ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2018-19

Prepared for the
California Department of Public Health,
Office of Problem Gambling

by the University of California Los Angeles
Gambling Studies Program

UCLA
GAMBLING STUDIES PROGRAM

CalGETS Annual Treatment Services Report

Fiscal Year 2018-19

Contents

EXECUTIVE SUMMARY

Overview

California Gambling Education and Treatment Services (CalGETS) is a statewide program for clients with problem gambling and affected individuals (AIs) (family members and friends affected by someone with problem gambling). Over 1,400 individuals received treatment through CalGETS in fiscal year (FY) 2018-19. Services are accessible to all California residents, aged 18 and older, at no cost to the client. Oversight of CalGETS is conducted by the California Office of Problem Gambling (OPG) and the University of California, Los Angeles (UCLA) Gambling Studies Program (UGSP). Since the beginning of CalGETS in 2009, over 15,200 individuals have received treatment through the program to address the harmful impacts of problem gambling. CalGETS provides treatment to a broad spectrum of gamblers and AIs. Treatment is provided via a range of treatment modalities in the Treatment Services Network and is available in a variety of languages. At follow-up, CalGETS clients report improved quality of life and satisfaction with the treatment services.

Provider Treatment Services Network

Licensed providers and agencies offer treatment services in various formats to address the diverse needs of individuals with a gambling disorder and or AIs, including:

- **Outpatient** treatment is offered by a network of OPG-authorized, licensed providers. Gamblers and AIs participate in individual and group treatment that is based on the provider's treatment approach and philosophy. Treatment incorporates CalGETS training and clinical guidance, which gives providers access to leading-edge knowledge and developments in the field of gambling treatment.
- **Intensive Outpatient (IOP)** allows clients to participate in three hours of gambling-specific treatment per day, three times per week and receive individual, group and family treatment.
- **Residential Treatment Programs (RTP)** address the treatment needs of clients who require a 24-hour residential treatment setting.
- **Problem Gambling Telephone Interventions (PGTI)** are provided in English, Spanish, and various Asian languages.

CalGETS Providers: A Diverse and Skilled Workforce

- CalGETS trains, authorizes, provides clinical guidance, and oversees 217 licensed mental health providers (with an average of 6.5 years of experience treating gambling), as well as oversees six treatment programs, all engaged in delivering evidenced-based treatment to gamblers and AIs.
- Treatment services are available in 31 languages/dialects.

CalGETS Treatment Outcomes (FY 2018-19)

Gamblers:

- 1,108 gamblers received treatment across the treatment network. Over two-thirds (69%) received outpatient services, 22% were served in PGTI, 5% were served in IOP, and 5% were served in RTP. Of gamblers enrolled in outpatient services, 11% were served in group treatment.
- The intensity of gambling urges reported by CalGETS clients from Intake to last treatment contact decreased by an average of 15 to 55 points (depending on treatment modality) on a self-reported 100-point scale.
- The degree to which clients perceived that gambling interfered with normal activities decreased on a 100-point scale by an average of 13 to 39 points (depending on treatment modality) between Intake and last treatment contact.

- Life satisfaction as measured by a self-reported 100-point scale increased from Intake to last treatment contact by an average of 10 to 16 points (depending on treatment modality).
- By the end of CalGETS treatment client levels of depression, on average, improved substantially.

CalGETS GAMBLER CHARACTERISTICS AT INTAKE: HEALTH AND WELLNESS

Medical Problems	The most common co-occurring health conditions of CalGETS clients are hypertension, obesity, and diabetes.
Smoking	Among CalGETS outpatient clients, 27% currently smoke. This percentage is more than twice the state average. In the residential treatment setting, the prevalence rate of smoking is 30%, down from 42% last year.
Alcohol Use	25% of CalGETS Outpatient clients report a binge drinking episode (for men, more than five drinks, and for women, more than four drinks in a single occasion) in the past month, compared to 16% of adult Californians reporting binge drinking in the past month (Centers for Disease Control and Prevention [CDC]).
Cannabis	According to the National Survey on Drug Use and Health (NSDUH), 19% of the population of California self-reported using cannabis within the past year. Across the treatment network, 18-20% of CalGETS clients used cannabis.
State of Health	According to the CDC, 18% of adults in California reported their health as "fair or poor" in 2018. In comparison, about 31% of gamblers across the treatment network reported their health as "fair or poor."
Health Insurance	About 80% of all CalGETS clients reported having health insurance, but less is known about their costs to maintain insurance, including premiums and deductibles.
Access to Health Care	At least 70% of CalGETS clients (except RTP clients at 61%) reported they currently have a physician they can access for primary care needs.
Depression	22% of CalGETS outpatient clients scored in the moderately severe to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 17% of adult Californians reporting any depression diagnosis (CDC).

Affected Individuals:

- 336 AIs received treatment across the treatment network.
- AIs are spouses/significant others (54%), children (19%), parents (11%), sibling (5%), or other relation (11%) of gamblers; and 73% of AIs are female.
- During treatment, both the degree to which AIs report that the problem gambler's behaviors interfered with normal activities and the degree to which they feel responsible for the gambler's treatment and recovery improved (decreased), while depression decreased, and life satisfaction increased.

AIs were similar to gamblers in terms of medical problems, state of health, insurance status and access to health care. However, AIs smoked less and drank alcohol less frequently than gamblers, and at rates similar to the general population.

Client Follow-up

Post-treatment follow-up interviews are designed for program evaluation and to assess the impact of treatment. UGSP added staff and completed 399 post-treatment telephone interviews. Results show that both gamblers' and AIs' improved quality of life sustained over time and that treatment participants are generally satisfied with treatment providers.

Clinical Innovations

Housed within UGSP, these projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. From FY 2016-17 through FY 2018-19, UGSP undertook a pilot study of the effectiveness of self-exclusion for problem gamblers. Self-exclusion is a procedure allowing people who have developed a gambling problem to complete a self-exclusion request form that bans the gambler from gambling establishments. A total of 76 gamblers were interviewed for the study and came from three groups, those in CalGETS treatment (n=54), those in CalGETS treatment plus self-excluding (n=10), and self-excluders who were not in CalGETS treatment (n=12). The three groups had similar scores on gambling severity and psychological measures. All three groups had high gambling severity and moderate to high levels of psychological distress.

1. CalGETS PROGRAM STRUCTURE

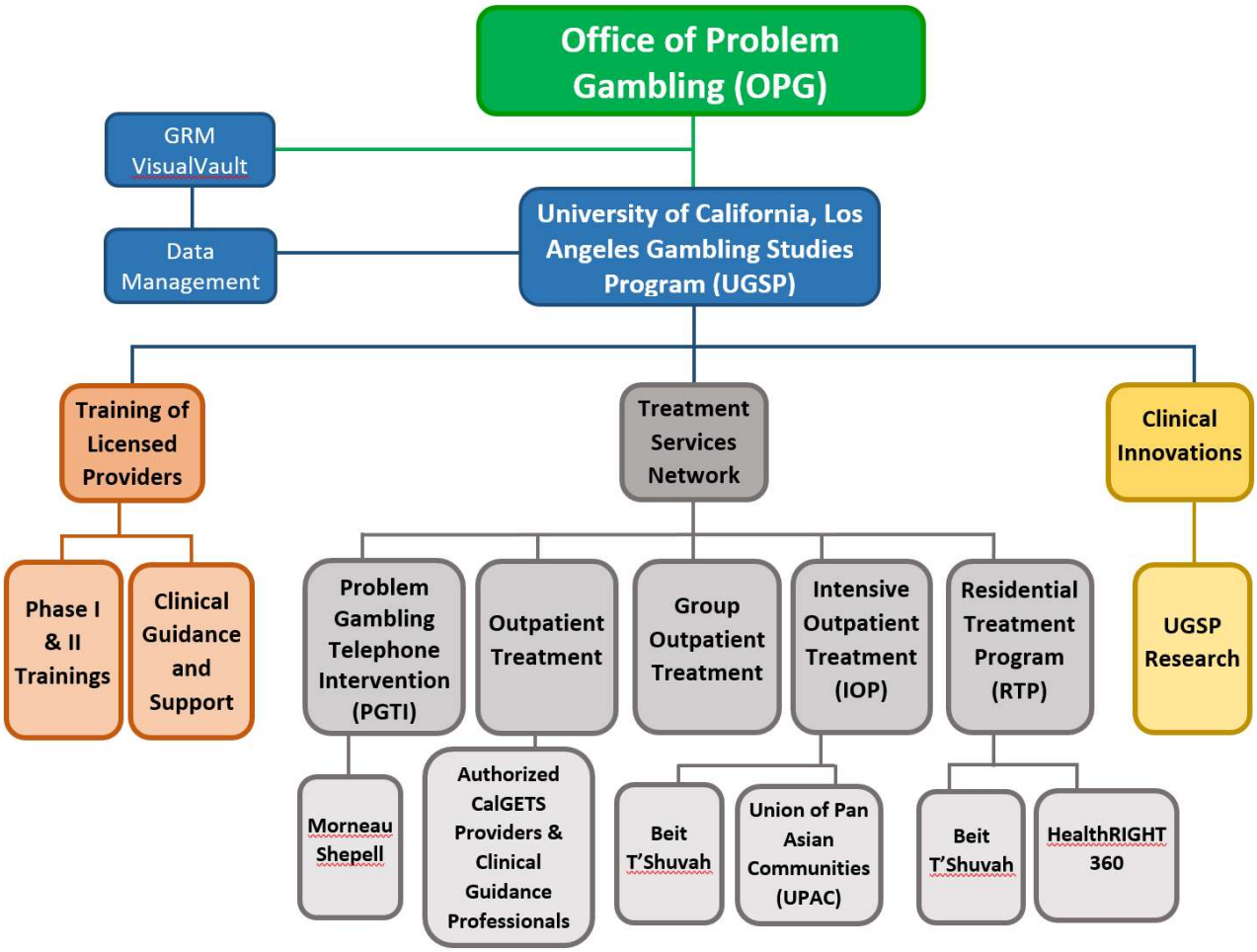
Introduction

The California Gambling Education and Treatment Services (CalGETS) program is the result of a collaboration between the California Department of Public Health Office of Problem Gambling (OPG) and the UCLA Gambling Studies Program (UGSP). This collaboration, which has been ongoing since 2009, has the following goals:

- Establish and maintain a statewide treatment program that will reduce the harmful impact of problem gambling in California.
- Establish a broad spectrum of treatment services using a stepped-care approach to address diverse multi-cultural treatment needs for those with problem gambling or affected individuals.
- Establish training events that will enhance the knowledge and therapeutic skills of licensed health providers.
- Disseminate screening tools and information about the availability of treatment services.
- Ensure that all eligible clients have access to treatment providers capable of addressing unique individual needs and preferences.
- Empower clients to be involved in the recovery process by being informed about and participating in all treatment decisions made about the services they receive.
- Enhance effective delivery of services, by monitoring client outcomes and evaluating information and data collected from providers and clients.

CalGETS consists of three main components: treatment provider training, a treatment services network, and a clinical innovations program. The treatment services network consists of the following: PGTI for gamblers and AIs, Outpatient (Individual and Group) treatment for gamblers and AIs, IOP treatment for gamblers only, and Residential treatment for gamblers only. Participant follow-up interviews are conducted by UGSP for the treatment services network. The CalGETS collaborative model is outlined in **Figure 1**. Descriptions of the components are provided below.

FIGURE 1. CalGETS COLLABORATIVE MODEL



Training of Licensed Providers

In order to become an authorized CalGETS provider, licensed mental health providers attend training comprised of one 7.5-hour online course and three additional on-site 7.5-hour training days. Upon completing the required 30-hours of Phase I training, those who meet criteria to become an authorized provider in CalGETS are eligible to receive fee-for-service reimbursement from the State of California. Within two years of completing CalGETS provider authorization, providers are required to participate in 10 hours of CalGETS Clinical Guidance and Support, with 5 hours required in the first year. Clinical guidance is offered via telephone conference calls and led by a CalGETS Clinical Guidance Professional with extensive experience in the diagnosis and management of gambling-related problems.

As part of CalGETS compliance, authorized providers must complete 5 hours of gambling-specific Continuing Education Units each calendar year, beginning after their first year of authorization. CalGETS-authorized providers are given the opportunity to participate in Phase II training sessions, which consist of five-hour, single-day trainings provided by OPG and UGSP. Phase II training is intended to deliver advanced study and current information on gambling disorder treatments. Additionally, UGSP and OPG staff members conduct in-person compliance monitoring reviews of active providers to ensure compliance with CalGETS policies and procedures.

Treatment Services Network

The Treatment Services Network offers a continuum of evidenced-based services to individuals with gambling disorders and to those affected by someone with gambling disorder. These services are offered at no cost to California residents and treatment is available in 31 languages/dialects. Within the Treatment Services Network, the following treatment services are offered:

Outpatient (Individual and Group). Gamblers and AIs may receive up to three treatment blocks of eight face-to-face sessions from the authorized CalGETS provider network. Licensed providers use their own clinical experience and treatment philosophies, along with CalGETS training to provide evidence-based services. During FY 2018-19, there were 217 active, authorized CalGETS providers, offering services in over 31 languages and dialects. Gamblers and AIs may also receive 24 in-treatment group sessions. This does not include the mandatory individual screening prior to attending group in-treatment sessions or the individual end-of-group session. Group treatment sessions may be comprised of a mixture of gamblers and AIs, and must include 3-10 participants.

Intensive Outpatient (IOP). Gamblers may receive up to three 30-day treatment blocks (up to 90 days) of more IOP care. Beit T'Shuvah Right Action Gambling Program in Los Angeles and Union of Pan Asian Communities (UPAC) in San Diego currently provide IOP services three hours per day, three times per week to clients requiring more intensive services. Services include individual, group, and family counseling.

Residential Treatment Programs (RTP). Individuals with gambling disorder, including those with significant comorbidity, may receive up to three 30-day treatment blocks (up to 90 days) of residential care. RTP services are offered through two residential facilities: Beit T'Shuvah Right Action Gambling Program in Los Angeles and HealthRIGHT 360 in San Francisco. Individuals in RTP attend groups on a daily basis, receive individual therapy once per week, and are encouraged to attend 12-step groups. Treatment addressing comorbid conditions such as mood disorders and substance abuse is provided as needed.

Problem Gambling Telephone Intervention (PGTI). Gamblers and AIs may receive up to three treatment blocks of eight sessions in the PGTI program. Telephone intervention allows access to treatment services for clients who may be disabled, lack transportation, or live in rural areas of the state where outpatient services are not available. PGTI services are provided in English, Spanish, and Asian languages. Intake is provided by Morneau Shepell, the toll-free helpline administrator, that then coordinates referrals to PGTI providers. Services are delivered by licensed, trained mental health providers with the intention of immediate service delivery and the goal of transferring clients to outpatient services if needed.

Treatment Participant Follow-up

UGSP collects follow-up information from CalGETS clients to determine whether they have benefitted from the services they received. CalGETS clients who consent to follow-up are contacted at 30, 90, and 365 days after exiting treatment. Participants are queried on satisfaction with treatment, current gambling behaviors, depression, and quality of life. Referrals to additional treatment are provided when requested.

Clinical Innovations

This component of CalGETS consists of ongoing and innovative research designed to advance the field, and establish best practices and evidence-based treatments for gamblers and AIs throughout California.

2. FY 2018-19 TREATMENT REPORT DATA SOURCES AND METHODS

Data Sources

Data are obtained from the CalGETS client forms, Version 3.0. Data are entered by CalGETS providers into the CalGETS Data Management System (DMS), an online, real-time data entry, storage, and reporting system. The DMS user interface allows providers to enter client data directly into the CalGETS database as they collect it. These data are confidential and stored on encrypted GRM Information Management Services/VisualVault servers and are available to designated analysts at GRM, OPG, and UGSP to run reporting functions on the data in the system. During FY 2018-19, all providers entered their data into the DMS.

Instruments

Gamblers

Patient Health Questionnaire-9 (PHQ-9) (Kroenke & Spitzer, 2002): The PHQ-9 consists of nine items assessing both severity of depressive symptoms and the presence of a provisional depressive disorder diagnosis. Each of the nine items is scored on a scale ranging from 0 (not at all) to 3 (nearly every day) with total scores ranging from 0 to 27. If five or more of the depressive symptoms are endorsed as "more than half the days" and at least one of those symptoms includes depressed mood or anhedonia (loss of the ability to feel pleasure), a provisional diagnosis of major depression is given. The ninth item asks about thoughts of self-harm or suicide and, if it is endorsed at all, counts towards the total for a depressive disorder diagnosis.[1] As a measure of severity, there are four threshold cutoff points for mild (5-9), moderate (10-14), moderately-severe (15-19), and severe (20 or more). Data support both the diagnostic and severity functions for PHQ-9 Scores (Kroenke & Spitzer, 2002). There are also data that suggest that the PHQ-9 is sensitive to changes in depression over time in treatment (Löwe, Kroenke, Herzog, & Gräfe, 2004).

National Opinion Research Center's DSM-IV Screen for Gambling Problems (NODS): A modified version of the NODS (Gerstein et al., 1999) is used to assess clients' past year gambling problems. This has been revised to reflect DSM-5 gambling disorder criteria. The Modified NODS combines questions to produce the 9 items needed to calculate a DSM-5 NODS score. It uses a true/false format and results in scores ranging from 0 to 9 with each of the items endorsed as "true" counting as 1 towards the total score. A score of 0 indicates a low-risk gambler, 1 to 3 indicates problem gambling behavior that does not meet full criteria for gambling disorder, 4 to 5 indicates a mild gambling disorder, 6 to 7 indicates a moderate gambling disorder, and 8 to 9 indicates a severe gambling disorder.

Life Satisfaction: A single question is used to assess life satisfaction: "How would you rate your overall life satisfaction?" This item is rated on a scale from 0 (Least Satisfied) to 100 (Most Satisfied); higher scores indicate greater life satisfaction.

Urges to Gamble: A single question is used to assess the strength of urges to gamble: "How strong are your urges to gamble?" It is rated on a scale from 0 (No Urges) to 100 (Strongest Urges). Higher scores indicate stronger urges to gamble.

Interference with Normal Activities: The question "How much has gambling interfered with your normal activities?" assesses gambling-related interference in daily life. Respondents rate life

[1] Clients who endorse thoughts of self-harm or suicide are immediately assisted by providers, or, if they endorse these thoughts during follow-up calls, are immediately put in touch with UGSP clinicians.

interference on a scale ranging from 0 (No Interference) to 100 (Extreme Interference). Higher scores indicate greater life interference due to gambling.

Affected Individuals (AIs)

PHQ-9: See Above.

Life Satisfaction: See Above.

Responsibility for Gambler's Recovery: AIs' feelings of responsibility for the gambler's recovery are assessed by asking, "How much responsibility do you have for the problem gambler's treatment and recovery?" Respondents answer using a 100-point scale ranging from 0 (No Responsibility) to 100 (Complete Responsibility); higher scores indicate a greater sense of responsibility.

Time Dealing with Consequences: Respondents are asked "What percentage of time do you spend dealing with the consequences of problem gambling?" Responses are rated on a scale ranging from 0 to 100; with higher scores indicating more time dealing with consequences.

Gambler's Interference with Normal Activities: A single item, "How much has the problem gambler's behaviors interfered with your normal activities?" is used to assess the gambler's interference with the respondent's normal activities. A scale ranging from 0 (No Interference) to 100 (Extreme Interference) is used to rate this item. Higher scores indicate more interference.

Analyses

It should be noted that during FY 2018-19 some issues may have impacted data collection and/or reporting. These issues include:

- DMS reporting and data exporting processes had revealed technical issues (i.e., unclear delineation of missing or skip-pattern missing data) that were addressed in programming.
- DMS programming issues prevented follow-up calls from being made during much of July and August 2018. This issue was corrected.
- DMS exporting issues for the follow-up data resulted in an incomplete dataset. This issue was corrected by an additional dataset export by UGSP.

In FY 2018-19 there were changes to the data reporting instruments that resulted in differences in how items are reported from past years. For the most part, the changes were made so that CalGETS reporting would conform to standard health reporting surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDC BRFSS). These changes include:

- Refining the definition of binge drinking from 5 drinks on an occasion for all, to 5 drinks on an occasion for men and 4 drinks on an occasion for women.
- Asking about drug and alcohol use over the past 30 days rather than the past year.

In the current report, unduplicated admissions are reported (i.e., using only first admission for individuals with multiple admissions in the FY). As a result, the number of treatment episodes, including levels of outcomes achieved, may be higher than reflected in this report. Frequency and percentage information is reported and does not necessarily represent significant differences between groups or across administration periods. It should be noted that, as is typical of psychological treatment, client attrition occurs over time resulting in diminishing sample sizes after treatment entry.

Outpatient treatment is offered in blocks of eight sessions, and IOP and RTP are offered in 30-day treatment blocks. Clients may discontinue treatment at any time, not just at the end of a scheduled

treatment block. This means the "dose" of treatment a client receives may vary not only by the type of treatment they participate in, but also in how long they chose to participate. To ensure we capture data about clients as they leave treatment (Last Treatment Contact), we utilize data from the End of Treatment (EOT) form, or, from the client's last In-Treatment form when an EOT form is not available.

3. CalGETS PROVIDERS AND TRAINING

Trained CalGETS providers deliver treatment services through the Treatment Services Network. Clients are referred to the network from a number of sources including a problem gambling helpline (1-800-GAMBLER), UGSP or OPG websites, health care professionals, outreach campaigns, providers' websites, information provided at gambling venues, and other sources. CalGETS providers are mental health professionals who are trained to ensure that high quality services are available for individuals seeking treatment. In addition to clinical training on the treatment of gambling disorder, CalGETS providers receive training on program quality assurance (i.e., specifying timelines for providers to make contact and meet with referrals, determining client eligibility according to CalGETS criteria, collecting and completing all required forms, referring clients to other programs and services if clinically indicated, and providing culturally and linguistically appropriate services). In FY 2018-19, UGSP and OPG conducted one Phase I training in August 2018.

Shortly after the close of FY 2018-19, UGSP conducted a survey with all active CalGETS providers to obtain information on provider characteristics and experiences with CalGETS (2018 Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2018, unless given an exemption. The Treatment Services Network had 217 licensed providers who were authorized to provide services to gamblers and AIs at some point during the 2018-19 fiscal year; the responses of 213 of these providers who remained active or decided to participate after suspension or termination are included in the 2018 Provider Survey. **Table 1** details the number of clinicians and providers who completed Phase I training during FY 2018-19. Additionally, CalGETS clinical supervisors delivered 113 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

TABLE 1. CalGETS TRAINING

	FY 2018-19
Training	
Licensed mental health clinicians who completed Phase I	46
Licensed mental health clinicians who completed Phase I and became authorized providers	28
Authorized providers who completed Phase II	N/A

Providers' demographic information is provided below (**Table 2**). Providers were primarily female, and reported their race/ethnicity as: 65% White, 11% Asian, 10% Hispanic/Latino, and 7% Black/African American.

TABLE 2. CalGETS PROVIDERS: DEMOGRAPHICS FROM ANNUAL UGSP PROVIDER SURVEY REPORT

	FY 2018-19
Gender	n=213
Female	76%
Male	24%
Choose not to disclose	<1%
Race/Ethnicity	n=213
White	65%
Asian	11%
Hispanic/Latino	10%
Black/African American	7%
Multiracial	1%
Native Hawaiian/Pacific Islander	<1%
Choose not to designate or Other	4%

The data on CalGETS providers indicate that they are experienced mental health providers. On average, providers who completed the survey had been licensed for 14.8 years and had treated individuals with gambling disorder for an average of 6.5 years. In FY 2018-19, 70% of providers were Licensed Marriage and Family Therapists (LMFT), 15% were Licensed Clinical Social Workers (LCSW), 8% were Psychologists (PhD), 3% were Clinical Psychologists (PsyD), 1% hold a Master's degree in Social Work (MSW) and 2% had other clinical degrees (Licensed Professional Clinical Counselor). CalGETS providers reach clients for whom English is not their primary language - 28% reported providing treatment services in languages other than English. Of those, 50% indicated that they provided services in Spanish, 44% provided services in an Asian language, and 14% provided services in other languages; including Arabic, Armenian, Hebrew, Persian, and Russian (these total over 100% because some providers offered services in multiple languages in addition to English). Over half (57%) of CalGETS providers offered educational materials in languages other than English.

A majority of providers rated the following CalGETS provider training program components as extremely or very beneficial:

- Phase I Training (83%)
- Phase II Training (67%)
- Supplemental recommended reading materials (54%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 94% planned to continue as authorized CalGETS providers into the next fiscal year.

4. GAMBLER TREATMENT SERVICE OUTCOMES

The sections below summarize demographics and outcomes for gamblers receiving treatment from CalGETS providers. Results are grouped according to treatment services offered during FY 2018-19.

Treatment Service Provision

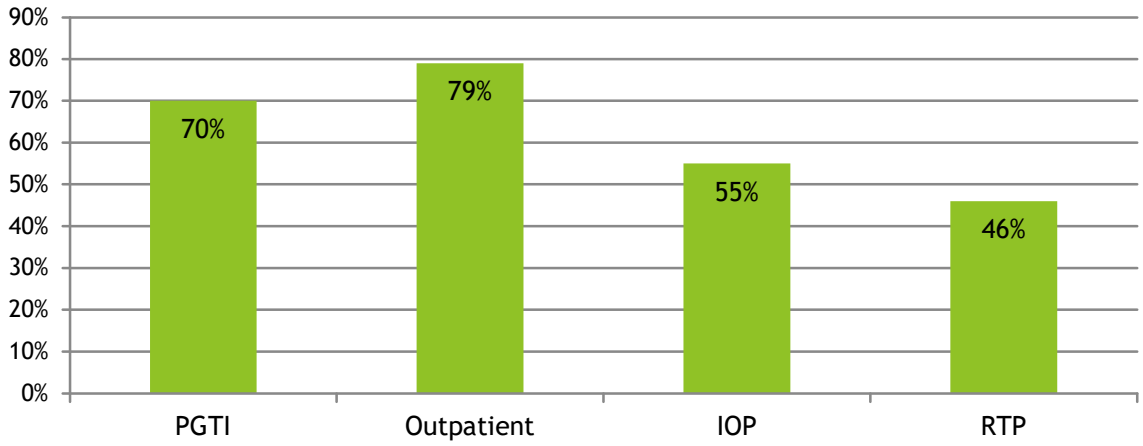
In FY 2018-19, a total of 1,108 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (69%) enrolled in Outpatient, followed by PGTI (22%), RTPs (5%), and IOPs (5%). Of these clients, 7% also participated in Outpatient Group services.

TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED

	N	Percentage
Outpatient	760	69%
Outpatient Group	*(80)*	-
Intensive Outpatient Program (IOP)	55	5%
Residential Treatment Programs (RTP)	54	5%
Problem Gambling Telephone Intervention (PGTI)	239	22%
Total[2]	1,108	100%

The provider network offers rapid entry into treatment from the time of first contact with a provider (**Figure 2**). The vast majority of clients enter treatment within one week.

FIGURE 2. TREATMENT SERVICES: PERCENTAGE OF CLIENTS ENTERING TREATMENT WITHIN 7 DAYS OF FIRST CONTACT



As shown in Table 4, race/ethnicity varies by modality. Compared to the California population, White, Non-Hispanics are over-represented and Hispanic/Latinos are under-represented in the treatment population. (More detailed analyses of race/ethnicity are available in the appendix.)

[2] Percentages may add up to greater than 100% due to rounding. The total for gamblers does not include clients in Outpatient Group treatment because they are also enrolled in Outpatient and are counted there.

TABLE 4. TREATMENT SERVICES: RACE/ETHNICITY OF GAMBLERS BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 760	IOP N = 55	RTP N = 54	PGTI N = 239	Total N = 1,108	CA Population[3] N = 39,536,653
White, Non-Hispanic only[4]	47%	66%	54%	43%	48%	27%
Black or African American only	7%	13%	13%	9%	8%	7%
American Indian/Alaskan Native only	<1%	0%	0%	1%	<1%	2%
Asian/Pacific Islander only	20%	9%	15%	20%	22%	16%
Hispanic or Latino only	13%	4%	13%	16%	13%	39%
Other race/ethnicity only	6%	6%	0%	7%	6%	-
Multiracial or Multi-ethnic[5]	7%	4%	6%	3%	6%	-

[3] Quick Facts: California, US Census Bureau, accessed 10/17/2018, at https://www.census.gov/quickfacts/ca.

[4] "Only" categories specify the percentage of respondents who identify with each ethnic or racial designation, alone and not in combination with any other ethnic or racial designation.

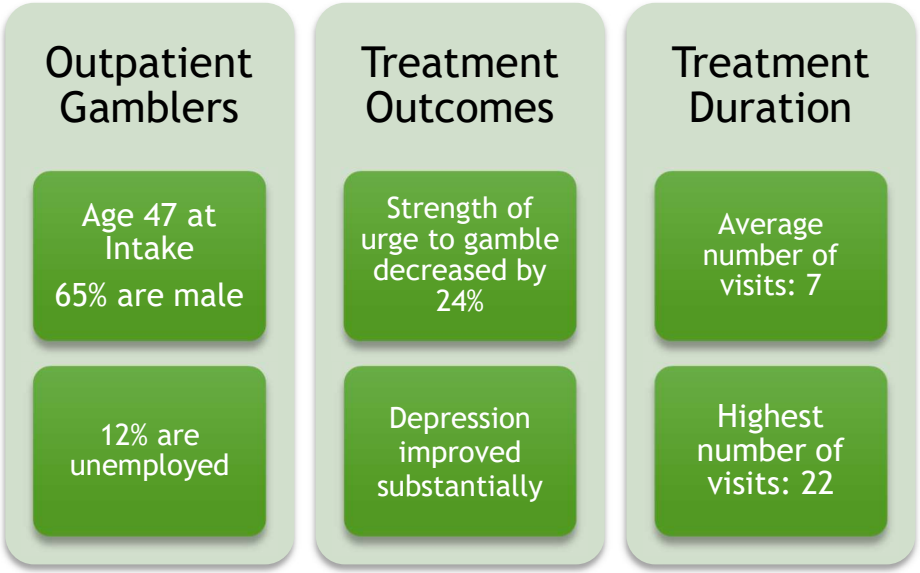
[5] "Multiracial or Multi-ethnic" category specifies the percentage of respondents who identify with multiple ethnic or racial designations.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown earlier in Table 3,[6] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 760 clients who enrolled in outpatient. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2018-19, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (32%), family/friends (14%), UCLA Gambling Studies Program (13%), Gamblers Anonymous/Gam-Anon (12%), former clients (7%), health care professionals (6%), the California Council on Problem Gambling (4%), and the OPG website (3%). In addition, 9% cited other sources including media (television, radio, newspaper, billboard), casino signage, community presentations, Internet searches that yielded the CalGETS website, treatment providers' websites, or the Psychology Today referral website. The number of sessions completed by outpatient gambler clients (n=760) varied:

- 14% of clients had only an Intake session
- 58% received 1-8 treatment sessions
- 22% received 9-16 treatment sessions
- 6% received 17-22 treatment sessions

Some individuals may be continuing treatment into FY 2019-20, but these additional sessions are not counted in the percentages above.

[6] Unduplicated admissions are reported here (i.e., only the first admission is used for individuals with multiple admissions in the FY).

Demographics

Outpatient clients had an average age of 47 years and two-thirds (65%) were male. Less than half of clients identified their race as White, Non-Hispanic (47%), followed by 20% reporting Asian/Pacific Islander, 13% Hispanic/Latino, 7% African American, 6% another race/ethnicity, and 7% Multiracial/Multi-ethnic. (More detailed analyses of gender and race ethnicity are available in the appendix.) Clients are, for the most part, well-educated – more than three-quarters reported completing some college or above. The reported household income varied widely from less than $15,000 per year to over $200,000 (**Table 5**).

TABLE 5. OUTPATIENT GAMBLER: DEMOGRAPHICS

FY 2018-19	(N=760)
Age	n=760
Mean Age	47 years old
Gender	n=760
Male	65%
Female	35%
Other	<1%
Race/Ethnicity (for those reporting a single category only)	n=760
White, Non-Hispanic	47%
Asian/Pacific Islander	20%
Hispanic or Latino	13%
Black or African American	7%
American Indian/Alaskan Native	<1%
Other race/ethnicity	6%
Multiracial or Multi-ethnic	7%
Education	n=760
Less than High School	5%
High School	17%
Some College	38%
Bachelor's Degree	31%
Graduate/Professional Degree	9%
Household Income	n=760
Less than $15,000	8%
$15,000-$24,999	7%
$25,000-$34,999	9%
$35,000-$49,999	13%
$50,000-$74,999	17%
$75,000-$99,999	12%
$100,000-$149,999	14%
$150,000-$199,999	6%
$200,000 or more	7%
Decline to state	9%

Note: Two cases from the Outpatient program for gamblers were missing education and household income data.

Gambling Severity

An overwhelming proportion of gamblers (98%) who sought outpatient treatment through CalGETS could be classified as having mild to severe gambling disorder (**Table 6**), including 92% with moderate to severe gambling disorder, while 2% reported one to three problem gambling behaviors.

TABLE 6. OUTPATIENT GAMBLER: GAMBLING DISORDER (NODS DSM-5) CLASSIFICATION

Severity	NODS Score	N	%
Problem gambling behavior	1 to 3	15	2%
Mild gambling disorder	4 to 5	45	6%
Moderate gambling disorder	6 to 7	197	26%
Severe gambling disorder	8 to 9	503	66%

Gambling Behaviors

At Intake, outpatient clients (n=760) were asked to indicate both their typical gambling locations and the types of gambling activities that they have engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (85%).

Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines (56%), blackjack (36%), and poker (28%) were the most commonly selected gambling activities.

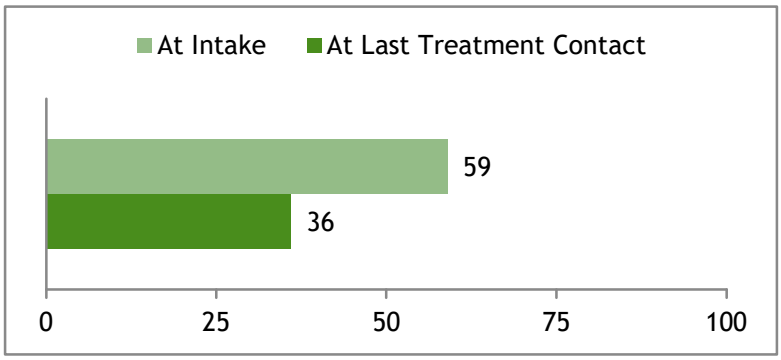
- At **tribal casinos,** clients most frequently stated that they played slot machines (50%), blackjack (27%), and poker (16%).
- At **other casinos,** clients most frequently reported playing slot machines (24%), blackjack (17%), and poker (11%).
- At **cardrooms,** clients most often reported playing poker (18%), and blackjack (18%).
- On the **Internet**, clients most often indicated playing poker (6%), slots (6%), and blackjack (5%).
- Finally, clients reported gambling on the Lottery (23%), sporting events (16%), and horse racing (4%).

Intake to Last Treatment Contact Outcomes (LTC)

In order to measure the impact of treatment, perceived negative impact of gambling, urge to gamble, life satisfaction, and depression were assessed at Intake and LTC.

Outpatient clients reported less interference of gambling with their normal activities at last treatment contact compared to Intake. On a scale from 0-100, where higher scores indicate a greater impact of gambling on other activities, average scores decreased by 23 points from Intake to last treatment contact (**Figure 4**).[7]

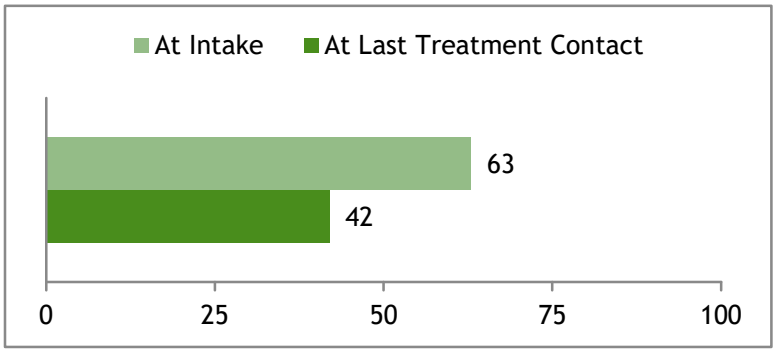
FIGURE 4. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=671, LTC N=512.

Among outpatient clients, the average intensity of the urge to gamble from Intake to last treatment contact decreased by 21 points on the 100-point scale. Lower scores at last treatment contact indicated a less intense urge to gamble after receiving outpatient services (**Figure 5**).

FIGURE 5. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT

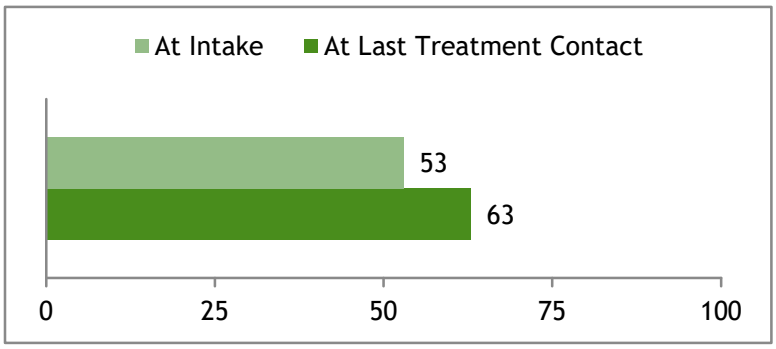


Note: Intake N=697, LTC N=614.

[7] However, there is sample attrition between intake and last treatment contact that may affect the last treatment contact average.

Over the course of treatment, outpatient clients reported an improvement of 10 points on average in overall life satisfaction (**Figure 6**). As above, life satisfaction was measured on a 100-point scale.

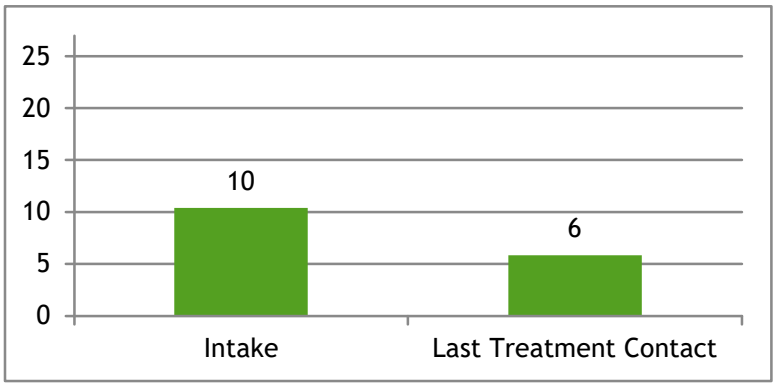
FIGURE 6. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=745, LTC N=740.

During FY 2018-19, treatment participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment episode. Outpatient clients showed, on average, moderate depression at Intake and mild depression at their last treatment session (**Figure 7**).

FIGURE 7. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=760, LTC N=669.

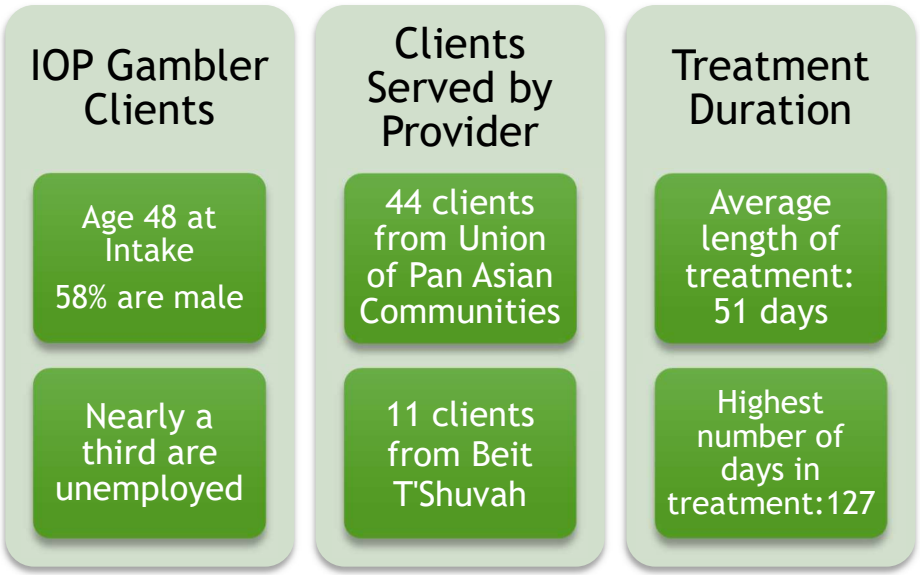
Group Outpatient

A total of 80 clients participated in group treatment in FY 2018-19. Of these participants, 22 were AIs and 58 were gamblers. The average age of AI clients was 40 years old and about 95% were female. The average age of gambler clients was 54 years old and about 52% were female. The majority of gamblers (65%) were referred to group by a CalGETS provider. Other referral sources included Gamblers Anonymous (14%), former CalGETS clients (12%), health care professionals (5%), and other sources (4%). The majority of AIs were referred to group by a CalGETS provider (68%) and health care professionals (18%). Three individuals reported referrals from other sources. The primary types of gambling reported by gamblers at group screening were black jack (43%), slot machines (28%), sports betting (10%), poker (8%), and roulette (3%). Tribal casinos were the most frequently reported gambling venue (29%), followed by card rooms (10%), and casinos (9%). Fourteen percent of gambler participants, and 18% of AIs reported moderately severe to severe depression at screening.

Intensive Outpatient Program (IOP)

Data were available from 55 clients enrolled at Intake in IOP during FY 2018-19 (**Figure 8**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=44) or Beit T'Shuvah (N=11). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

FIGURE 8. INTENSIVE OUTPATIENT PROGRAM SNAPSHOT



Demographics

A total of 55 clients entered IOP during FY 2018-19. IOP clients' average age was 48. About two-thirds (66%) identified as White, Non-Hispanic only, followed by 13% African American only, 9% Asian/Pacific Islander only, 4% Hispanic/Latino only, 6% as another race/ethnicity only, and 4% as Multiracial or Multi-ethnic. Like Outpatient clients, IOP clients have fairly high levels of education with 84% reporting some college education or higher. Although clients' household income varied from less than $15,000 per year to $200,000 or higher, 33% of IOP clients reported an income less than $35,000 and 7% declined to state their household income.

Gambling Severity

All IOP clients met criteria established in the DSM-5 for gambling disorder (100%). Specifically, 2% were classified with mild gambling disorder (endorsing 4-5 criteria), 18% with moderate gambling disorder (endorsing 6-7 criteria), and 80% with severe gambling disorder (endorsing 8-9 criteria).

Gambling Behaviors

IOP clients were asked at Intake to indicate both their typical gambling locations and the types of gambling activities that they engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (92%).

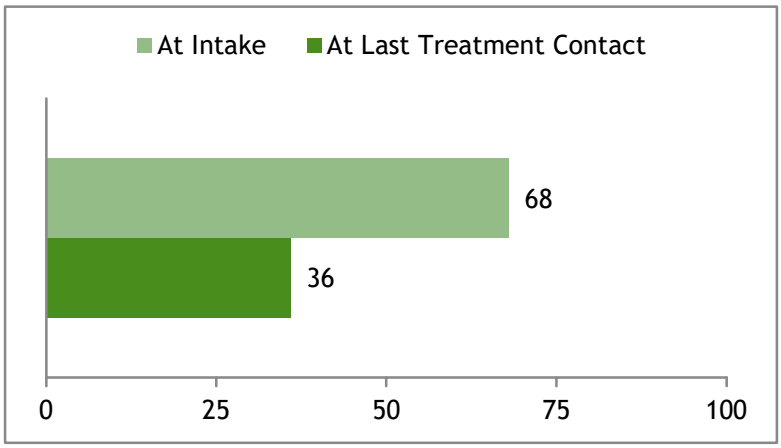
Across all venues the most commonly selected gambling activities were slot machines (51%), blackjack (44%), and poker (31%).

- At **tribal casinos,** IOP clients most frequently stated that they played slot machines (49%), blackjack (33%), and poker (24%).
- At **other casinos,** clients most frequently reported playing poker (18%), slot machines (16%), and blackjack (15%).
- At **cardrooms,** clients most often reported playing blackjack (24%) and poker (22%).
- On the **Internet**, clients most often indicated playing poker (16%), slots (9%), and blackjack (7%)
- Finally, clients reported gambling on the Lottery (22%), sporting events (7%), and stocks (7%).

Intake to Last Treatment Contact Outcomes

Treatment outcomes are measured by examining gambling interference with normal activities, intensity of gambling urge, life satisfaction, and depression. At intake, 6-8 of the 55 IOP clients had missing data on the first three measures, and, 12-13 of the clients had missing data at last treatment contact. IOP clients' reports of interference by gambling with their normal activities showed an average decrease of 32 points from Intake to last treatment contact (**Figure 9**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

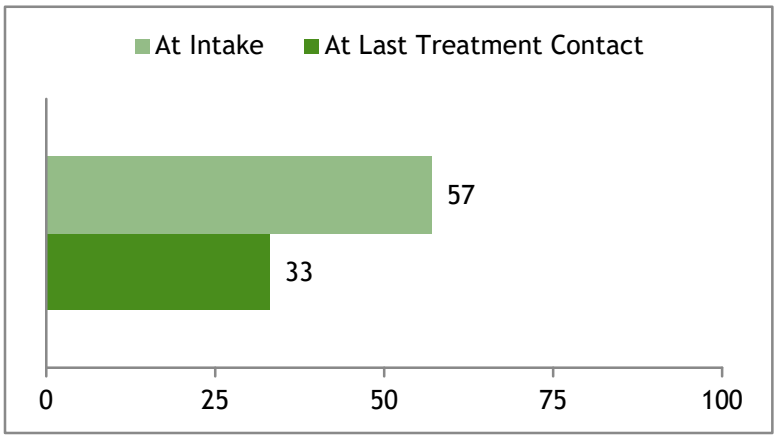
FIGURE 9. IOP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=48, LTC N=43.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to last treatment contact by an average of 24 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble (**Figure 10**).

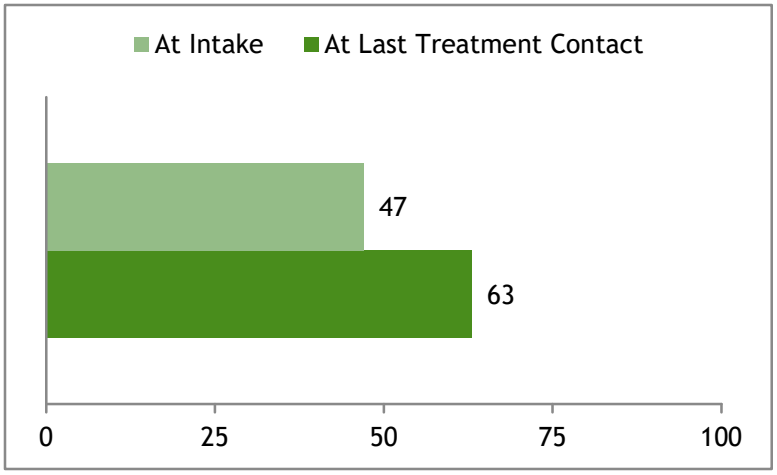
FIGURE 10. IOP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=49, LTC N=43.

IOP clients entered treatment reporting life satisfaction scores similar to Outpatient clients. Over the course of treatment, IOP clients reported an improvement of 16 points on average in overall life satisfaction (**Figure 11**). As above, life satisfaction was measured on a 100-point scale.

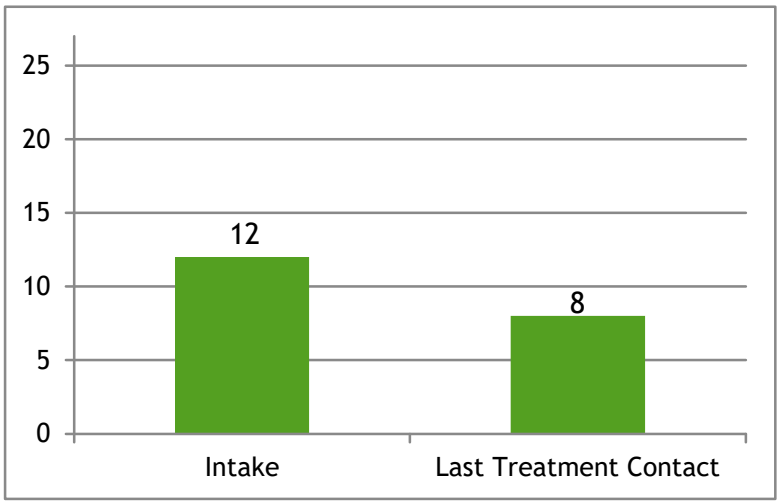
FIGURE 11. IOP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=47, LTC N=42.

During FY 2018-19, IOP participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. They showed, on average, moderate depression at Intake and mild depression at their last treatment contact (**Figure 12**).

FIGURE 12. IOP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT LAST TREATMENT CONTACT

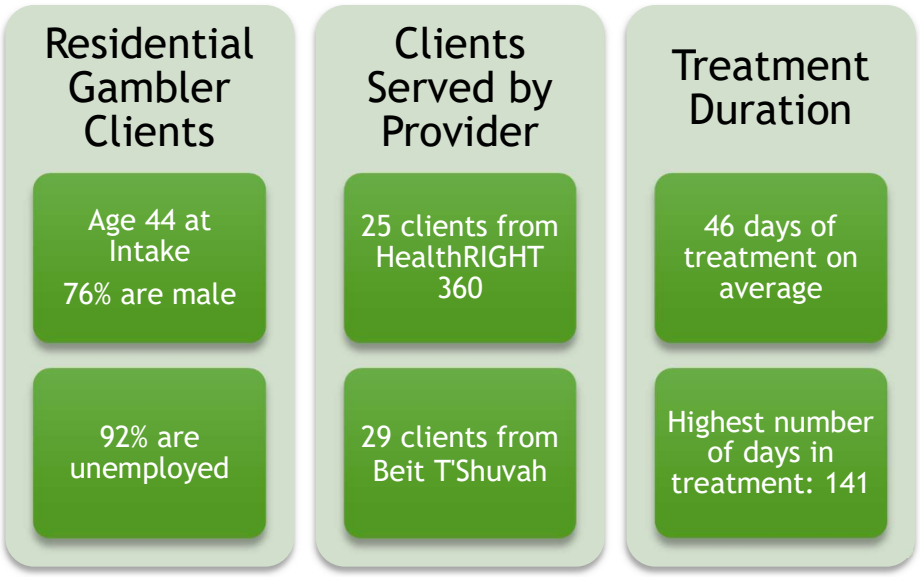


Note: Intake N=55, LTC N=46.

Residential Treatment Programs (RTP)

Data were available from 54 clients enrolled at Intake in RTP during FY 2018-19 (**Figure 13**). Clients received treatment from either HealthRIGHT 360 (N=25) or Beit T'Shuvah (N=29). The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 13. RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT



Demographics

About half (54%) identified as White, Non-Hispanic only, followed by 13% African American only, 13% Hispanic/Latino only, 15% Asian/Pacific Islander only, and 6% as Multiracial or Multi-ethnic. RTP clients have less education than Outpatient and IOP clients, but still have fairly high levels of education, with 51% reporting some college education or higher. Similar to IOP clients, RTP clients also reported lower household income, with 74% reporting that their income was less than $35,000 and 52% reporting income less than $15,000 per year.

Gambling Severity

All clients enrolled in RTP treatment met DSM-5 criteria for gambling disorder.[8] Specifically, 2% were classified with mild gambling disorder, 2% with moderate gambling disorder, and 96% with severe gambling disorder.

[8] One client had missing gambling severity data.

Gambling Behaviors

RTP clients (n=54) were asked at Intake to indicate both their typical gambling locations and the types of gambling activities that they engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (87%).

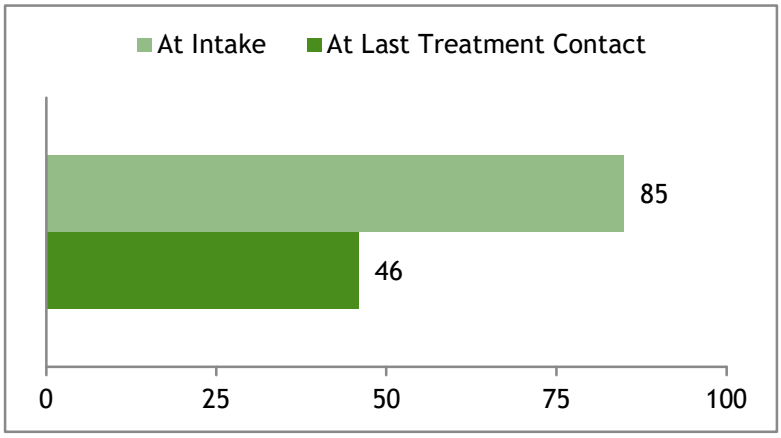
Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, slot machines, poker, blackjack, sporting events, and the lottery were the most commonly selected gambling activities.

- At **tribal casinos,** clients most frequently stated that they played slot machines (54%), poker (41%), and blackjack (37%).
- At **other casinos,** clients most frequently reported playing slot machines (44%), poker (35%), and blackjack (33%).
- At **cardrooms,** clients most often reported playing poker (43%) and blackjack (32%).
- On the **Internet**, clients most often indicated playing slots (17%), blackjack (17%), poker (15%), and video poker (13%).
- Finally, clients reported gambling on sporting events (35%), the Lottery (22%), dice (15%), and horse racing (9%).

Intake to Last Treatment Contact Outcomes

Intake to last treatment contact data are available on 34 of the 54 clients who entered residential treatment in FY 2018-19.[9] By the end of treatment, the average rating of interference by gambling with normal activities decreased by 39 points among RTP clients (**Figure 14**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

FIGURE 14. RTP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT

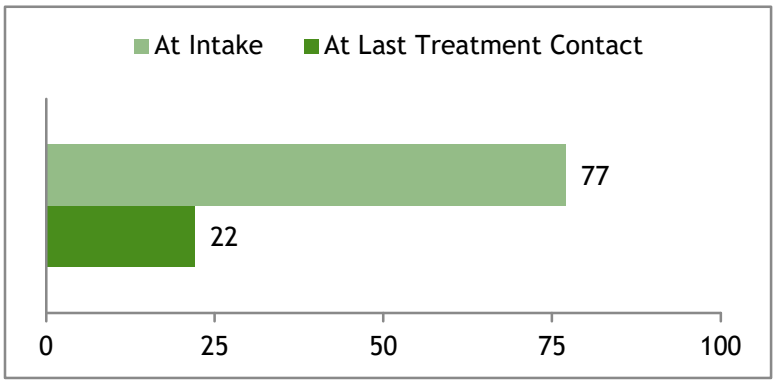


Note: Intake N=34, LTC N=30.

[9] DMS programming issues had the effect of decreasing the number of valid responses. Due to the large number of missing, the results may not be representative of RTP client outcomes.

Among RTP clients, the intensity of the urge to gamble, on average, decreased from Intake to last treatment contact by 55 points on the 100-point scale.[10] Lower scores at LTC indicated a less intense urge to gamble (**Figure 15**).

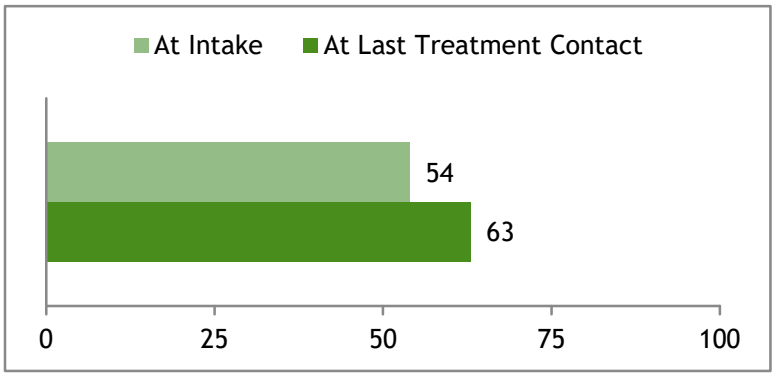
FIGURE 15. RTP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=34, LTC N=31.

Over the course of treatment, RTP clients reported an improvement of 9 points on average in overall life satisfaction (**Figure 16**). As above, life satisfaction was measured on a 100-point scale.

FIGURE 16. RTP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT

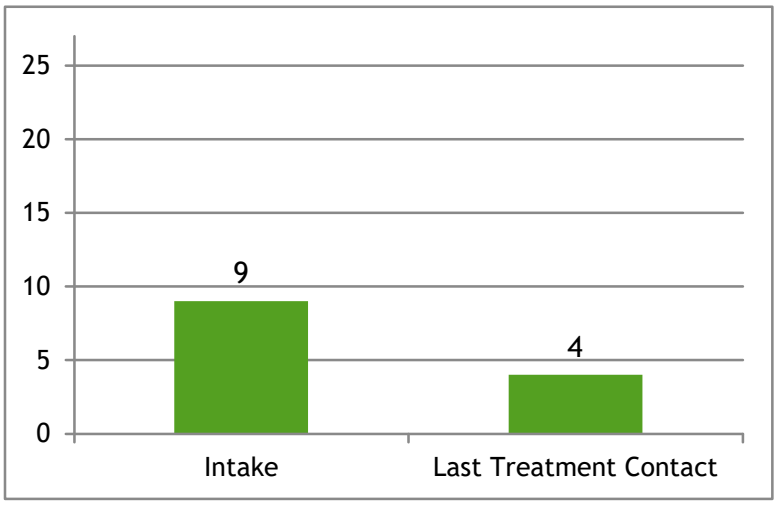


Note: Intake N=33, LTC N=31.

[10] DMS programming issues had the effect of decreasing the number of valid responses. Due to the large number of missing, the results may not be representative of RTP client outcomes.

During FY 2018-19, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and LTC. They showed, on average, a considerable improvement in depression from mild depression at Intake to below the threshold for depression at last treatment contact (**Figure 17**).

FIGURE 17. RTP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT LAST TREATMENT CONTACT

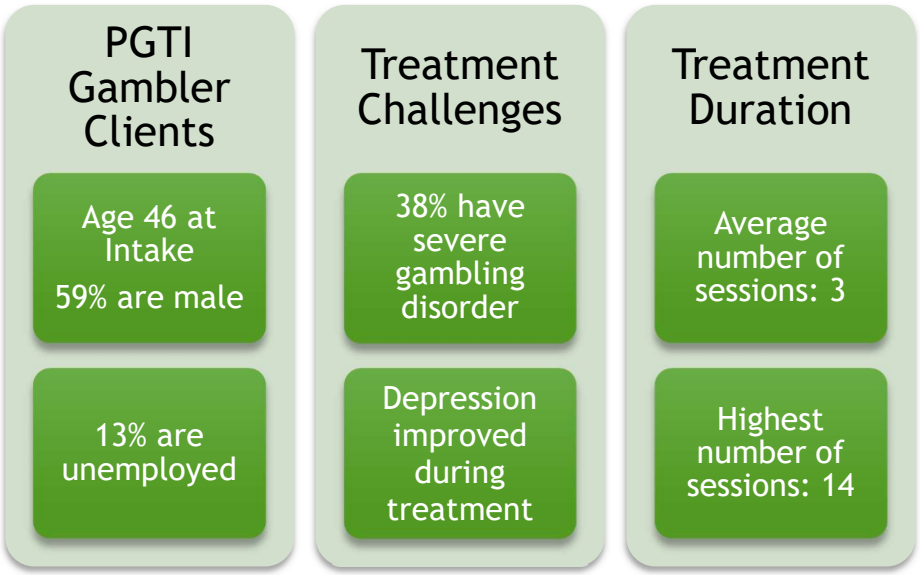


Note: Intake N=54, LTC N=54.

Problem Gambling Telephone Intervention (PGTI)

As described above, PGTI services are provided over the telephone to gamblers and AIs throughout California. Telephone intervention allows access to treatment services for clients who may be disabled, lack transportation, or live in rural areas of the state where outpatient services are not available. Services are provided in English, Spanish, Mandarin, Cantonese, Vietnamese, Korean, Tagalog, Hindi, and additional languages.

FIGURE 18. PGTI PROGRAM SNAPSHOT



The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for PGTI gamblers served. Findings are reported by language group and/or in aggregate.

Within PGTI, data were available for 239 gambler clients enrolled at Intake during FY 2018-19. Of the 239 total clients assessed at Intake, 162 received further treatment services.

Clients participating in PGTI (n=239) most often reported being referred by the Helpline (1-800-GAMBLER) (51%); casino signage (11%), the California Council on Problem Gambling (11%); media (television, radio, newspapers, billboards 8%), or by family or friends (7%).

PGTI clients (n=239) participated in three treatment sessions on average, with a maximum of 14 sessions in total.

Demographics

Gamblers in PGTI treatment were, on average, 46 years old and predominately male, with varying household incomes. Of PGTI clients, 43% were White, Non-Hispanic only, followed by 22% Asian/Pacific Islander only, 16% Hispanic/Latino only, 9% African American only, 7% another race/ethnicity only, and 3% Multiracial/Multi-ethnic. (See the appendix for more detailed gender and race/ethnicity information.) In addition, almost two-thirds had completed some college or more. (**Table 7**).

TABLE 7. PGTI GAMBLER: DEMOGRAPHICS

FY 2018-19	N=239
Age	(n=239)
Mean Age	46 years old
Gender	(n=239)
Male	59%
Female	37%
Unknown	3%
Race/Ethnicity (for those reporting a single category only)	(n=239)
White, Non-Hispanic only	43%
Asian/Pacific Islander only	20%
Hispanic or Latino only	16%
Black or African American only	9%
American Indian/Alaskan Native only	1%
Other race/ethnicity only	7%
Multiracial or Multi-ethnic	3%
Education	(n=239)
Less than High School	10%
High School	26%
Some College	26%
Bachelor's Degree	33%
Graduate/Professional Degree	5%
Household Income	(n=239)
Less than $15,000	10%
$15,000-$24,999	5%
$25,000-$34,999	5%
$35,000-$49,999	13%
$50,000-$74,999	16%
$75,000-$99,999	11%
$100,000-$149,999	11%
$150,000-$199,999	6%
$200,000 or more	5%
Decline to state	19%

Gambling Severity

Of those enrolled in PGTI services, 92% could be classified as having mild to severe gambling disorder (**Table 8**).

TABLE 8. PGTI GAMBLER: GAMBLING DISORDER (NODS DSM-5) CLASSIFICATION

	Severity	NODS Score	N	%
PGTI (N=239)	Problem gambling behavior	1 to 3	19	8%
	Mild gambling disorder	4 to 5	55	23%
	Moderate gambling disorder	6 to 7	75	31%
	Severe gambling disorder	8 to 9	90	38%

Gambling Behaviors

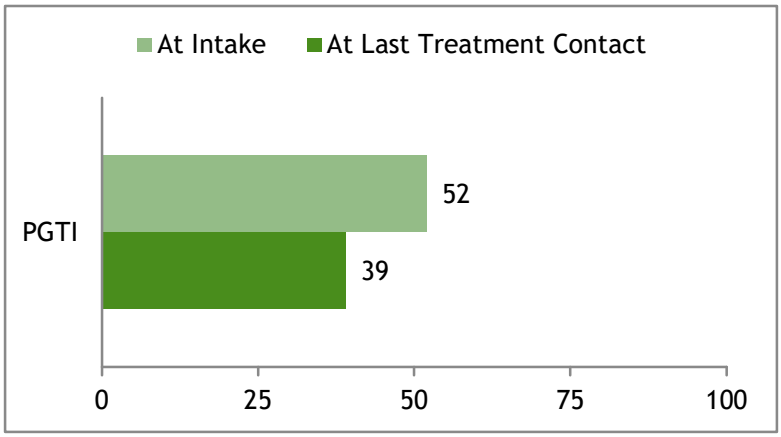
PGTI clients were asked at Intake to describe their gambling behaviors and the types of gambling activities they have engaged in over the last 12 months. Typical gambling locations included casinos, mentioned by 87% of clients and food/convenience stores for Lottery tickets (28%). Across all venues, the three most common gambling activities were slot machine (56%), blackjack (28%), and poker (23%).

Clients were able to select multiple activities at each of the major gambling venues. PGTI clients reported gambling activities at tribal casinos most often and the most frequent activities were slot machines (63%), blackjack (27%), and poker (23%). The other major gambling activity was the Lottery (33%).

Intake to Last Treatment Contact Outcomes

By the end of treatment, the average rating of interference by gambling with normal activities decreased by 13 points among PGTI clients (**Figure 19**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. [11]

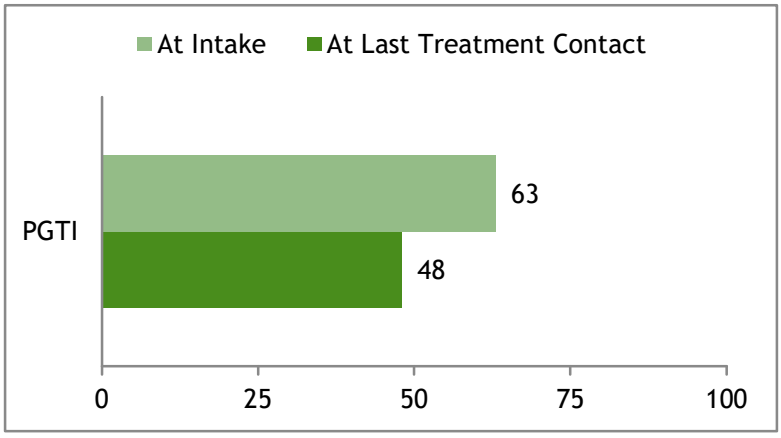
FIGURE 19. PGTI GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=198, LTC N=129

Among PGTI clients, the intensity of the urge to gamble, on average, decreased from Intake to their last treatment contact by 15 points on the 100-point scale. Lower scores at clients' last treatment contact indicated a less intense urge to gamble (**Figure 20**).

FIGURE 20. PGTI GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT

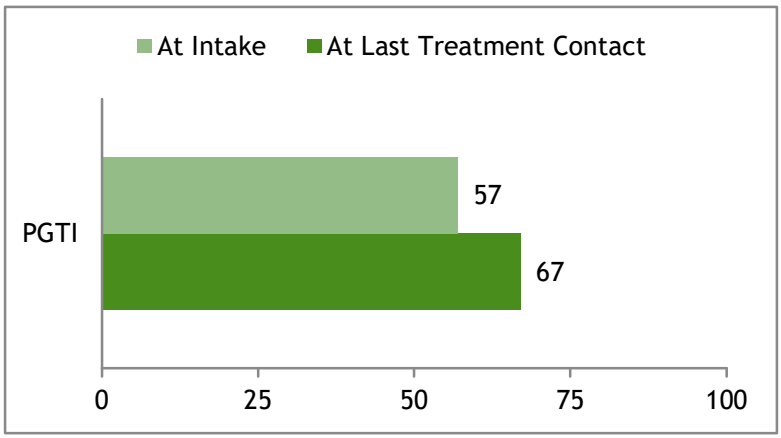


Note: Intake N=225, LTC N=150

[11] Due to technical issues described in Section 2, Data Sources and Methods, there were a large number of missing data for the interference with normal activities, gambling urge, and life satisfaction questions. For example, intake data on interference by gambling with normal activities are available on only 198 of the 239 PGTI clients who participated in treatment in FY 2018-19.

Over the course of treatment, PGTI clients reported an improvement of 10 points on average in overall life satisfaction (**Figure 21**). As above, life satisfaction was measured on a 100-point scale.

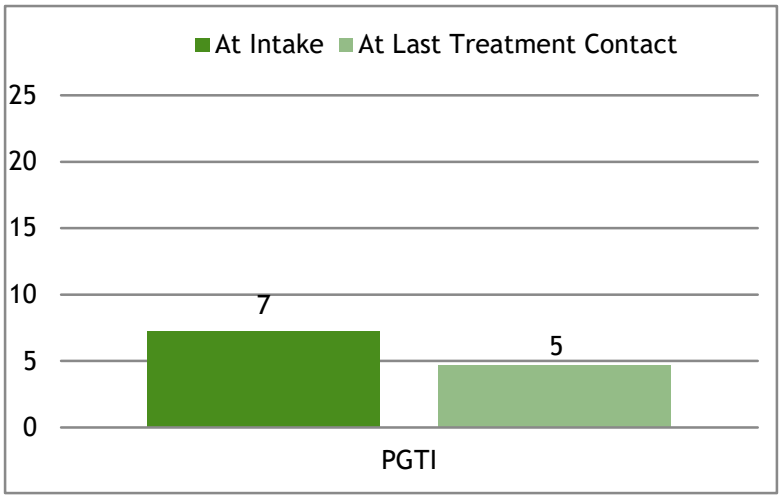
FIGURE 21. PGTI GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=226, LTC N=151

During FY 2018-19, PGTI participants' levels of depression were measured using the PHQ-9 both at Intake and at the last treatment contact. Clients showed, on average, mild depression at Intake and subclinical levels of depression at the last treatment contact (**Figure 22**).

FIGURE 22. PGTI GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=239, LTC N=162

Health Information on Gamblers

Co-Occurring Health Conditions

A notable percentage of gamblers reported co-occurring health conditions and problematic health behaviors at Intake.

TABLE 9. GAMBLERS: MOST COMMONLY REPORTED CO-OCCURRING HEALTH RELATED CONDITIONS

	Self-Reported Hypertension	Self-Reported Diabetes	Self-Reported Obesity	Obesity Calculated from BMI
Outpatient (N = 760)	17%	11%	10%	27%
IOP (N = 55)	7%	6%	11%	38%
RTP (N = 54)	22%	6%	6%	22%
PGTI (N = 239) [12]	11%	11%	3%	26%
California adults[13]	28%	11%	--	25%

- The most commonly self-reported co-occurring health related conditions were hypertension, diabetes, and obesity. Self-reported percentages for obesity are lower than those calculated from body mass index (BMI). Using BMI standards, approximately one-quarter of CalGETS clients are obese.
- Compared to California adults, smoking percentages were high across the treatment services network – 27% of Outpatient clients reported smoking, more than twice the state average.[14] There was a notable change in the percentage of RTP clients reporting smoking, which decreased to 30% from 42% last year. Similarly, 31% of IOP clients reported smoking. Among PGTI clients, 20% reported smoking.
- About 31% of gamblers across the treatment services network (ranging from 29 - 32% depending on type of treatment attended) reported their health as fair or poor. This compares to 18% of adults in California reporting their health as "fair or poor" in 2018, according to the Centers for Disease Control and Prevention.[15]

[12] 49 PGTI clients had missing data for the BMI calculation.

[13] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online], 2017. [accessed Dec 03, 2018]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

[14] California Department of Public Health, California Tobacco Control Program, California Tobacco Facts and Figures 2015, Sacramento, CA, 2015.

[15] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online], 2018. [accessed Jan 13, 2020]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

Co-Occurring Psychiatric Disorders

Anxiety and mood disorders were the most common co-occurring mental health conditions reported (**Table 10**).

TABLE 10. GAMBLERS: CO-OCCURRING PSYCHIATRIC DISORDERS TREATED FOR IN THE PAST YEAR

	Mood Disorders	Psychotic Disorders	Anxiety Disorders	Substance Use Disorders	Personality Disorder	ADD/ ADHD
Outpatient (N = 760)	27%	1%	11%	5%	1%	5%
IOP (N = 55)	49%	6%	26%	9%	2%	9%
RTP (N = 54)	52%	4%	22%	19%	2%	2%
PGTI (N = 239)	19%	2%	7%	1%	1%	2%

- 22% of CalGETS outpatient clients, 25% of IOP, 19% of RTP, and 15% of PGTI clients scored in the moderately severe to severe depression range at Intake as measured by the PHQ-9. This is compared to 17% of adult Californians reporting any diagnosis of depression.[16]
- IOP clients had the highest prevalence of anxiety disorders and ADD/ADHD among the treatment network and had relatively high levels of mood, anxiety, and substance use disorders compared to clients in other modalities.
- RTP clients had the highest prevalence of mood and substance use disorders across the treatment system.

Substance Use Behaviors

- Among Outpatient clients, 60% reported that they drank alcoholic beverages at intake. In other treatment modalities, a smaller percentage of clients reported current drinking: 51% among IOP clients, 24% among RTP clients, and 41% among PGTI clients.
- Of CalGETS Outpatient clients, 25% reported at least one binge drinking episode (more than five drinks in a single occasion for men, more than four drinks in a single occasion for women) in the past month. This is compared to the 16% of California adults who reported any binge drinking in the past month.[17]
- Cannabis was the most frequently reported substance used in the past month across the treatment services network, with 18-20% of CalGETS clients in Outpatient, IOP, and RTP reporting use of cannabis. This is similar to the percentage reported in the National Survey on Drug Use and Health (NSDUH), 19% of the population of California self-reported using cannabis within the past year.[18] Approximately 9% of PGTI clients reported cannabis use in the past month.
- A higher percentage of RTP clients reported use of all drugs compared to clients in other types of treatment services, with 20% reporting cannabis use, 18% reporting methamphetamine use,

[16] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2018. [accessed Jan 13, 2020]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

[17] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Web Enabled Analysis Tool [online]. 2016. [accessed Jan 29, 2019]. URL: https://nccd.cdc.gov/weat/index.html#/crossTabulation/view.

[18] Substance Abuse and Mental Health Services Administration, 2017-2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). 2019. [accessed Jan 20, 2020]. URL: http://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates.

9% reporting use of cocaine, and 6% reporting use of narcotics. Additionally, of the RTP clients who reported drinking alcohol (24%), on average they reported binge drinking 7 times in the past month, more than three times the number reported by clients in any other treatment service.

The co-occurrence of various medical problems and risk factors emphasizes the need for CalGETS providers to refer to medical professionals in order to address health-related issues. Because both RTPs have experience providing substance abuse treatment, they are better able to meet the complex needs of the CalGETS clients in residential treatment who have co-occurring substance abuse issues. The high incidence of mental health issues among CalGETS clients, in addition to their gambling-related problems, validates the use of licensed mental health professionals as the primary source of our workforce. At least 80% of all clients in all treatment modalities reported having health insurance and at least 70% report that they currently have a physician that they can access for primary care needs (except RTP clients at 67% and 61%, respectively); therefore, they may be covered for co-occurring conditions like those identified above.

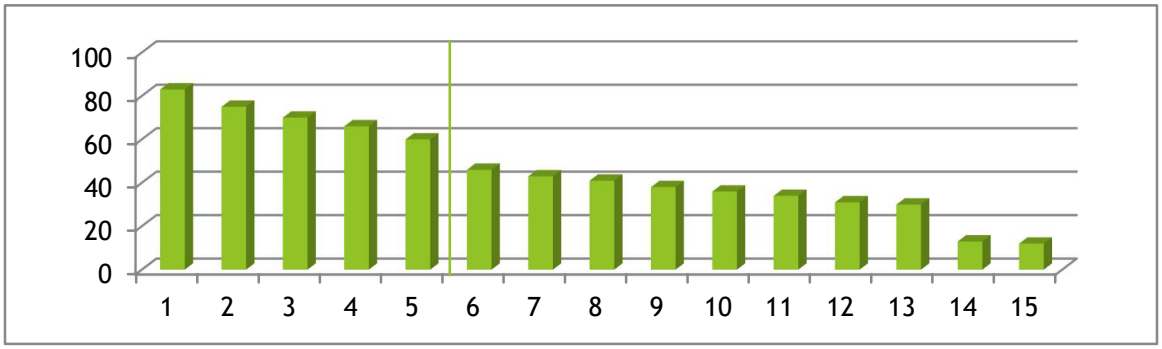
5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2018-19 data that were available from the DMS on AIs' demographics and treatment service outcomes. The data were collected on forms completed by clients at Intake, during treatment, and at the last treatment contact or from the End of Treatment form.

Treatment Service Provision

Data were available at Intake from a total of 336 AI clients. Most (95%) were served as outpatients (n=318). The remaining 18 clients received treatment from PGTI. The number of Outpatient treatment sessions AIs attended ranged from 0 to 21. AI attendance in Outpatient was strong during the primary treatment sessions (sessions 1-5). Forty-six percent continued treatment after session 5 (**Figure 23**).

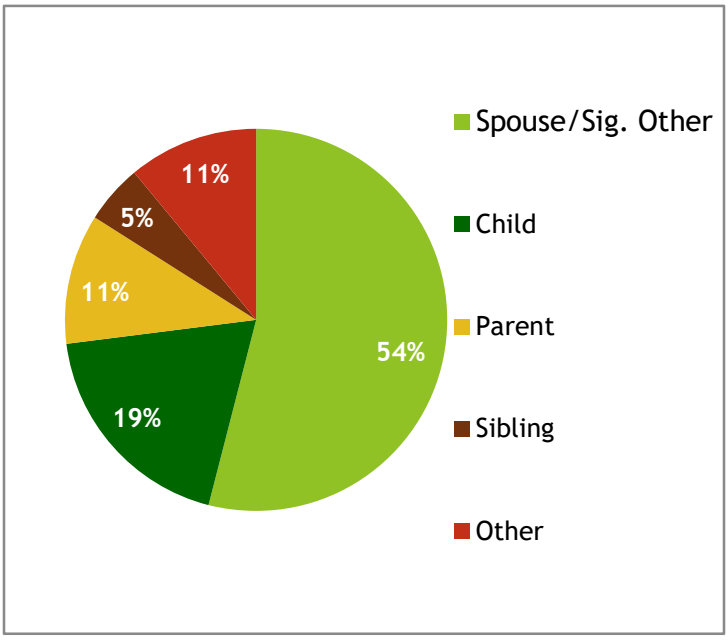
FIGURE 23. OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Note: N=318

Of the 318 outpatient AI clients, about half (54%) identified as a spouse or significant other, 19% as a child of, and 11% as a parent of a gambler (**Figure 24**).

FIGURE 24. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

AIs in Outpatient treatment were 43 years old, on average, and predominately female (73%), whereas a majority of gambler clients are male. About half were White, Non-Hispanic, followed by 22% Hispanic/Latino, 18% Asian/Pacific Islander, 6% African American, 5% another race/ethnicity, 4% Multiracial/Multi-ethnic, and 1% American Indian/Alaskan Native. Similar to Outpatient gamblers, Outpatient AIs have widely varying household incomes and high education levels, with a greater percentage (79%) attending some college or higher (**Table 11**).

TABLE 11. OUTPATIENT AI: DEMOGRAPHICS

FY 2018-19	(N=318)
Age	n=318
Mean Age	43 years old
Gender	n=318
Male	27%
Female	73%
Race/Ethnicity (for those reporting a single category only)	n=317
White, Non-Hispanic only	45%
Asian/Pacific Islander only	18%
Hispanic or Latino only	22%
Black or African American only	6%
American Indian/Alaskan Native only	1%
Other race/ethnicity only	4%
Multiracial or Multi-ethnic	5%
Education	n=318
Less than High School	6%
High School	14%
Some College	32%
Bachelor's Degree	28%
Graduate/Professional Degree	19%
Household Income	n=348
Less than $15,000	10%
$15,000-$24,999	8%
$25,000-$34,999	6%
$35,000-$49,999	10%
$50,000-$74,999	18%
$75,000-$99,999	15%
$100,000-$149,999	14%
$150,000-$199,999	8%
$200,000 or more	7%
Decline to State	5%

Treatment Service Findings

Intake to Last Treatment Contact Outcomes

As seen in **Table 12**, AIs, on average, have mild depression scores at Intake and lower depression scores at their last treatment contact (PHQ-9 range is 0 – 27). Average life satisfaction scores (measured on a scale from 0 to 100) are moderate at Intake and at LTC are slightly higher. The degree to which AIs feel that the problem gambler's behaviors have interfered with normal activities and the degree to which they feel responsible for the gambler's treatment and recovery both improved (decreased), on average, from treatment Intake to the last treatment contact (both measured on a scale from 0 to 100).

TABLE 12. OUTPATIENT AI: INTAKE TO LAST TREATMENT CONTACT OUTCOMES

	Intake Mean	Last Treatment Contact Mean
Depression (PHQ-9) score	9	5
Life satisfaction	55	64
Degree to which problem gambler's behaviors have interfered with normal activities	59	46
Feel responsible for gambler's treatment and recovery	49	32

Note: Depression Intake N=318, LTC N=279; life satisfaction Intake N=307, LTC N=267; interfere with normal activities Intake N=289, LTC=209; feel responsible Intake N=287, LTC N=225.

Health Information on Affected Individuals

Co-occurring health diagnoses were less common among AIs than gamblers; however, some AIs participating in the outpatient program reported health-related issues. Health problems reported by 5% or more of Outpatient AI clients were hypertension, obesity, and diabetes. Twenty-one percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking was 10% in FY 2018-19, an uptick from FY 2017-18 (5%), but similar to the percentage of smokers among Californians (10%). [19]

Also of note was the lower percentage of Outpatient AIs who reported current drinking (49%) relative to Outpatient gamblers (60%). Cannabis use in the past 30 days was reported by 13% of Outpatient AIs, while 2% reported use of cocaine, 2% reported methamphetamine use, and 1% reported opioid use in the past 30 days. Similar to past years, in FY 2018-19, 72% of Outpatient AIs rated their health as good to excellent at Intake.

In regard to co-occurring psychiatric disorders reported at Intake, 23% of Outpatient AI clients reported treatment in the past year for mood disorders, 10% for anxiety disorders, 2% for attention deficit disorders, 2% reported treatment for psychotic disorders, 2% for substance abuse disorders, and less than 1% for personality disorders. Using the PHQ-9 criteria, 21% reported moderate to severe depression symptoms.

[19] Vuong TD, Zhang X, Roeseler A. California Tobacco Facts and Figures 2019. Sacramento, CA: California Department of Public Health; May 2019.

6. FOLLOW-UP OF TREATMENT PARTICIPANTS

UGSP staff members collect follow-up data from clients served within Outpatient, IOP, and RTP modalities using GRM/VisualVault's web-based DMS. Follow-up interviews with treatment participants take place at 30 days, 90 days, and one year post-discharge. For those clients who agree to participate in follow-up interviews, the DMS automatically generates follow-up forms for each client who completes an EOT form or has discontinued treatment for more than 90 days. Beginning in January of 2017, UGSP put extra staff resources into client follow-up and began making five attempts to reach clients for follow-up interviews. For FY 2018-19, therefore, five attempts were made to reach each client. Technical issues resulted in reduced numbers for this fiscal year. [20]

Table 13, below, is a breakdown of all follow-up attempts, completed interviews, and closed cases (i.e., clients who were unable to be reached after five attempts) for the gamblers and AIs who agreed to follow-up during FY 2018-19. The numbers differ slightly from DMS data because they are based on call logs. UGSP made nearly 3,900 attempts to reach clients for follow-up interviews; completing 399 interviews, and ultimately closing 192 cases when clients were unable to be reached. It should be noted that cases are closed after 5 attempts at a particular follow-up point, but attempts to reach an individual begin anew at the next time point.

TABLE 13. FOLLOW-UP: ATTEMPTS, COMPLETED INTERVIEWS, AND CLOSED CASES

	30-day			90-day			1-Year			Total		
	G	AI	Total	G	AI	Total	G	AI	Total	G	AI	Total
Attempts	816	180	**996**	1219	292	**1511**	1165	227	**1392**	3200	699	**3899**
Completed	89	21	**110**	127	35	**162**	99	28	**127**	315	84	**399**
Closed	31	6	**37**	61	12	**73**	69	13	**82**	161	31	**192**

Note: G = Gamblers, AI = Affected individuals

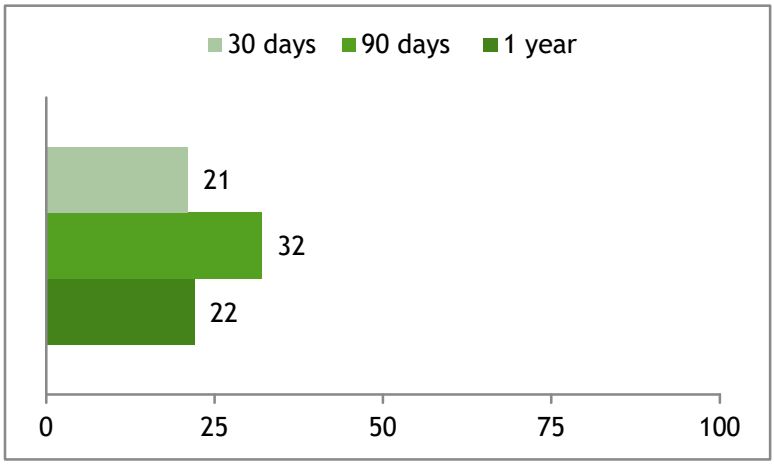
Follow-up results are presented below for the largest group of gamblers receiving treatment, Outpatient gamblers.

[20] UGSP was unable to make follow-up calls throughout July and August of 2018 due to issues with the DMS update.

Gamblers: Outpatient Follow-up Results

UGSP conducted 30-day, 90-day, and one-year follow-up interviews with gamblers who received Outpatient treatment. In these interviews, we measured a number of quality-of-life variables, including the degree to which gambling interfered with clients' normal activities, intensity of urges to gamble, overall life satisfaction, and level of depression. During the post-treatment period, the degree to which gambling interfered with clients' normal activities, on average, remained low (**Figure 25**).[21]

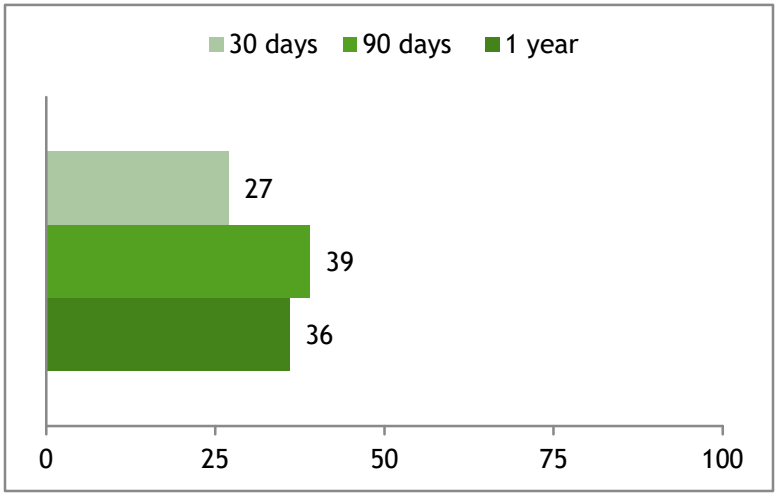
FIGURE 25. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT FOLLOW-UP



Note: 30 days N=55, 90 days N=76, 1 year N=40.

Likewise, the intensity of the urge to gamble, on average, was low during the post-treatment period, remaining at or below 40 points on the 100-point scale (**Figure 26**).

FIGURE 26. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT FOLLOW-UP

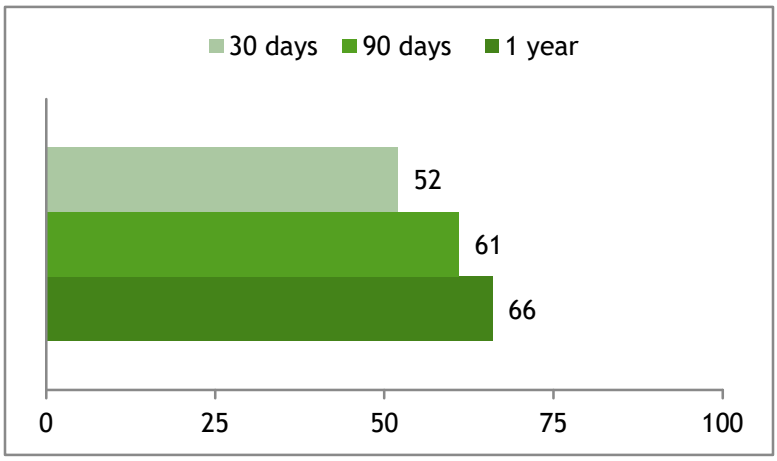


Note: 30 days N=72, 90 days N=96, 1 year N=56.

[21] Follow-up data is cross-sectional (i.e., during FY 2018-19, clients providing data for the 30 day post-treatment interviews may not be the same as those providing data for the 1-year post-treatment interviews).

Clients' average overall life satisfaction increased during the post-treatment period (**Figure 27**). As above, life satisfaction was measured on a 100-point scale.

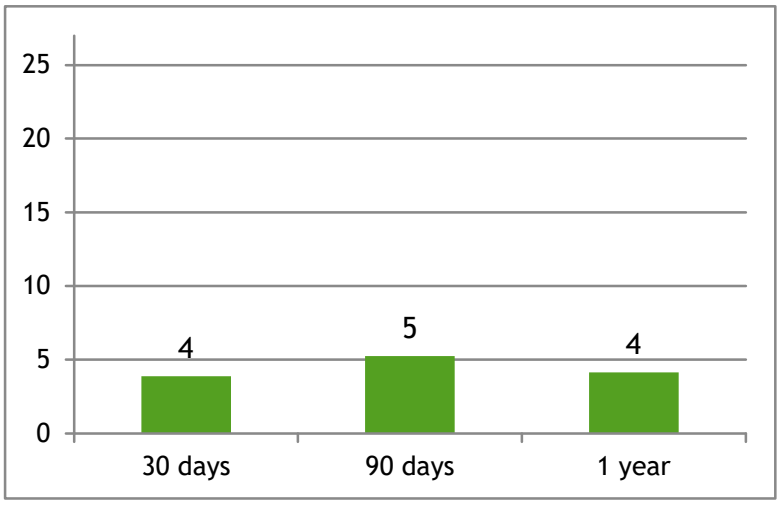
FIGURE 27. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT FOLLOW-UP



Note: 30 days N=84, 90 days N=147, 1 year N=80.

As shown in **Figure 28**, the average depression (PHQ-9) score was 3.88 at 30 days post-treatment, indicating sub-clinical levels of depression. At the 90-day and one-year follow-ups, the depression score remained between 4 and 6, still within the sub-clincial to mild depression range.

FIGURE 28. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT FOLLOW-UP



Note: 30 days N=85, 90 days N=150, 1 year N=82.

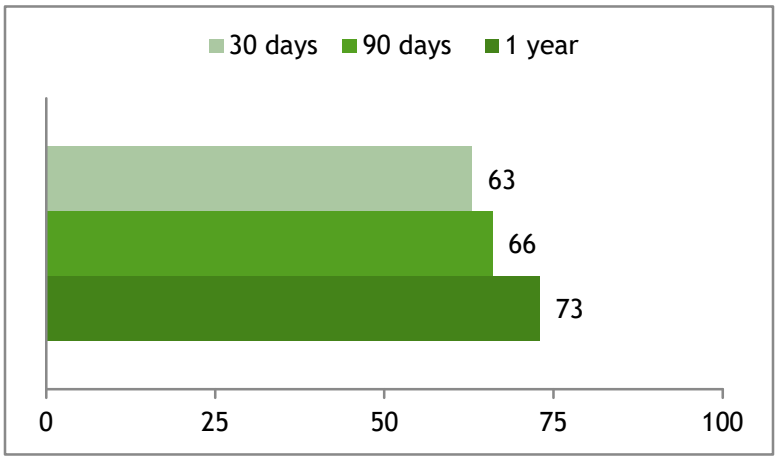
AIs: Outpatient Follow-up Results

UGSP also conducted 30-day, 90-day, and one-year follow-up interviews with AIs who received Outpatient treatment. In these interviews, we measured a number of quality-of-life variables, including the degree to which the problem gambler's behaviors interfered with normal activities, the degree to

which they feel responsible for gambler's treatment and recovery, overall life satisfaction, and level of depression. Below, we present life satisfaction and level of depression data for the AI group.[22]

AI clients' average overall life satisfaction increased during the post-treatment period (**Figure 29**). As above, life satisfaction was measured on a 100-point scale.

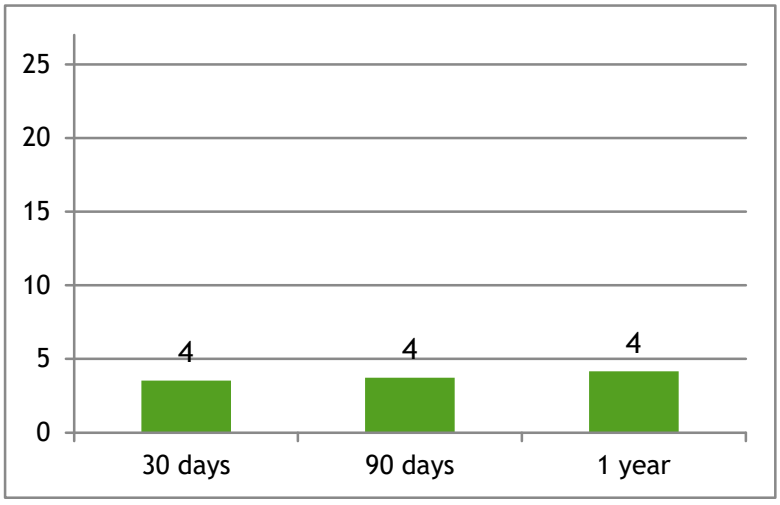
FIGURE 29. AI: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT FOLLOW-UP



Note: 30 days N=29, 90 days N=33, 1 year N=34.

As shown in **Figure 30**, the average depression (PHQ-9) score was 3.52 at 30 days post-treatment, indicating sub-clinical levels of depression. At the 90-day and one-year follow-ups, the depression score remained below five, still within the sub-clincial range.

FIGURE 30. AI: MEAN PHQ-9 DEPRESSION SCORE AT FOLLOW-UP



Note: 30 days N=29, 90 days N=33, 1 year N=34.

[22] Due to technical issues, the other two scales have a high percent of missing values and are not presented here.

Gamblers and AI: Feedback on Treatment Experiences

At follow-up, clients from across the treatment network were also asked for feedback on the treatment services received. Combining the three follow-up periods, of the 70 gambler clients offering comments on their treatment experiences, 58 (83%) had positive comments, 6 (9%) had negative comments, and 6 (9%) had neutral or mixed comments. In general, clients who had positive comments had high praise for the therapeutic relationship they had with treatment providers and/or the helpfulness of the treatment services. Clients' negative comments typically reflected concerns about the therapeutic relationship with specific providers. Most neutral comments were positive about the treatment but expressed a desire for more treatment.

Of the 32 AIs who provided feedback on their treatment experiences, 27 (84%) offered positive comments and 5 (16%) offered neutral or mixed comments. None offered negative comments this year. In general, those with positive comments had positive comments about the therapeutic relationship with the treatment provider and/or found the services helpful, particularly in understanding problem gambling. Neutral comments can be characterized as clients having needs or expectations that were not fully met by the program.

7. CLINICAL INNOVATIONS

Housed within UGSP, clinical innovations projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders.

Self-Exclusion

During FY 2018-19 the clinical innovations project involved a self-exclusion pilot study for problem gamblers. Self-exclusion is a procedure allowing people who have developed a gambling problem to create external controls to help them be more responsible in their gambling practices. This involves completing a self-exclusion request form and is a voluntary program that bans the gambler from gambling establishments. Because there is a paucity of research examining the effectiveness of self-exclusion, UCLA Gambling Studies Program investigated specific aspects of these programs in California. These aspects include the process of enrollment, the appropriate lengths of time, the scope of self-exclusion (whether it applies to one gambling facility or state-wide), enforcement for violations, and how names are added or removed from a list. We also sought to understand the characteristics of gambling patrons who chose to self-exclude such as demographic variables, gambling behaviors, level of gambling severity, type of gambler, consequences, and so on.

A total of 76 gamblers were interviewed for the study and came from three groups, those in CalGETS treatment (n=54), those in CalGETS treatment plus self-excluding (n=10), and self-excluders who were not in CalGETS treatment (n=12). The three groups had similar scores on gambling severity and psychological measures. All three groups had high gambling severity and moderate to high levels of psychological distress. The results also counter the notion that self-excluders are mere “recreational gamblers” who self-exclude on an impulse after one significant financial loss. The self-excluders in this study were not only problem gamblers, they met diagnostic criteria for gambling disorder with significant gambling-related consequences and exhibited psychological distress related to anxiety, depression, stress proneness and overall dissatisfaction with life. Among factors that exerted a moderate to large effect on the decision to self-exclude, were feeling a loss of control over gambling behavior, and, chronic patterns of financial losses or problems (both 81%). A high percentage of study participants appeared to reach a point where they perceived their gambling activities as a waste of time (59%). Surprisingly, family, friends, or a romantic partner exerted less influence on the decision to self-exclude (41%). Therapists also appear to have played a role (23%), at least among self-excluders who were in treatment.

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APPENDIX: DETAILED RACE/ETHNICITY AND GENDER CATEGORIES

TABLE 14. GAMBLERS: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 760	IOP N = 55	RTP N = 54	PGTI N = 239	Total N = 1,097	CA Population[23] N = 39,536,653
White, Non-Hispanic only[24]	47%	66%	54%	43%	48%	27%
Black or African American only	7%	13%	13%	9%	8%	7%
American Indian/Alaskan Native only	<1%	0%	0%	1%	<1%	2%
Asian/Pacific Islander only	20%	9%	15%	20%	19%	16%
Hispanic or Latino only	13%	4%	13%	16%	13%	39%
Other race/ethnicity only	6%	6%	0%	7%	6%	-
Multiracial or Multi-ethnic[25]	7%	4%	6%	3%	6%	-
Race/Ethnicity (for those reporting single AND multiple categories)						
White, Non-Hispanic only or with another race/ethnicity[26]	53%	67%	56%	46%	52%	
Black or African American only or with another race/ethnicity	8%	13%	15%	10%	9%	
American Indian/Alaskan Native only or with another race/ethnicity	1%	0%	2%	1%	1%	
Asian/Pacific Islander only or with another race/ethnicity	21%	9%	15%	17%	20%	
Hispanic or Latino only or with another race/ethnicity	16%	7%	17%	19%	17%	
Other race/ethnicity only or with another race/ethnicity	7%	7%	2%	7%	7%	

[23] Quick Facts: California, US Census Bureau, accessed 10/17/2018, at https://www.census.gov/quickfacts/ca.

[24] "Only" categories specify the percentage of respondents who identify with each ethnic or racial designation, alone and not in combination with any other ethnic or racial designation.

[25] "Multiracial or Multi-ethnic" category specifies the percentage of respondents who identify with multiple ethnic or racial designations.

[26] "Only or with another race/ethnicity" categories specify the percentage of respondents who identify with each ethnic or racial designation, whether alone or in combination with other ethnic or racial designations.

TABLE 15. GAMBLERS: GENDER DETAILS BY TREAMENT MODALITY

Gender Categories	Outpatient N = 760	IOP N = 55	RTP N = 54	PGTI N = 239	Total N = 1,108
Gender – assigned at birth					
Male	65%	58%	76%	60%	64%
Female	35%	42%	24%	37%	36%
Unknown	-	-	-	3%	<1%
Gender – current self-described gender					
Male	65%	58%	76%	60%	64%
Female	35%	40%	24%	40%	36%
Transgender woman	<1%	-	-	-	<1%
Transgender man	-	2%	-	-	<1%

TABLE 16. AI: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 317[27]	PGTI N = 18	Total N = 336	CA Population[28] N = 39,536,653
White, Non-Hispanic only[29]	45%	50%	45%	27%
Black or African American only	6%	11%	7%	7%
American Indian/Alaskan Native only	1%	0%	<1%	2%
Asian/Pacific Islander only	18%	33%	19%	16%
Hispanic or Latino only	22%	6%	21%	39%
Other race/ethnicity only	4%	0%	4%	-
Multiracial or Multi-ethnic[30]	5%	0%	5%	-
Race/Ethnicity (for those reporting single AND multiple categories)				
White, Non-Hispanic only or with another race/ethnicity[31]	47%	50%	47%	
Black or African American only or with another race/ethnicity	8%	11%	8%	
American Indian/Alaskan Native only or with another race/ethnicity	1%	0%	<1%	
Asian/Pacific Islander only or with another race/ethnicity	19%	33%	20%	
Hispanic or Latino only or with another race/ethnicity	25%	6%	24%	
Other race/ethnicity only or with another race/ethnicity	4%	0%	5%	

[27] One AI outpatient client did not report race/ethnicity.

[28] Quick Facts: California, US Census Bureau, accessed 10/17/2018, at https://www.census.gov/quickfacts/ca.

[29] "Only" categories specify the percentage of respondents who identify with each ethnic or racial designation, alone and not in combination with any other ethnic or racial designation.

[30] "Multiracial or Multi-ethnic" category specifies the percentage of respondents who identify with multiple ethnic or racial designations.

[31] "Only or with another race/ethnicity" categories specify the percentage of respondents who identify with each ethnic or racial designation, whether alone or in combination with other ethnic or racial designations.

TABLE 17. AI: GENDER DETAILS BY TREAMENT MODALITY

Gender Categories	Outpatient N = 318	PGTI N = 18	Total N = 336
Gender – assigned at birth			
Male	27%	0%	26%
Female	73%	100%	74%
Unknown	-	-	-
Gender – current self-described gender			
Male	28%	0%	26%
Female	72%	100%	74%
Transgender woman	-	-	-
Transgender man	-	-	-

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