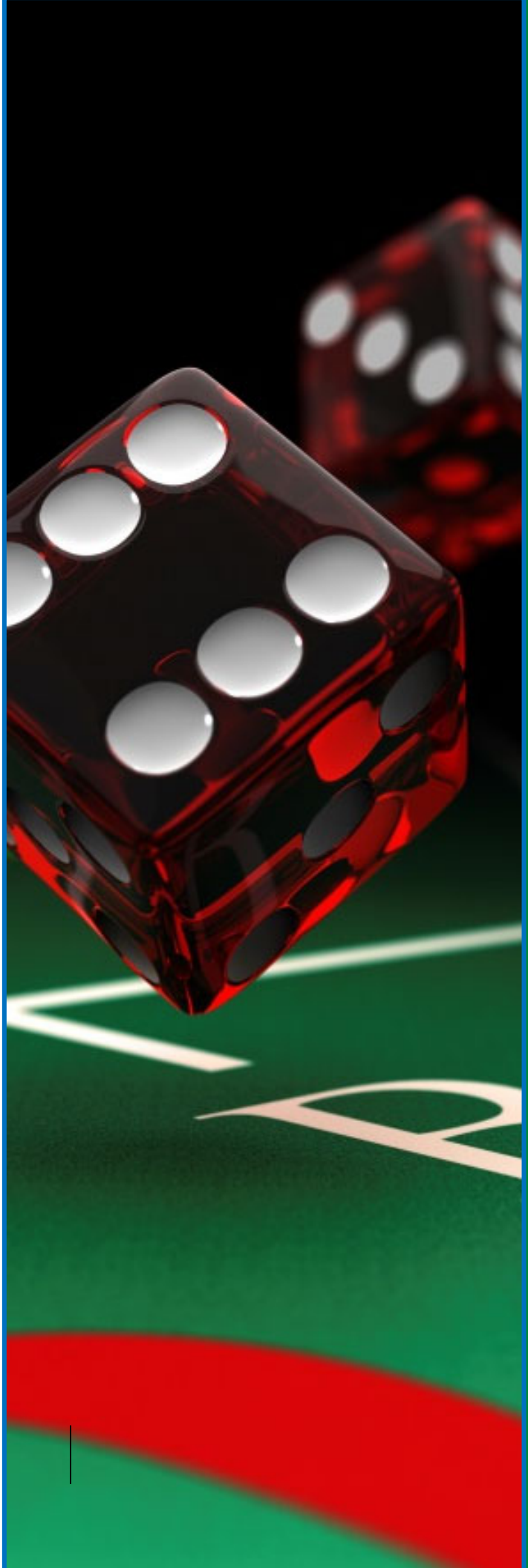


ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2019-20

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 2019-20

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 850 individuals received treatment through CalGETS in fiscal year (FY) 2019-20. 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 Department of Public Health (CDPH) 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 16,250 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 211 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.

COVID Impact on CalGETS

- COVID-19 shelter-in-place and similar directives resulted in a reduction in intakes during the last three months of FY 2019-20. CalGETS RTP programs temporarily halted new admissions to the programs, but continued to treat clients already receiving services.
- To address these issues, CalGETS/OPG approved telehealth services via telephone for all treatment types. CalGETS/OPG also approved requests (with clinical justification) for additional blocks of treatment for those receiving IOP and RTP.
- UGSP developed questions on COVID impact on treatment for incorporation in the annual Provider Survey.

CalGETS Treatment Outcomes (FY 2019-20)

Gamblers:

- 874 gamblers received treatment across the treatment network. Over two-thirds (69%) received outpatient services, 21% were served in PGTI, 6% were served in IOP, and 4% were served in RTP. Of gamblers enrolled in outpatient services, 13% 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 18 to 31 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 8 to 34 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 9 to 11 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, 24% currently smoke. This percentage is more than twice the state average. In IOP, the prevalence rate of smoking is 32%, among PGTI clients 21%, and among RTP clients 16%.
Alcohol Use	24% 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. Among CalGETS outpatient clients, 21% 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 32% 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 reported they currently have a physician they can access for primary care needs.
Depression	18% 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:

- 248 AIs received treatment across the treatment network. Most (93%) were served as outpatients (n=231). The remaining 17 clients received treatment from PGTI.
- AIs are spouses/significant others (52%), children (17%), parents (12%), siblings (9%), or other relation (10%) of gamblers; and 75% 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). Depression also 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 completed 362 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 Integrations

Housed within UGSP, these projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY2019-20, UGSP and OPG worked with two community agencies to develop proposals to address disparities among those reached for CalGETS education and treatment.

1. CalGETS PROGRAM STRUCTURE

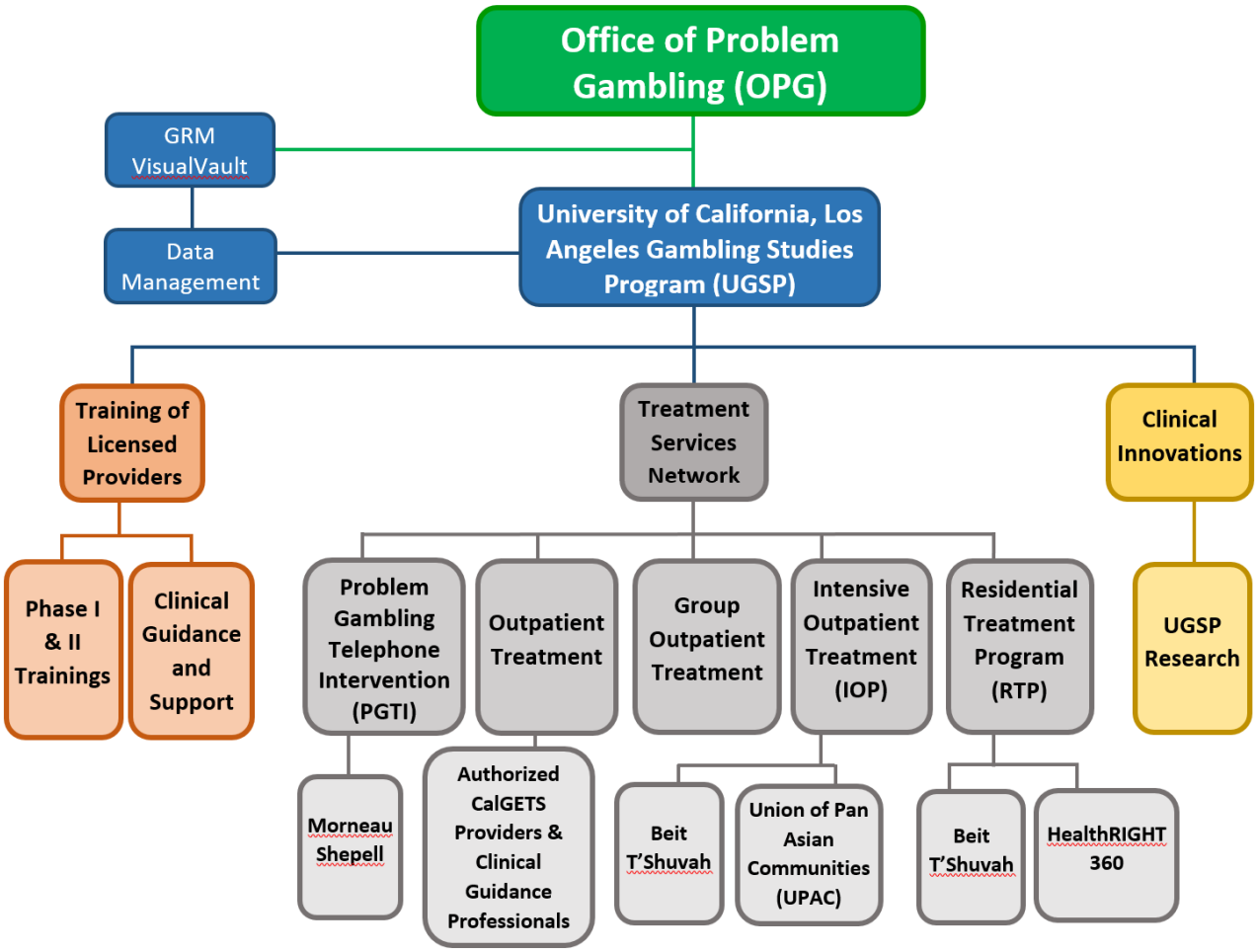
Introduction

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 University of California, Los Angeles (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 (AIs).
- 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.[1]

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 three or more 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 2019-20, there were 211 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

[1] Statewide COVID-19 restrictions prevented the completion of in-person compliance monitoring.

gambling behaviors, depression, and quality of life. Referrals to additional treatment are provided when requested.

Clinical Integrations

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 2019-20 TREATMENT REPORT DATA SOURCES AND METHODS

Data Sources

Data are obtained from the CalGETS client forms. 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 2019-20, 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.[2] 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

[2] 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

In FY 2018-19 we made changes to the data reporting instruments resulting in differences in how items are reported from past years. This was done 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). The current dataset continues these changes which 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. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Version 26. Data distributions were examined and, if necessary, extreme outliers were trimmed to reduce the effect of possibly spurious values.

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), family or friends, Gamblers Anonymous (GA), former clients, UGSP or OPG websites, health care professionals, outreach campaigns, 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 2019-20, UGSP and OPG conducted one Phase I training in August 2019. During March 2-3, OPG and UGSP conducted a two-day training Summit for CalGETS providers and others. Trainings originally scheduled for FY 2019-20 were delayed due to COVID-19 restrictions. The Phase II training on the topic of attention-deficit/hyperactivity disorder (ADHD) originally scheduled for May 2020, was offered as an online training on October 19-21, 2020. The FY 2020-21 Phase I training originally scheduled for August 2020, has been postponed to January and February 2021 and will be conducted online.

Shortly after the close of FY 2019-20, UGSP conducted a survey with all active CalGETS providers to obtain information on provider characteristics and experiences with CalGETS (2020 Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2020, unless given an exemption. The Treatment Services Network had 211 licensed providers who were authorized to provide services to gamblers and AIs at some point during the 2019-20 fiscal year; the responses of 190 of these providers who remained active or decided to participate after suspension or termination are included in the 2020 Provider Survey. **Table 1** details the number of clinicians and providers who completed Phase I training during FY 2019-20. Additionally, CalGETS clinical supervisors delivered 68 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

TABLE 1. CalGETS TRAINING

	FY 2019-20
Training	
Licensed mental health clinicians who completed Phase I	28
Licensed mental health clinicians who completed Phase I and became authorized providers	7
Authorized providers who completed Phase II	N/A

Providers' demographic information is presented below (**Table 2**). Providers were primarily female, and reported their race/ethnicity as: 63% White, 13% Asian, 11% Hispanic/Latino, and 6% Black/African American.

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

	FY 2019-20
Gender	n=190
Female	75%
Male	24%
Transgender	<1%
Race/Ethnicity	n=190
White	63%
Asian	13%
Hispanic/Latino	11%
Black/African American	6%
Multiracial	2%
Native Hawaiian/Pacific Islander	<1%
Choose not to designate or Other	4%

The data on CalGETS providers indicates that they are experienced mental health providers. On average, providers who completed the survey had been licensed for 15.6 years and had treated individuals with gambling disorder for an average of 7.3 years. In FY 2019-20, 70% of providers were Licensed Marriage and Family Therapists (LMFT), 17% were Licensed Clinical Social Workers (LCSW), 6% were Psychologists (PhD), 4% were Clinical Psychologists (PsyD), 1% hold a Master's degree in Social Work (MSW), 1% Licensed Professional Clinical Counselors (LPCC), and 1% had other clinical degrees. CalGETS providers reach clients for whom English is not their primary language: 27% reported providing treatment services in languages other than English. Of those, 43% indicated that they provided services in Spanish, 38% provided services in an Asian language, and 17% provided services in other languages; including Armenian, Hebrew, Persian, and Russian. Over half (58%) 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 (81%)
- Phase II Training (69%)
- Clinical Guidance Sessions (51%)
- Annual Summit (50%)
- Supplemental recommended reading materials (42%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 87% 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 2019-20.

Treatment Service Provision

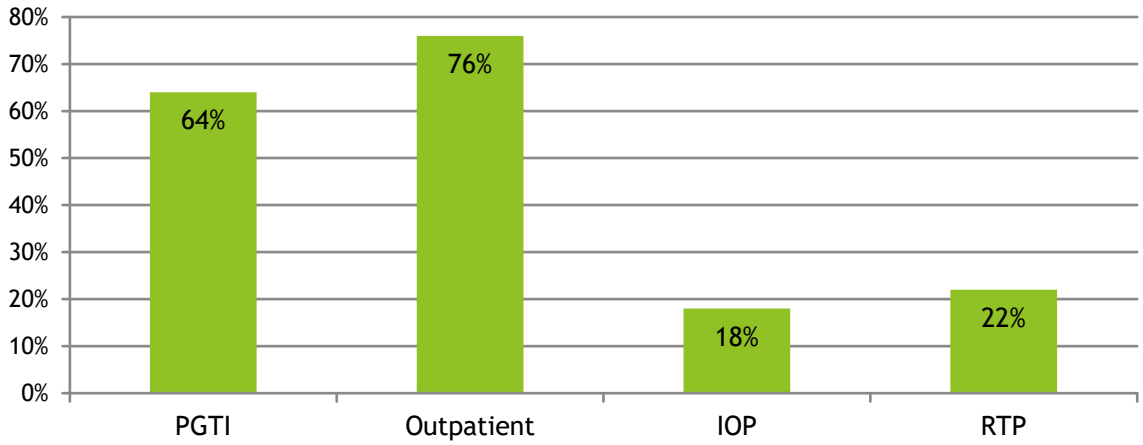
In FY 2019-20, a total of 874 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (69%) enrolled in Outpatient, followed by PGTI (21%), IOP (6%), and RTP (4%). Of these clients, 13% also participated in Outpatient Group services.

TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED

	N	Percentage
Outpatient	606	69%
Outpatient Group	*(76)*	-
Intensive Outpatient Program (IOP)	56	6%
Residential Treatment Programs (RTP)	32	4%
Problem Gambling Telephone Intervention (PGTI)	180	21%
Total[3]	874	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 in PGTI and Outpatient entered treatment within one week. Entry into IOP and RTP was delayed after COVID-19 shelter-in-place directives went into place.

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.)

[3] Throughout this report, percentages may add up to greater than 100% due to rounding. The total 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 = 601	IOP N = 56	RTP N = 31	PGTI N = 180	Total N = 868	CA Population[4] N = 39,536,653
White, Non-Hispanic only[5]	49%	59%	61%	36%	48%	27%
Asian/Pacific Islander only	17%	9%	19%	23%	18%	16%
Hispanic or Latino only	14%	13%	3%	14%	14%	39%
Black or African American only	11%	7%	13%	14%	11%	7%
American Indian/Alaskan Native only	1%	0%	0%	1%	<1%	2%
Other race/ethnicity only	4%	5%	0%	5%	4%	-
Multiracial or Multi-ethnic[6]	5%	7%	3%	7%	5%	-

Note: Race/ethnicity responses were missing for 5 Outpatient and 1 RTP client.

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

[5] "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.

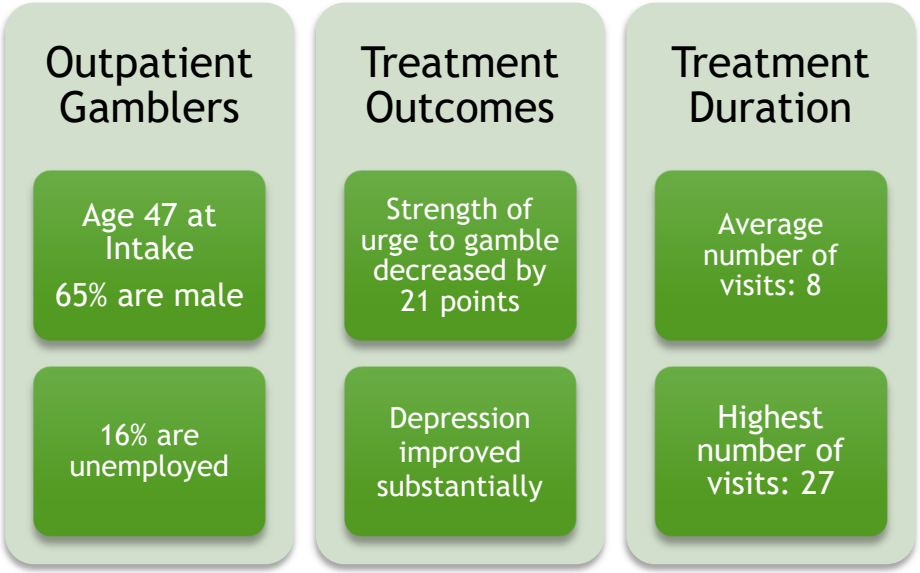
[6] "Multiracial or Multi-ethnic" category specifies the percentage of respondents who identify with multiple ethnic or racial designations.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown earlier in Table 3,[7] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 606 clients who enrolled in outpatient. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2019-20, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (28%), family/friends (15%), Gamblers Anonymous/Gam-Anon (13%), former clients (11%), UCLA Gambling Studies Program (9%), health care professionals (9%), the California Council on Problem Gambling (2%), and the OPG website (2%). In addition, 11% 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=606) varied:

- 12% of clients had only an Intake session
- 51% received 1-8 treatment sessions
- 27% received 9-16 treatment sessions
- 11% received 17-27 treatment sessions

Some individuals may be continuing treatment into FY 2020-21, but these additional sessions are not counted in the percentages above.

[7] 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 (49%), followed by 17% reporting Asian/Pacific Islander, 14% Hispanic/Latino, 11% African American, 1% American Indian/Alaska Native, 4% another race/ethnicity, and 5% Multiracial/Multi-ethnic. (More detailed analyses of gender and race ethnicity are available in the appendix.) Clients are, for the most part, well-educated; 60% reported completing some college or above. The reported household income varied widely from less than $15,000 per year to over $200,000, but 24% reported incomes of less than $35,000 (**Table 5**).

TABLE 5. OUTPATIENT GAMBLER: DEMOGRAPHICS

FY 2019-20	(N=606)
Age	n=606
Mean Age	47 years old
Gender	n=606
Male	65%
Female	35%
Other	<1%
Race/Ethnicity (for those reporting a single category only)	n=601
White, Non-Hispanic	49%
Asian/Pacific Islander	17%
Hispanic or Latino	14%
Black or African American	11%
American Indian/Alaskan Native	1%
Other race/ethnicity	4%
Multiracial or Multi-ethnic	5%
Education	n=605
Less than High School	4%
High School	15%
Some College	41%
Bachelor's Degree	30%
Graduate/Professional Degree	11%
Household Income	n=605
Less than $15,000	9%
$15,000-$24,999	5%
$25,000-$34,999	10%
$35,000-$49,999	14%
$50,000-$74,999	16%
$75,000-$99,999	14%
$100,000-$149,999	13%
$150,000-$199,999	5%
$200,000 or more	7%
Decline to state	5%

Note: Five cases from the Outpatient program for gamblers were missing race/ethnicity, and one case was 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	10	2%
Mild gambling disorder	4 to 5	40	7%
Moderate gambling disorder	6 to 7	126	22%
Severe gambling disorder	8 to 9	409	70%

Note: N=585, 21 cases had missing data

Gambling Behaviors

At Intake, outpatient clients (n=585) 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 (81%), followed by the Internet, (22%), lottery stores (15%), family/friends house (11%), and other locations.

Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines (61%), blackjack (38%), and poker (38%) were the most commonly selected gambling activities.

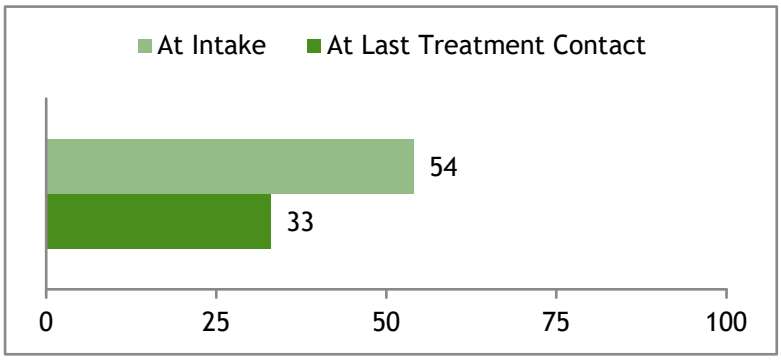
- At **tribal casinos,** clients most frequently stated that they played slot machines (48%), blackjack (30%), and poker (19%).
- At **other casinos,** clients most frequently reported playing slot machines (23%), blackjack (16%), and poker (10%).
- In the **community**, 22% of clients reported gambling on the Lottery.
- At **cardrooms,** clients most often reported playing poker (17%), and blackjack (15%).
- On the **Internet**, clients most often indicated playing slots (8%), poker (6%), and blackjack (6%).
- Finally, clients reported gambling on sporting events (18%), financial/stock markets (6%), and horse racing (5%).

Intake to Last Treatment Contact (LTC) Outcomes

In order to measure the impact of treatment, we analyzed the perceived negative impact of gambling, urge to gamble, life satisfaction, and depression 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 21 points from Intake to last treatment contact (**Figure 4**).[8]

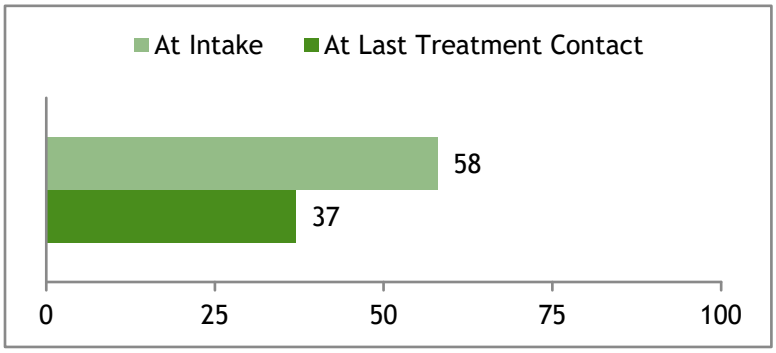
FIGURE 4. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=531, LTC N=440.

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

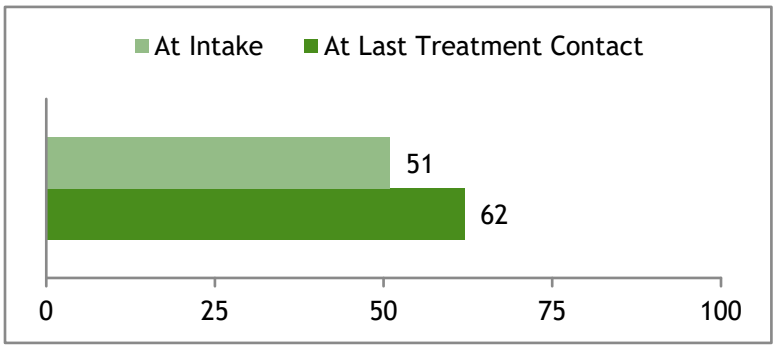


Note: Intake N=585, LTC N=528.

[8] However, there is sample attrition between Intake and last treatment contact that may affect the last treatment contact average. Intake sample had 75 cases missing.

Over the course of treatment, outpatient clients reported an improvement of 11 points on average in overall life satisfaction (**Figure 6**). As above, life satisfaction was measured on a 100-point scale.

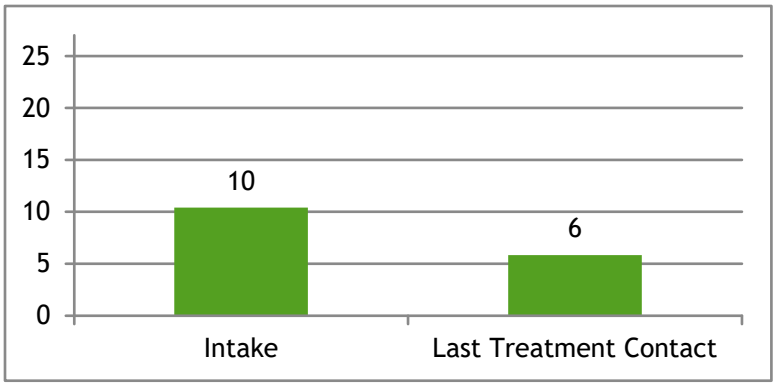
FIGURE 6. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=575, LTC N=533.

During FY 2019-20, treatment participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. Outpatient clients showed, on average, moderate depression at Intake and mild depression at their last treatment session (**Figure 7**). However, among these clients, 22% started treatment with moderately severe to severe depression.

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



Note: Intake N=585, LTC N=536.

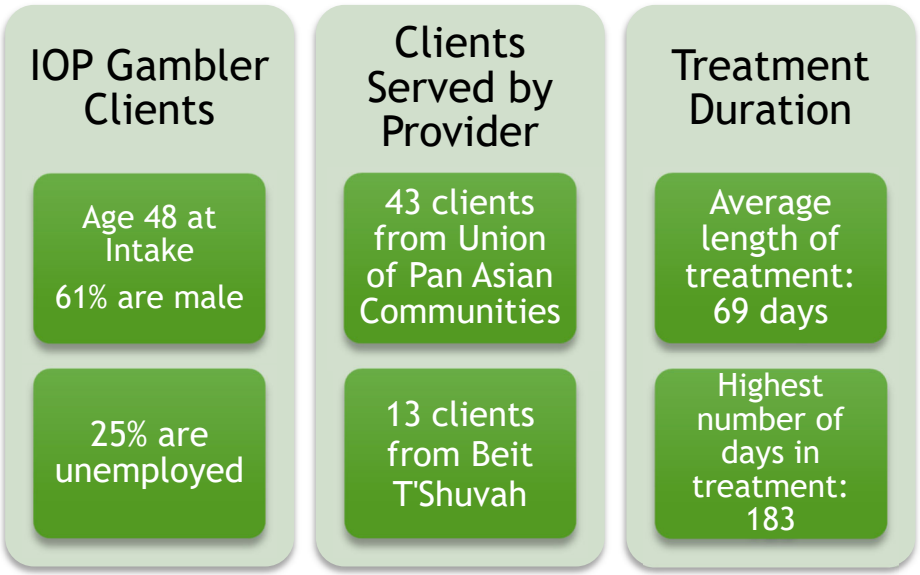
Group Outpatient

A total of 91 clients participated in group treatment in FY 2019-20. Of these participants, 76 were gamblers and 15 were AIs. The average age of gambler clients was 53 years old and about 58% were female. Half of gamblers (50%) were referred to group treatment by a CalGETS provider. Other referral sources included former CalGETS clients (22%), Gamblers Anonymous (20%), family or friends (5%), and other sources (3%). The average age of AI clients was 56 years old and about 80% were female. The majority of AIs were referred to group treatment by a CalGETS provider (80%). Three individuals reported referrals from other sources. The primary types of gambling reported by gamblers at group screening were slot machines (17%), poker (12%), and black jack (7%). Tribal casinos were the most frequently reported gambling venue (21%), followed by card rooms (12%), internet (5%), and casinos (4%). Thirteen percent of gambler participants reported moderately severe to severe depression at screening. This year, no AIs reported moderately severe to severe depression.

Intensive Outpatient Program (IOP)

Data were available from 56 clients enrolled at Intake in IOP during FY 2019-20 (**Figure 8**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=43) or Beit T'Shuvah (N=13). 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 56 clients entered IOP during FY 2019-20. IOP clients' average age was 48. About three-fifths (60%) identified as White, Non-Hispanic only, followed by 13% Hispanic/Latino only, 9% Asian/Pacific Islander only, 7% African American only, 7% as Multiracial or Multi-ethnic, and 5% as another race/ethnicity only. Like Outpatient clients, IOP clients have fairly high levels of education with 81% reporting some college education or higher. Although clients' household income varied from less than $15,000 per year to $200,000 or higher, 27% of IOP clients reported an income less than $35,000 and 9% 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 (89%).

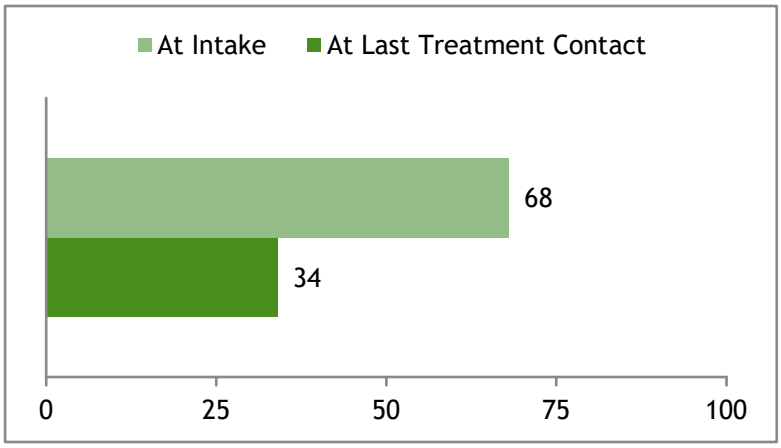
Across all venues the most commonly selected gambling activities were slot machines (61%), blackjack (38%), and poker (38%).

- At **tribal casinos,** IOP clients most frequently stated that they played slot machines (57%), blackjack (23%), and poker (16%).
- In the **community**, 23% of clients reported gambling on the Lottery.
- At **other casinos,** clients most frequently reported playing poker (21%), blackjack (21%), and slot machines (20%).
- At **cardrooms,** clients most often reported playing poker (16%) and blackjack (11%).
- On the **Internet**, clients most often indicated playing poker (14%), slots (13%), blackjack (9%), and video poker (5%).
- Finally, clients reported gambling on sporting events (14%), stocks/financial markets (13%), and bingo (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, 3-9 of the 56 IOP clients had missing data on the first three measures, and, 2-16 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 34 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.

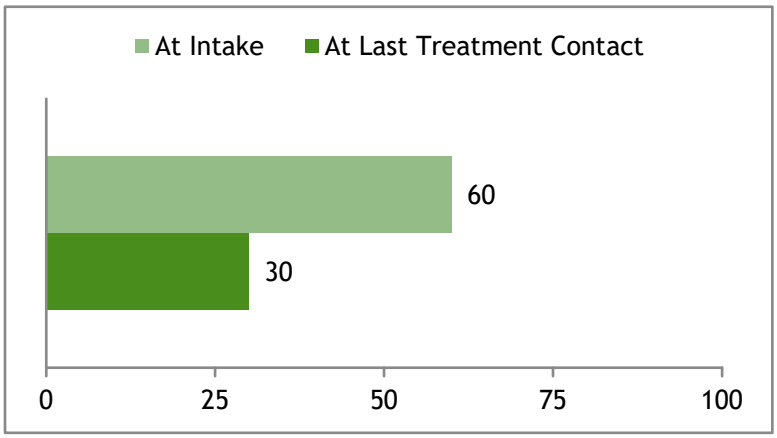
FIGURE 9. IOP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=48, LTC N=40.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to last treatment contact by an average of 30 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble (**Figure 10**).

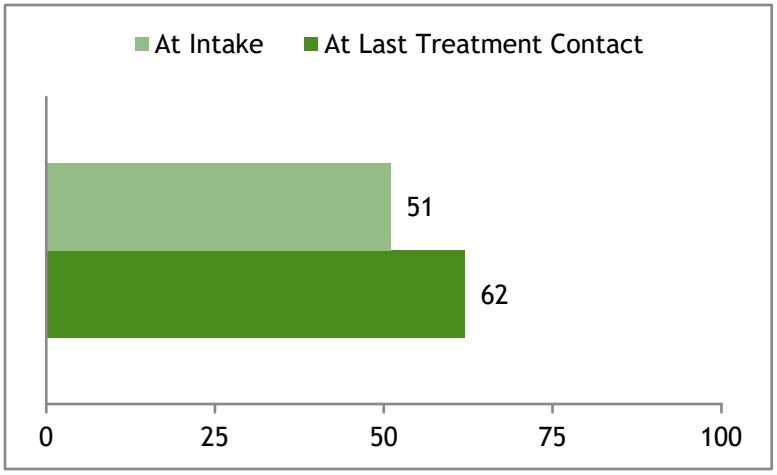
FIGURE 10. IOP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=47, LTC N=49.

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

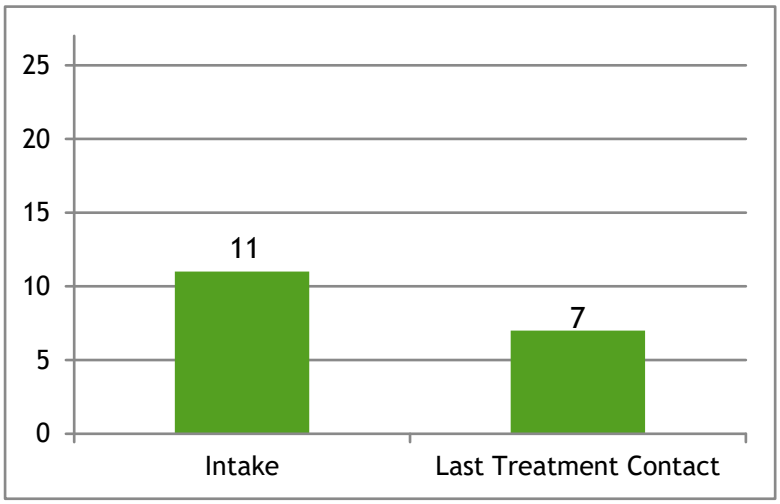
FIGURE 11. IOP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=53, LTC N=54.

During FY 2019-20, 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**). Nearly 29% entered treatment with moderately severe to severe depression.

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

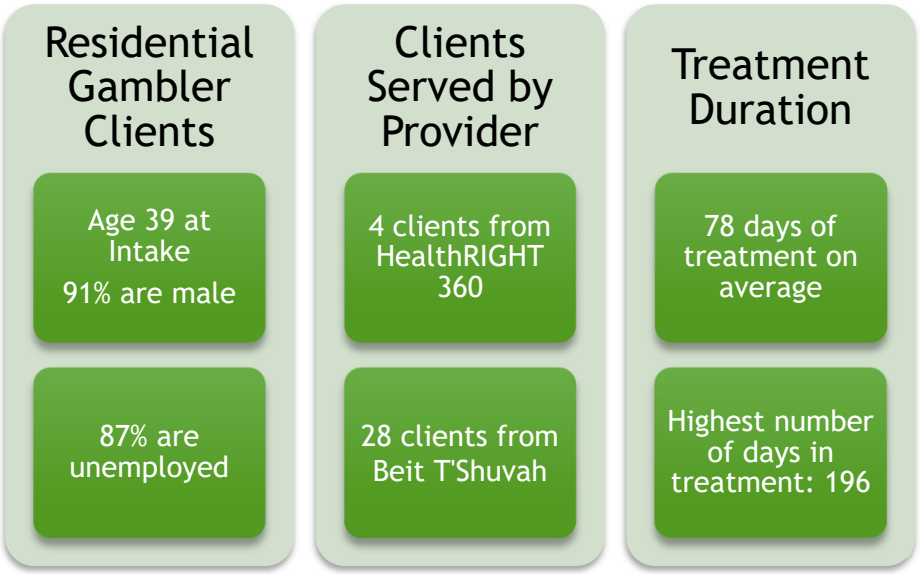


Note: Intake N=56, LTC N=55.

Residential Treatment Programs (RTP)

Data were available from 32 clients enrolled at Intake in RTP during FY 2019-20 (**Figure 13**). Clients received treatment from either HealthRIGHT 360 (N=4) or Beit T'Shuvah (N=28). Due to staffing changes and COVID-19 restrictions, HealthRIGHT 360 admitted very few clients during FY 2019-20. When COVID-19 shelter-in-place directives prevented new clients from being admitted to Beit T'Shuvah, OPG approved additional blocks of treatment (with clincial justification) for those currently in treatment. 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 three-fifths (61%) identified as White, Non-Hispanic only, followed by 19% Asian/Pacific Islander only, 13% African American only, 3% Hispanic/Latino only, and 3% as Multiracial or Multi-ethnic. RTP clients have less education than Outpatient and IOP clients, with 56% reporting some college education or higher. Similar to IOP clients, RTP clients also reported lower household income, with 25% reporting that their income was less than $35,000 and 16% reporting income less than $15,000 per year.

Gambling Severity

All clients enrolled in RTP treatment met DSM-5 criteria for gambling disorder. Specifically, 100% were classified with severe gambling disorder.

Gambling Behaviors

RTP clients (n=32) 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 (91%).

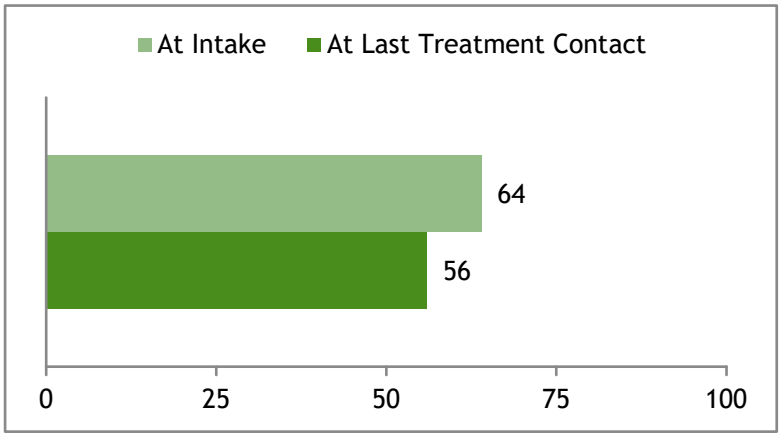
Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, poker, blackjack, slot machines, and sporting events were the most commonly selected gambling activities.

- At **tribal casinos,** clients most frequently stated that they played poker (47%), blackjack (28%), and slot machines (19%).
- At **other casinos,** clients most frequently reported playing poker (72%), blackjack (41%), and slot machines (22%).
- At **cardrooms,** clients most often reported playing poker (56%) and blackjack (38%).
- On the **Internet**, clients most often indicated playing poker (25%), blackjack (13%), and slots (6%).
- Finally, clients reported gambling on sporting events (22%), horse racing (9%), dice (6%), and bingo (6%).

Intake to Last Treatment Contact Outcomes

Intake to last treatment contact data are available on the 32 clients[9] who entered residential treatment in FY 2019-20. By the end of treatment, the average rating of interference by gambling with normal activities decreased by 8 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

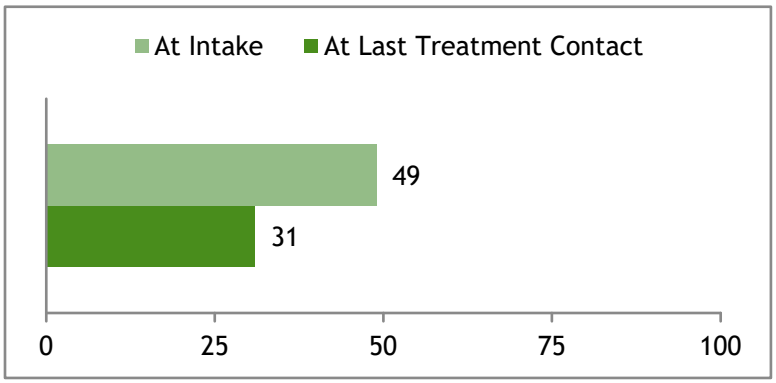


Note: Intake N=32, LTC N=31.

[9] There is missing data for one participant at last treatment contact or Intake.

Among RTP clients, the intensity of the urge to gamble, on average, decreased from Intake to last treatment contact by 18 points on the 100-point scale.[10] Lower scores at LTC indicated a less intense urge to gamble (**Figure 15**).

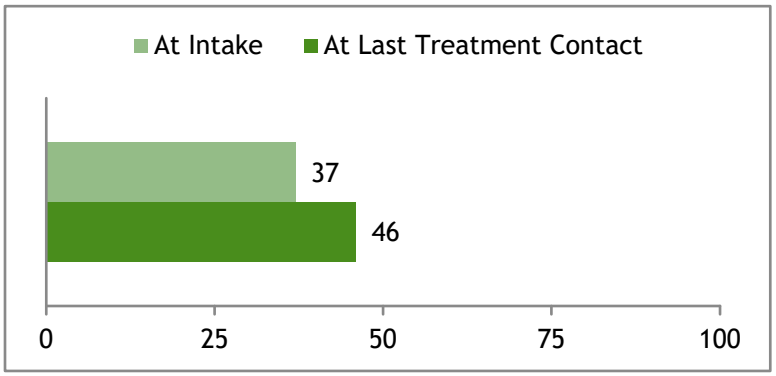
FIGURE 15. RTP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=32, 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

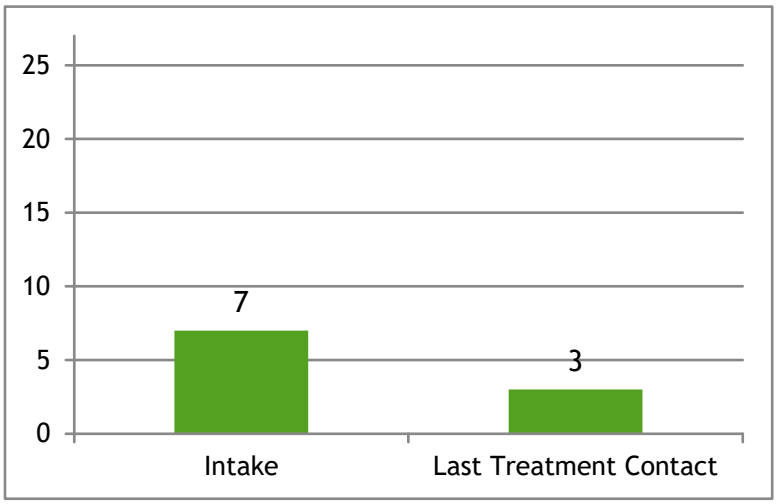


Note: Intake N=31, LTC N=32.

[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 2019-20, 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**). About 6% entered treatment with moderately severe to severe depression.

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

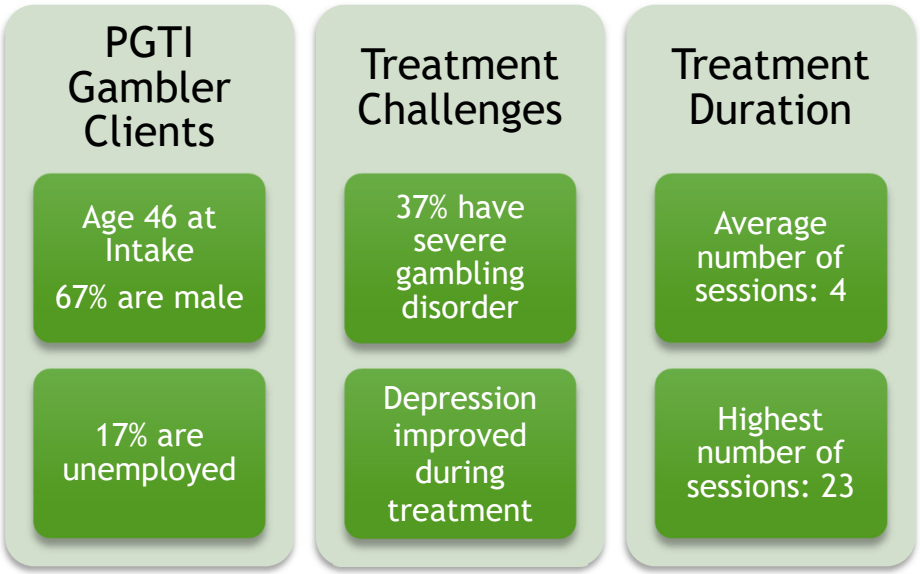


Note: Intake N=32, LTC N=32.

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 in aggregate.

Within PGTI, data were available for 180 gambler clients enrolled at Intake during FY 2019-20. Of the 180 total clients assessed at Intake, 123 received further treatment services.

Clients participating in PGTI (n=180) most often reported being referred by the Helpline (1-800-GAMBLER) (67%); casino signage (7%), UCLA Gambling Studies Program (6%), family or friends (6%), the California Council on Problem Gambling (5%); media (television, radio, newspapers, billboards) (3%), or by other sources (5%).

PGTI clients (n=180) participated in four treatment sessions on average, with a maximum of 23 sessions in total.

Demographics

Gamblers in PGTI treatment were, on average, 46 years old and predominately male. Household income varied widely, but 25% had yearly household incomes of less than $35,000. Among PGTI clients, 36% were White, Non-Hispanic only, followed by 24% Asian/Pacific Islander only, 14% Hispanic/Latino only, 14% African American only, 1% American Indian/Alaska Native, 4% another race/ethnicity only, and 7% 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 2019-20	N=180
Age	(n=180)
Mean Age	46 years old
Gender	(n=180)
Male	67%
Female	33%
Transgender	1%
Race/Ethnicity (for those reporting a single category only)	(n=180)
White, Non-Hispanic only	36%
Asian/Pacific Islander only	24%
Hispanic or Latino only	14%
Black or African American only	14%
American Indian/Alaskan Native only	1%
Other race/ethnicity only	4%
Multiracial or Multi-ethnic	7%
Education	(n=179)
Less than High School	3%
High School	35%
Some College	30%
Bachelor's Degree	25%
Graduate/Professional Degree	8%
Household Income	(n=179)
Less than $15,000	11%
$15,000-$24,999	7%
$25,000-$34,999	7%
$35,000-$49,999	15%
$50,000-$74,999	20%
$75,000-$99,999	13%
$100,000-$149,999	12%
$150,000-$199,999	6%
$200,000 or more	8%
Decline to state	2%

Gambling Severity

Of those enrolled in PGTI services, 94% 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=173)	Problem gambling behavior	1 to 3	11	6%
	Mild gambling disorder	4 to 5	36	21%
	Moderate gambling disorder	6 to 7	62	36%
	Severe gambling disorder	8 to 9	64	37%

Gambling Behaviors

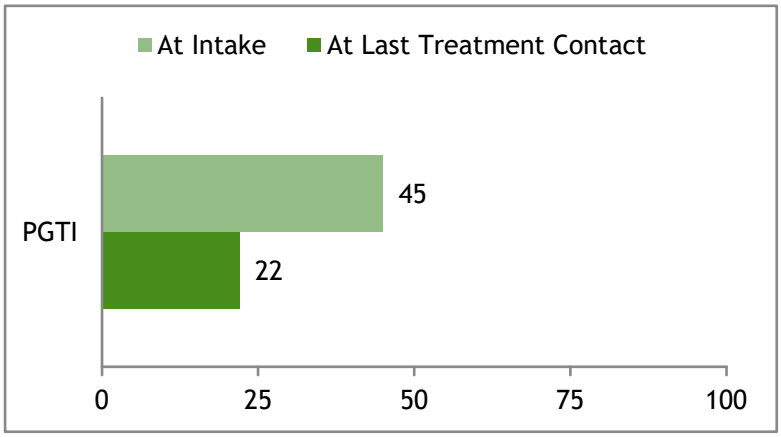
PGTI clients were asked at Intake to describe their gambling behaviors and the types of gambling activities they have engaged in over the last 12 months. Typical gambling locations included casinos, mentioned by 76% of clients, food/convenience stores for Lottery tickets (20%), and Internet (16%). Across all venues, the three most common gambling activities were slot machine (47%), blackjack (23%), poker (19%), and sports betting (9%).

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 (43%), blackjack (18%), and poker (13%). The other major gambling activity was the Lottery (21%).

Intake to Last Treatment Contact Outcomes

By the end of treatment, the average rating of interference by gambling with normal activities decreased by 23 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.

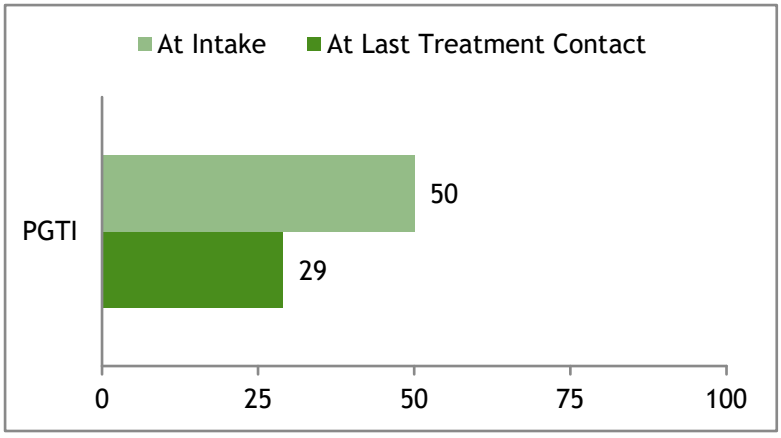
FIGURE 19. PGTI GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=171, LTC N=120

Among PGTI clients, the intensity of the urge to gamble, on average, decreased from Intake to their last treatment contact by 21 points on the 100-point scale. Lower scores at clients' last treatment contact indicated a less intense urge to gamble (**Figure 20**).

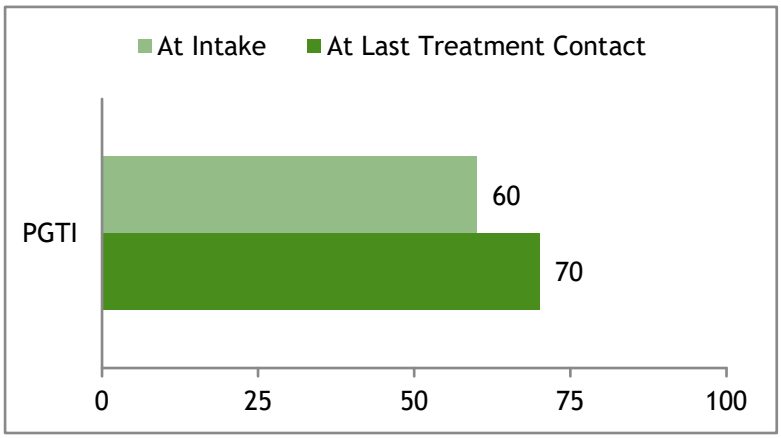
FIGURE 20. PGTI GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=170, LTC N=119

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.

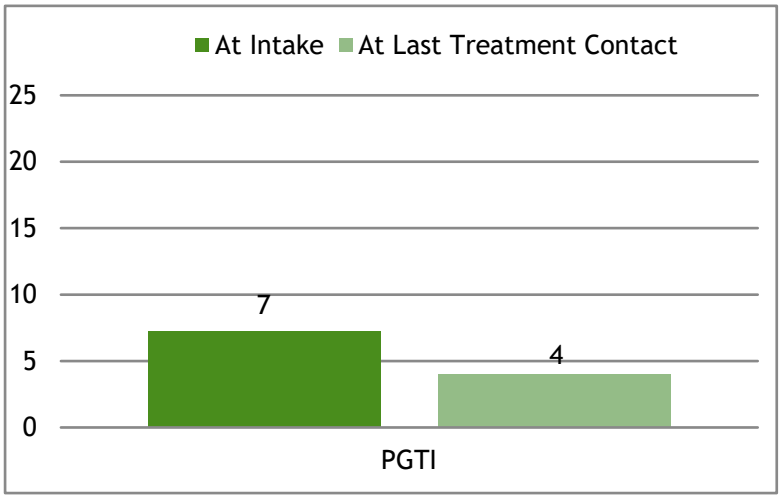
FIGURE 21. PGTI GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=172, LTC N=122

During FY 2019-20, 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=173, LTC N=123

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 = 585)	18%	11%	11%	30%
IOP (N = 56)	16%	13%	4%	30%
RTP (N = 32)	3%	3%	0%	6%
PGTI (N = 173) [11]	15%	7%	3%	29%
California adults[12]	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 29% of CalGETS clients are obese, higher than the percentage for California adults.
- Compared to California adults, smoking percentages were high across the treatment services network – 24% of Outpatient clients reported smoking, more than twice the state average.[13] There was a notable change in the percentage of RTP clients reporting smoking, which decreased to 16%, down from 30% last year and 42% the year before. Of IOP clients, 32% reported smoking. Among PGTI clients, 21% reported smoking.
- About 32% of gamblers across the treatment services network reported their health as fair or poor (35% in Outpatient, 45% in IOP, 6% in RTP, and 24% inPGTI). This compares to 18% of adults in California reporting their health as “fair or poor” in 2018, according to the CDC.[14]

[11] 16 PGTI clients had missing data for the BMI calculation.

[12] 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/.

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

[14] 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

Mood disorders and anxiety were the most common co-occurring mental health conditions reported and both show increases over last year (**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 = 585)	32%	3%	20%	7%	1%	5%
IOP (N = 56)	52%	4%	39%	11%	0%	5%
RTP (N = 32)	75%	3%	16%	9%	0%	0%
PGTI (N = 173)	28%	4%	16%	3%	1%	1%

- 22% of CalGETS outpatient clients, 29% of IOP, 6% of RTP, and 6% 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.[15]
- Throughout the treatment system, the percentage of anxiety disorders increased this year compared to last year. IOP clients had the highest prevalence of anxiety disorders.
- The percentage of mood disorders also increased this year, with RTP clients having high levels.

Substance Use Behaviors

- Among Outpatient clients, 53% reported that they drank alcoholic beverages at intake. In other treatment modalities, a smaller percentage of clients reported current drinking: 52% among IOP clients, 16% among RTP clients, and 43% among PGTI clients.
- Of Outpatient clients, 24% 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 reporting any binge drinking in the past month.[16]

Cannabis was the most frequently reported substance used in the past month across the treatment services network, with 21% of CalGETS clients in Outpatient reporting use of cannabis. This is higher than the 16% reported by Gallup for current use in the Western states.17 Approximately 14% of IOP, 13% of RTP, and 8% of PGTI clients reported cannabis use in the past month. However, clients also reported use of other substances (**Table 11**).

[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/.

[16] 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.

[17] Gallup, What percentage of Americans smoke marijuana? [online], 2019. [accessed August 5, 2020]. URL: https://news.gallup.com/poll/284135/percentage-americans-smoke-marijuana.aspx.

TABLE 11. GAMBLERS: SUBSTANCE USE IN THE PAST 30 DAYS

	Cocaine	Cannabis	Methamphetamine	Opiates	Binge Drinking
Outpatient (N = 585)	4%	21%	3%	3%	24%
IOP (N = 56)	0%	14%	0%	2%	16%
RTP (N = 32)	6%	13%	9%	6%	9%
PGTI (N = 173)	1%	8%	1%	1%	14%

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; therefore, they may be covered for co-occurring conditions like those identified above.

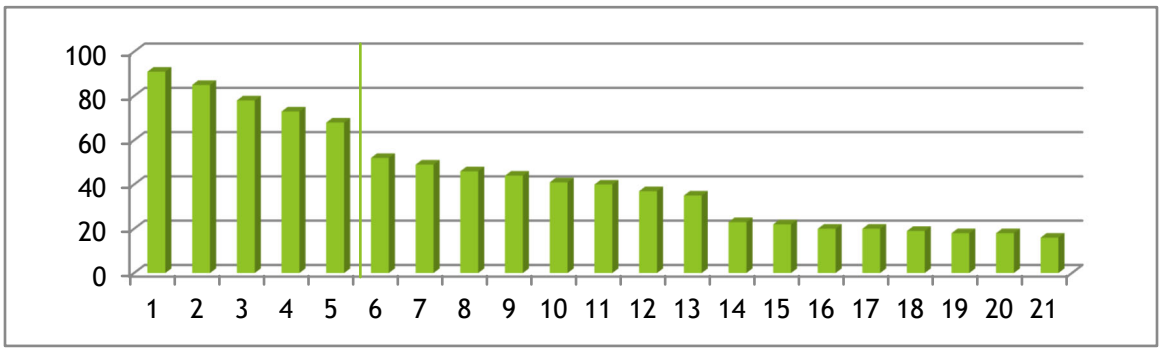
5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2019-20 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 248 AI clients. Most (93%) were served as Outpatients (n=231). The remaining 17 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). Fifty-two percent continued treatment after session 5 (**Figure 23**).

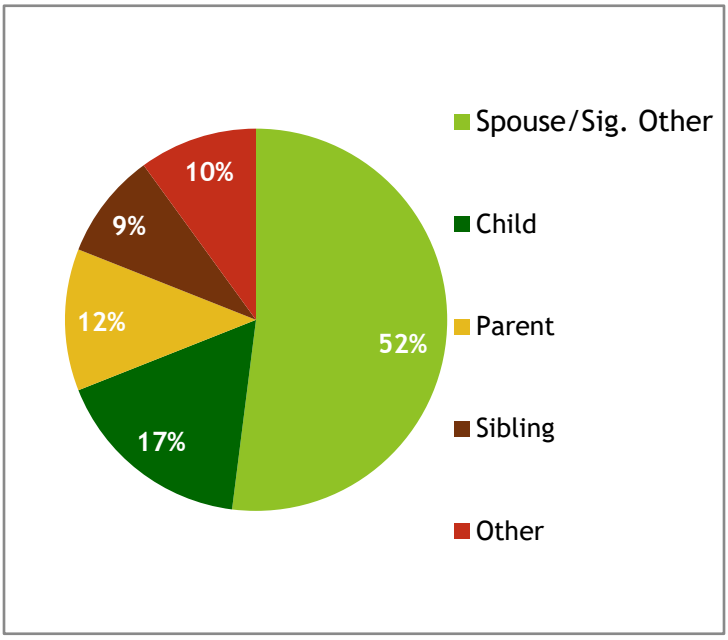
FIGURE 23. OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Note: N=248

Of the 248 Outpatient AI clients, about half (52%) identified as a spouse or significant other, 17% as a child of, 12% as a parent of, and 9% as a sibling of a gambler (**Figure 24**).

FIGURE 24. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

AIs in Outpatient treatment were 46 years old, on average, and predominately female (75%), whereas a majority of gambler clients are male. About half were White, Non-Hispanic, followed by 18% Hispanic/Latino, 16% Asian/Pacific Islander, 3% African American, 7% another race/ethnicity, and 4% Multiracial/Multi-ethnic. Similar to Outpatient gamblers, Outpatient AIs have widely varying household incomes and high education levels, with a greater percentage (86%) attending some college or higher (**Table 12**).

TABLE 12. OUTPATIENT AI: DEMOGRAPHICS

FY 2019-20	(N=231)
Age	n=231
Mean Age	46 years old
Gender	n=231
Male	25%
Female	75%
Transgender	<1%
Choose not to disclose	<1%
Race/Ethnicity (for those reporting a single category only)	n=229
White, Non-Hispanic only	52%
Asian/Pacific Islander only	16%
Hispanic or Latino only	18%
Black or African American only	3%
American Indian/Alaskan Native only	0%
Other race/ethnicity only	4%
Multiracial or Multi-ethnic	7%
Education	n=231
Less than High School	4%
High School	10%
Some College	30%
Bachelor's Degree	34%
Graduate/Professional Degree	22%
Household Income	n=231
Less than $15,000	8%
$15,000-$24,999	7%
$25,000-$34,999	5%
$35,000-$49,999	10%
$50,000-$74,999	16%
$75,000-$99,999	11%
$100,000-$149,999	17%
$150,000-$199,999	12%
$200,000 or more	9%
Decline to State	7%

Treatment Service Findings

Intake to Last Treatment Contact Outcomes

As seen in **Table 13**, 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 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 13. OUTPATIENT AI: INTAKE TO LAST TREATMENT CONTACT OUTCOMES

	Intake Mean	Last Treatment Contact Mean
Depression (PHQ-9) score	8	5
Life satisfaction	59	67
Degree to which problem gambler's behaviors have interfered with normal activities	52	29
Feel responsible for gambler's treatment and recovery	45	28

Note: Depression Intake N=228, LTC N=218; life satisfaction Intake N=228, LTC N=218; interfere with normal activities Intake N=211, LTC=215; feel responsible Intake N=198, LTC N=164.

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, chronic respiratory disease, and diabetes. Eighteen percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking was 5% in FY 2019-20, lower than the percentage of smokers among Californians (10%). [18]

Also of note was the lower percentage of Outpatient AIs who reported current drinking (47%) relative to Outpatient gamblers (53%). Cannabis use in the past 30 days was reported by 13% of Outpatient AIs, while 2% reported opioid use, 1% reported use of cocaine, and less than 1% reported methamphetamine use in the past 30 days. Similar to past years, in FY 2019-20, 29% of Outpatient AIs rated their health as fair or poor at Intake. Also, more than 80% reported that they had health insurance.

In regard to co-occurring psychiatric disorders reported at Intake, 24% of Outpatient AI clients reported treatment in the past year for mood disorders, 17% for anxiety disorders, 4% for attention deficit disorders, 1% for substance abuse disorders, 1% for personality disorders, and less than 1% reported treatment for psychotic disorders. Using the PHQ-9 criteria, no AI clients reported moderately severe to severe depression, but 18% reported moderate depression symptoms.

[18] 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 2019-20, therefore, five attempts were made to reach each client. Technical issues resulted in reduced numbers for this fiscal year. [19]

Table 14, 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 2019-20. The numbers differ slightly from DMS data because they are based on call logs. UGSP made greater than 3,900 attempts to reach clients for follow-up interviews; completing 362 interviews, and ultimately closing 235 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 14. 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	867	163	**1030**	1295	273	**1558**	1106	255	**1361**	3258	691	**3949**
Completed	81	18	**99**	132	27	**159**	85	19	**104**	298	64	**362**
Closed	35	9	**44**	83	21	**104**	78	9	**87**	196	39	**235**

Note: G = Gamblers, AI = Affected individuals

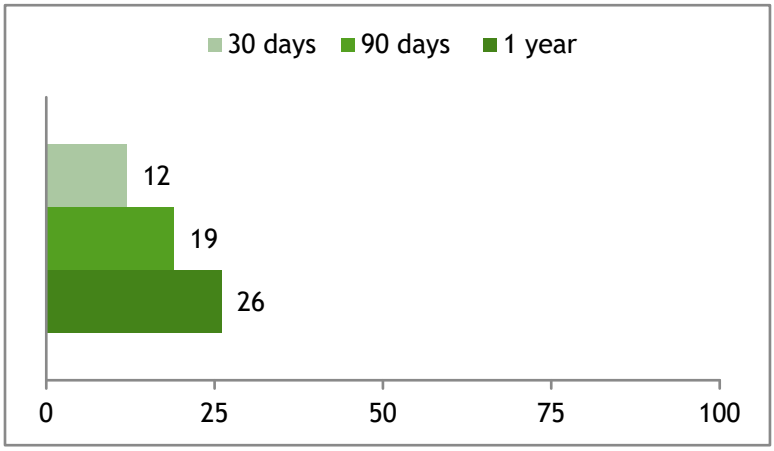
Follow-up results are presented below for the largest group of gamblers receiving treatment: Outpatient gamblers.

[19] UGSP had reduced call numbers in the 4th Quarter due to COVID-19 shelter-in-place requirements.

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 but was greater among clients reached at one year (**Figure 25**).[20]

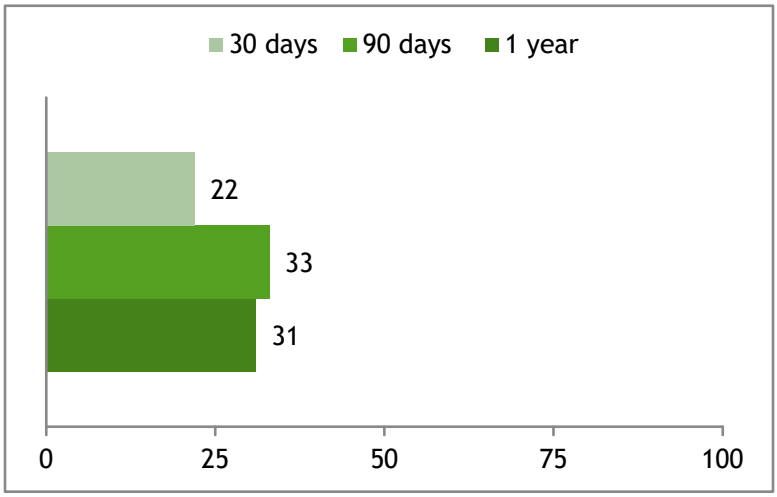
FIGURE 25. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT FOLLOW-UP



Note: 30 days N=49, 90 days N=61, 1 year N=53.

Likewise, the intensity of the urge to gamble, on average, was low during the post-treatment period, remaining below 35 points on the 100-point scale (**Figure 26**).

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

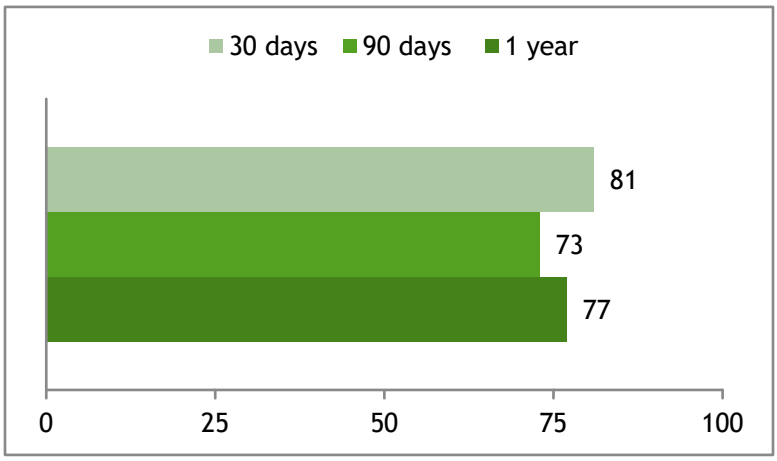


Note: 30 days N=53, 90 days N=78, 1 year N=58.

[20] Follow-up data is cross-sectional (i.e., during FY 2019-20, 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 remained fairly high during the post-treatment period (**Figure 27**). As above, life satisfaction was measured on a 100-point scale.

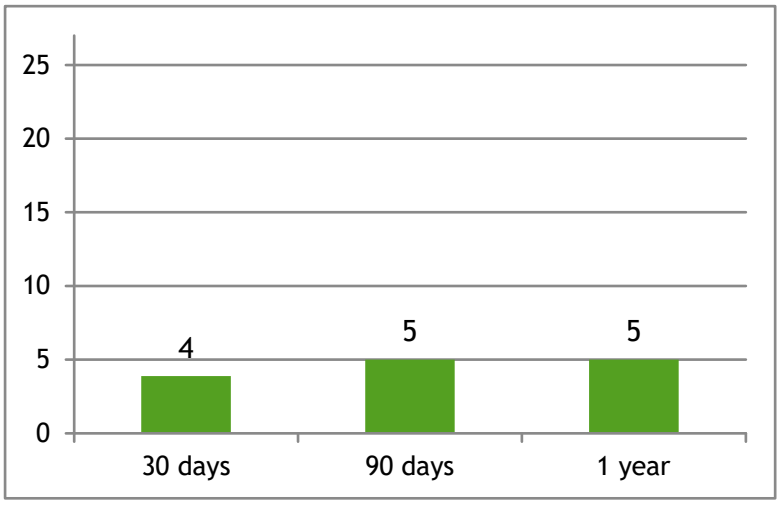
FIGURE 27. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT FOLLOW-UP



Note: 30 days N=56, 90 days N=91, 1 year N=73.

As shown in **Figure 28**, the average depression (PHQ-9) score was 4 at 30 days post-treatment, indicating sub-clinical levels of depression. At the 90-day and one-year follow-ups, the depression score was 5, indicating mild depression.

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



Note: 30 days N=57, 90 days N=91, 1 year N=73.

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. However, in FY 2019-20, UGSP interviewers were only able to reach 20 AI clients. Quality-of-life data was available for 17, which is below the number required for statistical analysis.

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 82 gambler clients offering comments on their treatment experiences, 73 (89%) had positive comments, 7 (9%) had negative comments, and 2 (2%) 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. Neutral comments were positive about the treatment but expressed a desire for more treatment or were positive about one provider while negative about another.

Of the 20 AIs who provided feedback on their treatment experiences, 17 (85%) offered positive comments, 1 (5%) had negative comments, and 2 (10%) offered neutral or mixed comments. In general, those with positive comments had positive remarks 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 such as wanting more treatment sessions, but expressing satisfaction with the sessions that they did receive.

7. CLINICAL INTEGRATIONS

Housed within UGSP, clinical integration projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY 2019-20, UGSP and OPG worked with two community agencies to develop proposals to address disparities among those reached for CalGETS education and treatment.

Facilitating Latino/a Community Utilization of CalGETS Services Vision y Compromiso

The planned pilot project in Los Angeles and San Diego Counties is designed to increase CalGETS utilization among Latino communities. There are three elements to this project: training, community outreach, and evaluation. For the training component, the UCLA Gambling Studies Program (UGSP) will develop gambling-specific training content informed by focus groups with Vision y Compromiso (VyC) promotores. VyC will deliver the training to promotores. For community outreach, VyC will develop and implement an outreach protocol for the two target counties. For the evaluation component, VyC and UGSP will assess the training and community outreach activities using qualitative and quantitative methods.

Gambling Disorder Screening at the Riverside San Bernardino Indian Health Clinic: A California Gambling Education and Treatment Services (CalGETS) Pilot Project

The planned project is a gambling disorder pilot project designed to provide education, screening, and treatment referrals for those with gambling problems in the tribal community. This project will be implemented by Riverside San Bernardino Indian Health Clinic (RSBIHC) with support from UGSP and OPG and will include plans for data sharing as well as an evaluation of the program implementation.

References

Gerstein, D., Volberg, R. A., Toce, M. T., Harwood, H., Johnson, R. A., Buie, T., ... & Hill, M. A. (1999). Gambling impact and behavior study: Report to the national gambling impact study commission. *Chicago: National Opinion Research Center*.

Kroenke, K & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*(9), 1-7.

Löwe, B., Kroenke, K., Herzog, W & Gräfe, K. (2004). Measuring depression outcome with a brief self-report instrument: sensitivity to change of the Patient Health Questionnaire (PHQ-9). *Journal of Affective Disorders, 81*, 61-66.

APPENDIX: DETAILED RACE/ETHNICITY AND GENDER CATEGORIES

TABLE 15. GAMBLERS: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 601	IOP N = 56	RTP N = 31	PGTI N = 180	Total N = 868	CA Population[21] N = 39,536,653
White, Non-Hispanic only[22]	49%	59%	59%	36%	48%	27%
Asian/Pacific Islander only	17%	9%	20%	24%	18%	16%
Hispanic or Latino only	14%	13%	3%	14%	14%	39%
Black or African American only	11%	7%	13%	14%	11%	7%
American Indian/Alaskan Native only	1%	0%	0%	1%	<1%	2%
Other race/ethnicity only	4%	5%	0%	4%	4%	-
Multiracial or Multi-ethnic[23]	5%	7%	3%	7%	5%	-
Race/Ethnicity (for those reporting single AND multiple categories)						
White, Non-Hispanic only or with another race/ethnicity[24]	50%	57%	63%	39%	48%	
Asian/Pacific Islander only or with another race/ethnicity	18%	10%	19%	26%	19%	
Hispanic or Latino only or with another race/ethnicity	16%	16%	6%	15%	16%	
Black or African American only or with another race/ethnicity	11%	8%	13%	14%	12%	
American Indian/Alaskan Native only or with another race/ethnicity	1%	0%	0%	1%	1%	
Other race/ethnicity only or with another race/ethnicity	5%	8%	0%	6%	5%	

Note: Race/ethnicity percentages for those reporting single AND multiple categories add up to greater than 100% because individuals can select more than one response. Data were missing for 5 Outpatient and 1 RTP client.

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

[22] "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.

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

[24] "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 16. GAMBLERS: GENDER DETAILS BY TREAMENT MODALITY

Gender Categories	Outpatient N = 606	IOP N = 56	RTP N = 32	PGTI N = 180	Total N = 874
Gender – assigned at birth					
Male	65%	61%	91%	66%	66%
Female	35%	39%	9%	34%	34%
Gender – current self-described gender					
Male	65%	61%	91%	66%	66%
Female	35%	39%	9%	33%	34%
Transgender woman	<1%	-	-	-	<1%
Transgender man	-	-	-	<1%	<1%
Other gender category	<1%	-	-	-	<1%

TABLE 17. AI: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 229[25]	PGTI N = 17	Total N = 246	CA Population[26] N = 39,536,653
White, Non-Hispanic only[27]	52%	24%	50%	27%
Black or African American only	3%	0%	2%	7%
Hispanic or Latino only	18%	6%	17%	39%
Asian/Pacific Islander only	16%	35%	17%	16%
American Indian/Alaskan Native only	0%	0%	0%	2%
Other race/ethnicity only	4%	23%	6%	-
Multiracial or Multi-ethnic[28]	7%	12%	7%	-
Race/Ethnicity (for those reporting single AND multiple categories)				
White, Non-Hispanic only or with another race/ethnicity[29]	54%	26%	52%	
Black or African American only or with another race/ethnicity	4%	5%	4%	
Hispanic or Latino only or with another race/ethnicity	20%	5%	19%	
Asian/Pacific Islander only or with another race/ethnicity	16%	42%	18%	
American Indian/Alaskan Native only or with another race/ethnicity	0%	0%	0%	
Other race/ethnicity only or with another race/ethnicity	6%	21%	7%	

[25] Two AI Outpatient clients did not report race/ethnicity.

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

[27] "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.

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

[29] "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 18. AI: GENDER DETAILS BY TREAMENT MODALITY

Gender Categories	Outpatient N = 231	PGTI N = 17	Total N = 248
Gender – assigned at birth			
Male	25%	24%	25%
Female	75%	76%	75%
Unknown	-	-	-
Gender – current self-described gender			
Male	25%	24%	25%
Female	74%	76%	75%
Transgender woman	-	-	-
Transgender man	<1%	-	<1%
Choose not to disclose	<1%		<1%

LIST OF TABLES

LIST OF FIGURES