casino, horse/dog racing, sports betting/school sports pools, internet gambling, etc. With that in mind,"

a. In the past 12 months, have you ever gambled more than you had planned to?
b. In the past 12 months, have you ever felt bad about the amount you bet, or about what happens when you bet money?
c. In the last 12 months, have you ever hidden from family or friends any betting slips, I.O.U.s, lottery tickets, money that you've won, or other signs of gambling?

Each gambling frequency requires a dichotomous answer (i.e. yes or no). If the respondent answers yes to one or more questions, further assessment, through a diagnostic interview, is advised.

SFY 2013/ 2014 Wood County ADAMHS Board Gambling Prevention Plan/Outcomes

"PLAY THE GAME DON'T LET THE GAME PLAY YOU" GAMBLING PREVENTION CAMPAIGN

The Wood County ADAMHS Board received $42,075 for gambling prevention and treatment services. The initiatives and outcomes of the plan are articulated in the following section.

Request a waiver to utilize gambling dollars in the following split; 88 % for prevention and 12% for treatment
Outcome: Waiver approved

Conduct a Needs Assessment to determine the scope of the problem in Wood County utilizing local evaluator Dr. Bill Ivoska .
Outcome: The plan recommends utilizing three established Wood County data collection mechanisms in the systematic collection of information on gambling behaviors and on problem gambling prevalence. These three established mechanisms are 1. The biennial ADAMHS Youth Survey, 2. The biennial Wood County Health Survey, and 3. The systematic collection of data from those who present themselves for treatment at ADAMHS sponsored clinical agencies, including COMPASS/Zepf Center, Behavioral Connections, and Family Services of Northwest Ohio. Collecting data from three different populations, youth, adult, and clinical, would provide three methodologically valid and reliable estimates of gambling behaviors in Wood County. The ADAMHS Board of Wood County will monitor gambling trends over time in each of the three populations. This type of monitoring trends over time has proven useful in the youth substance use field as seen in the Monitoring the Future study (Johnston, O'Malley, Bachman, & Schulenberg, 2009), and in the ADAMHS Youth Survey (Ivoska, 2014).

Continue to Develop a Wood County Task Force to develop the **"PLAY THE GAME DON'T LET THE GAME PLAY YOU"** campaign to raise awareness of problem gambling utilizing education and prevention messages aimed at the 'at risk', target population 18-25 year olds and the general population.

Outcome: The Wood County Gambling Task Force will be convening in July 2014 to begin planning for the 2014/2015 Problem Gambling Prevention Plan Objectives. The task force will identify specific marketing initiatives that need to be addressed in regard to the Problem Gambling Prevention Plan Objectives.

Gambling Addiction Counselor Training will be offered to those local providers who would like to have staff trained in 2014. Currently we have one agency, a satellite office of COMPASS that has counselors trained in gambling addiction.

Outcome: Provider agencies have sent a total of 4 clinicians to The Problem Gambling Training Series through Recovery Resources.   2 clinicians have completed all three courses. One clinician took a new job with another agency and the other clinician will complete the training next year. Will submit a formal request for remaining 2 employees to complete session 3 in the 2014/2015 plan.

Expand Billboard campaign in Northern Wood County

Outcome: The "Don't Let the Game Play You" billboard series been expanded in Northern Wood County. Total weekly impressions expected to be viewed in Wood County equals 395,667. The billboard raises awareness about problem gambling and connects viewers with Wood County resources to call for help! The billboard artwork is produced by Falcon Sports Properties as a part of the marketing objectives set in place at the beginning of the year. Based on the billboard artwork produced by Falcon Sports Properties, 3,000 Problem Gambling Prevention Resource Brochures were designed. The brochures were handed out at various BGSU Athletic Events, other community events and distributed to funded agencies.

3000 Gambling Prevention Resource Brochures designed and printed

The Brochures incorporate the *Don't Let the Game Play You* theme and offer the reader signs of at-risk gambling and resources for help in Wood County.   They have been distributed at BGSU games and other community events and to agencies in Wood County.

Expand Media Campaign at BGSU Athletic events targeting high risk individuals (18-25)

Outcome: This media campaign targeted the population group most at risk for problem gambling behavior. We included PSA's that were produced by Falcon Sports Properties which aired on the video board for 1 minute during all football and basketball games. This campaign reached, at least, 306,000 fans. The PSA was extremely direct and engaged the people watching it at all events. Also, we ran courtside rotational LED signage that promoted the "Don't Let the Game Play You" message and incorporated the phone number to call if help was needed. This signage was highly visible at the 30 plus events and was also seen on TV. This signage reached over 1.3 million people due to the TV reach. In efforts to continue the billboard campaign, one

permanent sign was placed in the main concourse of the BGSU Ice Arena, and one permanent sign was placed in the main concourse of the Stroh Center covering 150 plus events per year with an overall attendance of 710,000. Additionally, Falcon Sports Properties produced promotional items that fans/alumni/students could pick up from tables that were set up at major events. We were able to interact with Wood County residents while handing out promotional items and other marketing materials. This increased awareness of problem gambling behaviors and promoted Wood County ADAMHS Board's contact information. There were 250 hockey pucks, 600 magnets and 300 key chains with the message *Don't Let the Game Play You* that were produced and distributed at all of these high level events and at other community events. Furthermore, we promoted the *Don't Let the Game Play You* campaign on the BGSUFalcons.com website which receives 5.1 million views per year and 60 thousand unique visitors per month. This consisted of a branding campaign within a rotating button advertisement that was seen when people logged onto the website. Overall, this campaign reached Wood County residents in a fun, unique manner while promoting prevention of gambling AND treatment.

Conclusion

The systematic collection of data on gambling behaviors and practices in Wood County will begin in 2014. The analysis of these data must include the proper use of research methods so that changes in prevalence can be monitored over time. These include the post-hoc weighting of any collected sample data if the sample deviates from known Wood County demographics. These also include the use of gambling assessment instruments with good established correspondence between community prevalence studies and with clinical assessments.

This study recommends utilizing three established data collection mechanisms in the systematic collection of information on gambling behaviors and on problem gambling prevalence. These three mechanisms are 1. The biennial ADAMHS Youth Survey, 2. The biennial Wood County Health Survey, and 3. The systematic collection of data from those who present themselves for treatment at ADAMHS sponsored clinical agencies, including COMPASS/Zepf Center, Behavioral Connections, and Family Services of Northwest Ohio. Collecting data from three different populations, youth, adult, and clinical, would provide three estimates of gambling behaviors in Wood County.

For the ADAMHS Youth Survey, this research recommends a gambling participation survey rather than a brief survey of problem gambling. A participation survey would provide much needed data on the types and frequency of youth gambling behaviors. Additionally, there is no consensus in the literature regarding a brief survey of youth gambling.

For the Wood County Health Survey, this research recommends adding the three-item NODS-CliP or the four-item NODS-PERC into the Health Survey. The systematic collection of problem gambling behaviors, using the same instrument, following the same survey administration procedures, will provide consistent trend data

For the ADAMHS sponsored providers of clinical services in Wood County, this research also recommends adding the three-item NODS-CliP or the four-item NODS-PERC brief screen. One of these

brief screens should be added to the information collected at intake by those who present themselves for treatment. The systematic collection of intake and diagnostic data will give another estimate of the extent of problem gambling in Wood County

Data collected and input received from the Wood County Problem Gambling Task Force will be used to create and/or modify existing gambling prevention programming activities and to sharpen messages for gambling prevention.

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