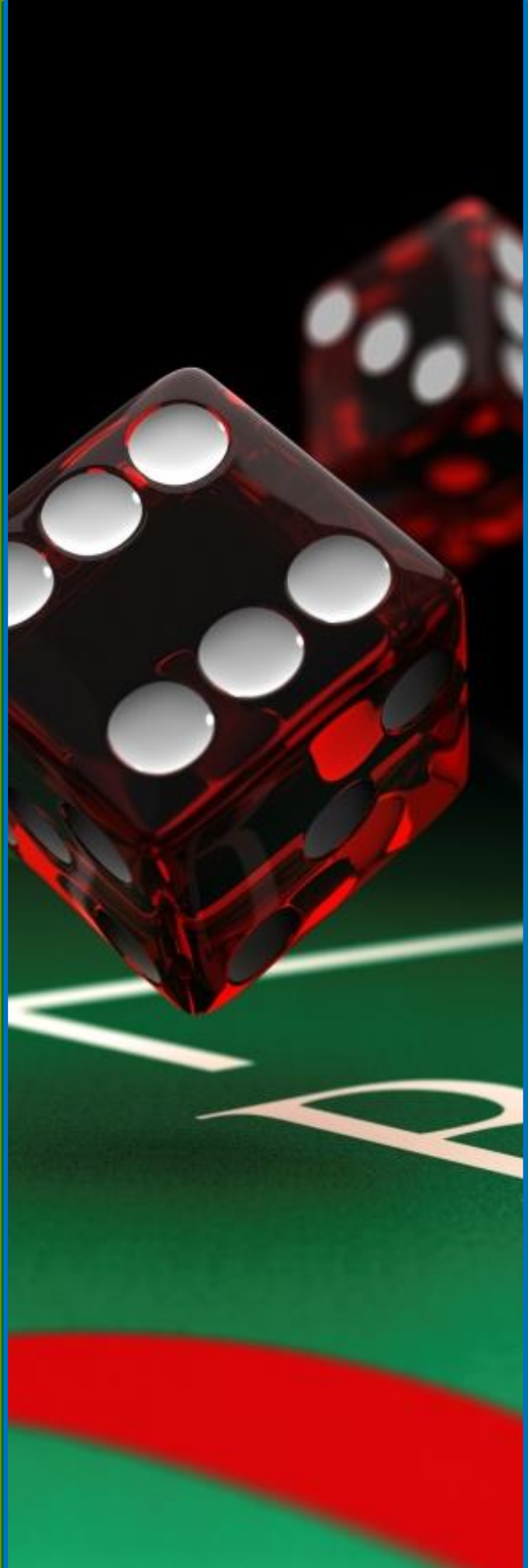


ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2016-17

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 2016-2017

Contents

EXECUTIVE SUMMARY

Overview

California Gambling Education and Treatment Services (CalGETS) is a statewide program for clients with problem gambling and affected individuals (family members and friends affected by someone with problem gambling). Over 1,600 individuals received treatment through CalGETS in Fiscal Year 2016-17. 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 12,500 individuals have received treatment through the program to address the harmful impact of problem gambling. CalGETS provides treatment to a broad spectrum of gamblers and affected individuals. 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 as well as affected individuals, including:

- **Outpatient** treatment is offered by a network of OPG-authorized, licensed providers. Gamblers and affected individuals 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 239 licensed mental health providers (with an average of 5½ years of experience treating gambling), as well as oversees six treatment programs, all engaged in delivering evidenced-based treatment to gamblers and affected individuals.
- Treatment services are available in 30 languages/dialects.

CalGETS Treatment Outcomes (FY 2016-17)

Gamblers:

- 1,210 gamblers received treatment across the treatment network. Three-quarters (73%) received outpatient services, 18% were served in PGTI (16% in English/Spanish and 2% in Asian languages), 4% were served in IOP, and 5% were served in RTP. Of gamblers enrolled in outpatient services, 3% were served in group treatment.
- The intensity of gambling urges reported by CalGETS clients from intake to end of treatment decreased by an average of 18 to 25 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 by an average of 12 to 41 points (on a 100-point scale) between intake and end of treatment.
- Life satisfaction as measured by a self-reported 100-point scale increased from intake to end of treatment by an average of 9 to 18 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, diabetes, and obesity.
Smoking	Among CalGETS outpatient clients, 27% currently smoke. This percentage is down from last year, but is more than twice the state average. In the residential treatment setting, the prevalence rate of smoking is 55%.
Alcohol Use	30% of CalGETS clients report a binge drinking episode (more than five drinks in a single occasion) in the past year, similar to 31% of adult Californians reporting the same (California HealthCare Foundation).
Marijuana	According to the National Survey on Drug Use and Health (NSDUH), 15% of the population of California self-reported using marijuana within the last 12 months. Across the treatment network, 15-35% of CalGETS clients use marijuana.
State of Health	According to the Centers for Disease Control and Prevention (CDC), 18% of adults in California reported their health as "fair or poor" in 2015. In comparison, about 30% of gamblers across the treatment network reported their health as "fair or poor."
Health Insurance	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 Healthcare	At least 70% of CalGETS clients (except RTP clients at 58%) reported they currently have a physician they can access for primary care needs.
Depression	24% of CalGETS clients scored in the moderately severe to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 14% of adult Californians reporting any depression diagnosis (CDC).

Affected Individuals:

- 405 affected individuals received treatment across the treatment network.
- Affected individuals are spouses/significant others (45%), children (21%) or parents (15%) of gamblers; and 75% of affected individuals are female.
- During treatment, the degree to which affected individuals 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 both improved (decreased), depression decreased, and life satisfaction increased.

Affected individuals were similar to gamblers in terms of medical problems, state of health, insurance status and access to health care. However, affected individuals 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 552 post-treatment telephone interviews, double the number completed in FY 2015-16. Results show that both gamblers' and affected individuals' 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. During FY 2016-17, UGSP initiated 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. It is a voluntary program which bans the gambler from gambling establishments. The study is ongoing.

1. CalGETS PROGRAM STRUCTURE

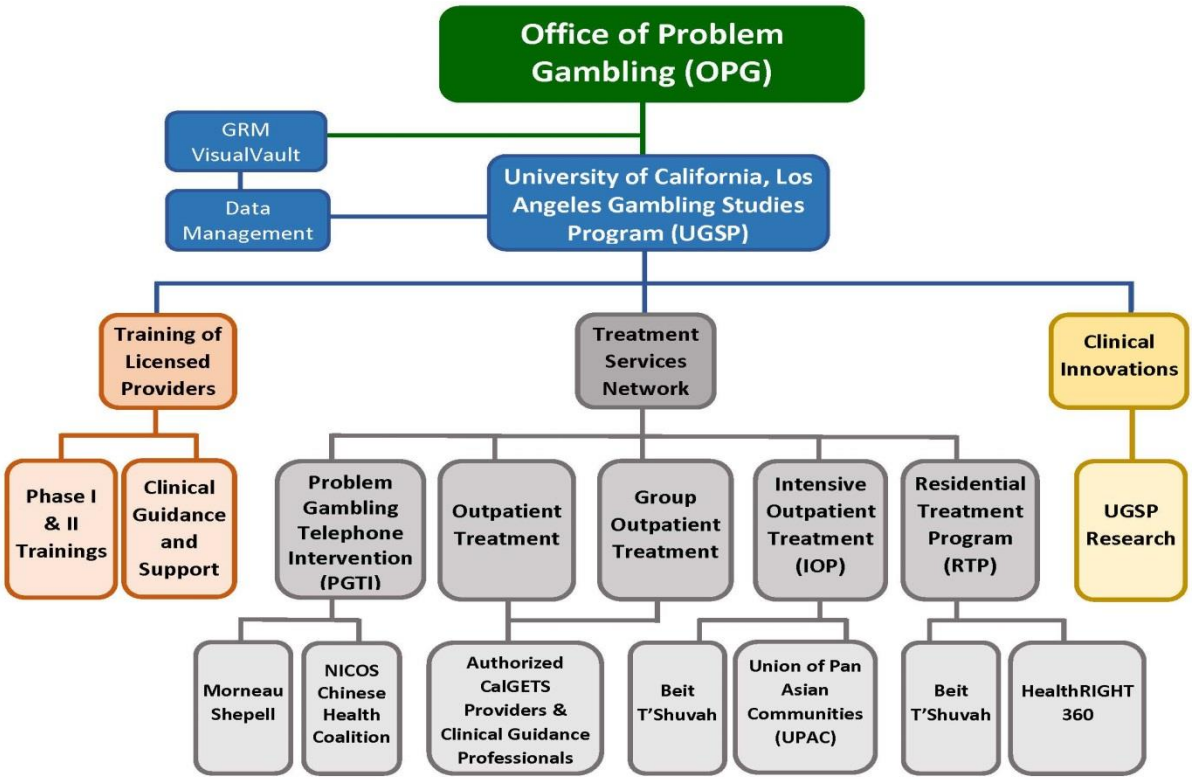
Introduction

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: Problem Gambling Telephone Intervention for gamblers and affected individuals, Outpatient (Individual and Group) treatment for gamblers and affected individuals, Intensive Outpatient treatment for gamblers only, and Residential treatment for gamblers only. Participant follow-up interviews are conducted 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 30 languages/dialects. Within the Treatment Services Network, the following treatment services are offered:

Outpatient (Individual and Group). Gamblers and affected individuals 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. At the end of FY 2016-17, there were 239 active, authorized CalGETS providers, offering services in over 30 languages and dialects. Gamblers and affected individuals 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 affected individuals, and must include 3-10 participants. Implementation of group outpatient treatment began with provider training in FY 2014-15.

Intensive Outpatient (IOP). Gamblers may receive up to three 30-day treatment blocks (up to 90 days) of more intensive outpatient 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 affected individuals may receive up to three treatment blocks of eight sessions in the problem gambling telephone intervention (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. Services are provided by Morneau Shepell in English and Spanish or NICOS Chinese Health Coalition (NICOS) in Mandarin, Cantonese, Vietnamese, Korean, Tagalog, and Hindi. 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 affected individuals throughout California.

2. FY 2016-17 TREATMENT REPORT DATA SOURCES AND METHODS

Data sources

Data are obtained from the CalGETS client forms, Version 2.0. 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/VisualVault servers and are available to designated analysts at GRM/VisualVault, OPG, and UGSP to run reporting functions on the data in the system. During FY 2016-17, all providers, except Morneau Shepell, entered their data into the DMS. Morneau Shepell entered client data into Filemaker Pro and then provided data files to UGSP for analysis.

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, 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), moderate (10), moderately-severe (15), and severe (20). 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).

Modified NODS: A modified version of the National Opinion Research Center's DSM-IV Screen for Gambling Problems (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.

[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 with Normal Activities: The question "How much has gambling interfered with your normal activities?" assesses gambling-related interference in daily life. Respondents rate life interference on a scale ranging from 0 (No Interference) to 100 (Extreme Interference). Higher scores indicate greater life interference due to gambling.

Affected Individuals

PHQ-9: See Above.

Life Satisfaction: See Above.

Responsibility for Gambler's Recovery: Affected individuals' 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 2016-17 some issues may have impacted data collection and/or reporting. These issues include:

- Transition from FileMaker-based data capture to the DMS among one of the CalGETS PGTI providers was not accomplished in FY 2016-17.
- UGSP's assessment of the DMS reporting and data exporting processes revealed technical issues (i.e., unclear delineation of missing or skip-pattern missing data).

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 from treatment entry.

Outpatient treatment is offered in blocks of eight sessions, and Intensive Outpatient (IOP) and Residential Treatment (RTP) are offered in 30-day treatment blocks. In order to ensure uniform data reporting from one modality to another, data from Intake and End of Treatment (EOT) are reported on rather than data from Intake and end of a treatment block. Clients complete EOT forms when they exit the program, which can occur before the end of the scheduled treatment block. Thus, it is important to note that EOT data may reflect different doses of treatment since discharge from treatment can occur at any time. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Version 24.

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 problem gambling helplines (1-800-GAMBLER and, specifically serving Asian languages, 1-888-968-7888[2]), UGSP or OPG websites, healthcare 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 (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).

The Phase I trainings for FY 2016-17 were held August 2016 and April 2017. Phase II training events were conducted by CalGETS in October 2016 and May 2017.

Shortly after the close of FY 2016-17, UGSP conducted a survey with all active CalGETS providers to obtain information on provider characteristics and experiences with CalGETS (2017 Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2017, unless given an exemption. The 2017 Provider Survey indicates that by the end of FY 2016-17, the Treatment Services Network had 256 licensed providers who were authorized to provide services to gamblers and affected individuals some time during the fiscal year. Of these, 239 providers returned surveys (response rate of 92.3%), and 17 were unreturned as those providers had been suspended/terminated during the response period. Two providers failed to complete the entire survey; as a result, those responses were omitted. **Table 1** details the number of clinicians and providers who completed Phase I and II training during FY 2016-17. Additionally, CalGETS clinical supervisors delivered 63 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

TABLE 1. CalGETS TRAINING

	FY 2016 17
Training	
Licensed mental health clinicians who completed Phase I	58
Licensed mental health clinicians who completed Phase I and became authorized providers	38
Authorized providers who completed Phase II	17

Providers' demographic information is provided below (**Table 2**). Providers were primarily female, and reported their race/ethnicity as: 66% White, 13% Asian, 9% Hispanic/Latino, and 7% Black/African American.

[2] Now discontinued, as of July 1, 2017 Asian language services are provided through 1-800-GAMBLER.

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

	FY 2016 17
Gender	n=239
Female	74%
Male	26%
Race/Ethnicity	n=239
White	66%
Asian	13%
Hispanic/Latino	9%
Black/African American	7%
Multiracial	2%
Native Hawaiian/Pacific Islander	<1%
Choose not to designate or Other	3%

The data on CalGETS providers indicates that they are experienced mental health providers. On average, providers who completed the survey had been licensed for 13.6 years and had treated individuals with gambling disorder for five-and-a-half years. In FY 2016-17, 72% of providers were Licensed Marriage and Family Therapists (LMFT), 14% were Licensed Clinical Social Workers (LCSW), 8% were Psychologists (PhD), 4% were Clinical Psychologists (PsyD), and 3% had other clinical degrees (MSW, EdD, RN). CalGETS providers reach clients for whom English is not their primary language - 22% reported providing treatment services in languages other than English. Of those, 49% provided services in Spanish, 47% providing services in an Asian language, and 12% provided services in other languages. Over half (56%) 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 (85%)
- Phase II Training (61%)
- Clinical Guidance and Support (51%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 95% 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 2016-17.

Treatment Service Provision

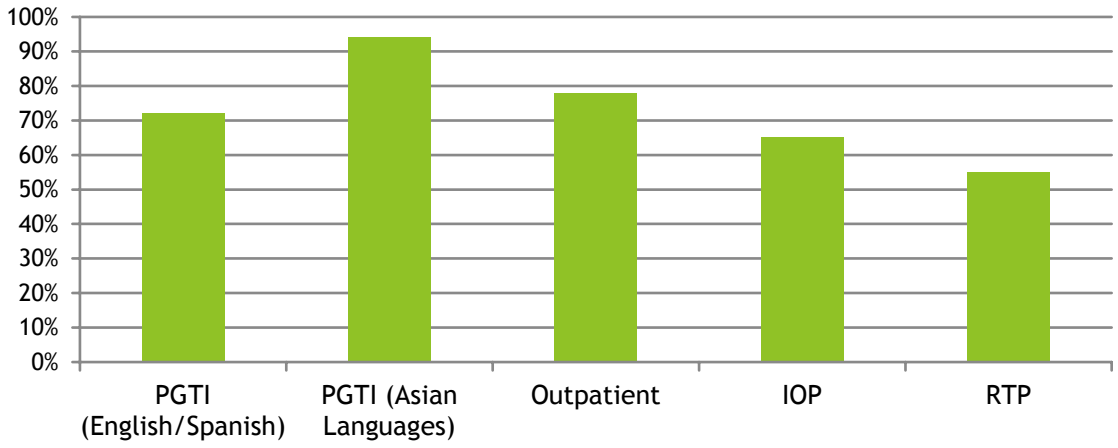
In FY 2016-17, a total of 1,210 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (73%) enrolled in Outpatient, followed by Problem Gambling Telephone Intervention (PGTI) (18%), Residential Treatment Programs (5%), Intensive Outpatient (4%), and 3% in Outpatient Group.

TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED

	N	Percentage
Outpatient	879	73%
Outpatient Group	*38*	*3%*
Intensive Outpatient Program (IOP)	54	4%
Residential Treatment Programs (RTP)	66	5%
Problem Gambling Telephone Intervention (PGTI) (English/Spanish languages)	192	16%
PGTI (Asian languages)	19	2%
Total[3]	1,210	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



[3] The total for gamblers does not include clients in Outpatient Group treatment because they are also enrolled in Outpatient and are counted there.

As shown in Table 4, race/ethnicity varies by modality. The total generally reflects the population of California, however, Hispanic/Latinos are under-represented in the treatment population.

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

Race/Ethnicity	PGTI English/ Spanish N 192	Outpatient N 875	IOP N 53	RTP N 65	Total N 1185	CA Population[4] N 39,250,017
White, Non-Hispanic	43%	46%	59%	52%	47%	38%
Black or African American	7%	10%	8%	8%	9%	7%
American Indian/ Alaska Native	0%	1%	0%	5%	1%	2%
Asian/Pacific Islander	18%	20%	23%	12%	20%	15%
Hispanic or Latino	27%	17%	8%	20%	19%	39%
Other	5%	7%	4%	3%	6%	-

Note: Only PGTI English/Spanish is reported in this table because all clients (N=19) in the PGTI Asian Language program reported Asian ethnicity.

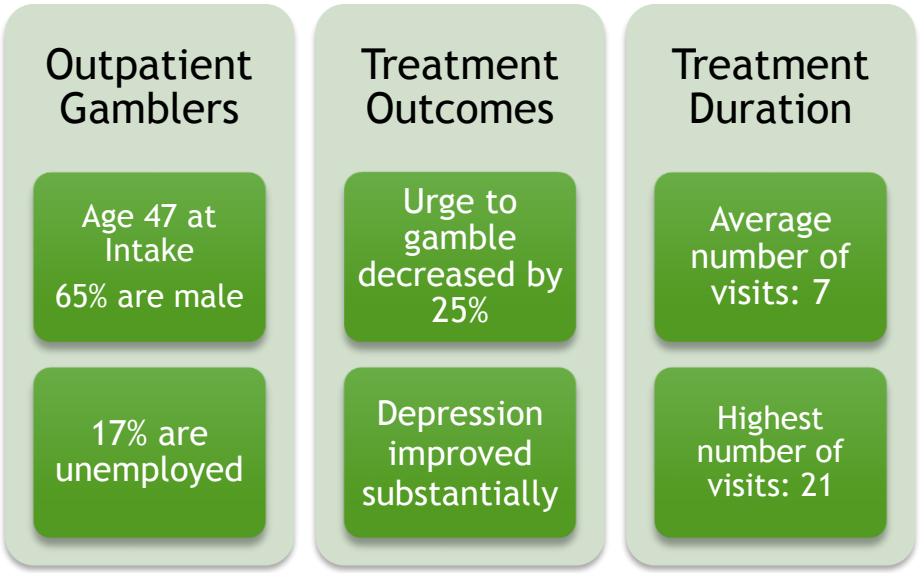
[4] Source: Quick Facts: California, United States Census Bureau, accessed online 12/16/2017 at https://www.census.gov/quickfacts/CA.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown in Table 3,[5] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 879 clients[6] who enrolled in outpatient. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2016-17, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (32%), family/friends (13%), health care professionals (10%), Gamblers Anonymous/Gam-Anon (10%), former clients (8%), California Council on Problem Gambling (4%), and OPG website (3%). In addition, 16% cited other sources including internet searches that yielded the CalGETS website, the treatment provider's website, the Psychology Today referral website, or the UCLA Gambling Studies website.

The number of sessions completed by outpatient gambler clients (n=879) varied:

- 14% of clients had only an intake session
- 60% received 1-8 treatment sessions
- 17% received 9-16 treatment sessions
- 9% received 17-21 treatment sessions

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

[6] Table Ns represent clients for whom data are available for that item. When Ns are less than 879, clients have declined to state for that item.

Some individuals may be continuing treatment into FY 2017-18, but these additional sessions are not counted in the percentages above.

Demographics

Outpatient clients had an average age of 47 years and two-thirds (65%) were male. Less than half of the clients identified their race as White (46%), followed by Asian/Pacific Islander (20%), Hispanic/Latino (17%), African American (10%), another race/ethnicity (7%), and American Indian/Alaska Native (1%). Clients are, for the most part, well-educated – more than three-quarters reported completing some college or above. The reported household income for outpatient clients varied widely from less than $10,000 per year to over $200,000 (**Table 5**).

TABLE 5. OUTPATIENT GAMBLER: DEMOGRAPHICS

FY 2016 17	(N 879)
Age	n=879
Mean Age	47 years old
Gender	n=879
Male	65%
Female	35%
Race/Ethnicity	n=875
White	46%
Asian/Pacific Islander	20%
Hispanic/Latino	17%
African American	10%
American Indian/Alaskan Native	1%
Another race/ethnicity	7%
Education	n=877
Less than High School	6%
High School	17%
Some College	38%
Bachelor's Degree	29%
Graduate/Professional Degree	10%
Household Income	n=842
Less than $15,000	14%
$15,000-$24,999	7%
$25,000-$34,999	8%
$35,000-$49,999	15%
$50,000-$74,999	17%
$75,000-$99,999	14%
$100,000-$149,999	14%
$150,000-$199,999	6%
$200,000 or more	6%

Gambling Severity

An overwhelming proportion of gamblers (97%) who sought outpatient treatment through CalGETS could be classified as having mild to severe gambling disorder (**Table 6**), while 3% 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	25	3%
Mild gambling disorder	4 to 5	92	11%
Moderate gambling disorder	6 to 7	211	24%
Severe gambling disorder	8 to 9	541	62%

Note: Ten outpatient gamblers had incomplete NODS data.

Gambling Behaviors

At Intake, outpatient clients (n=879) 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 (83%).

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

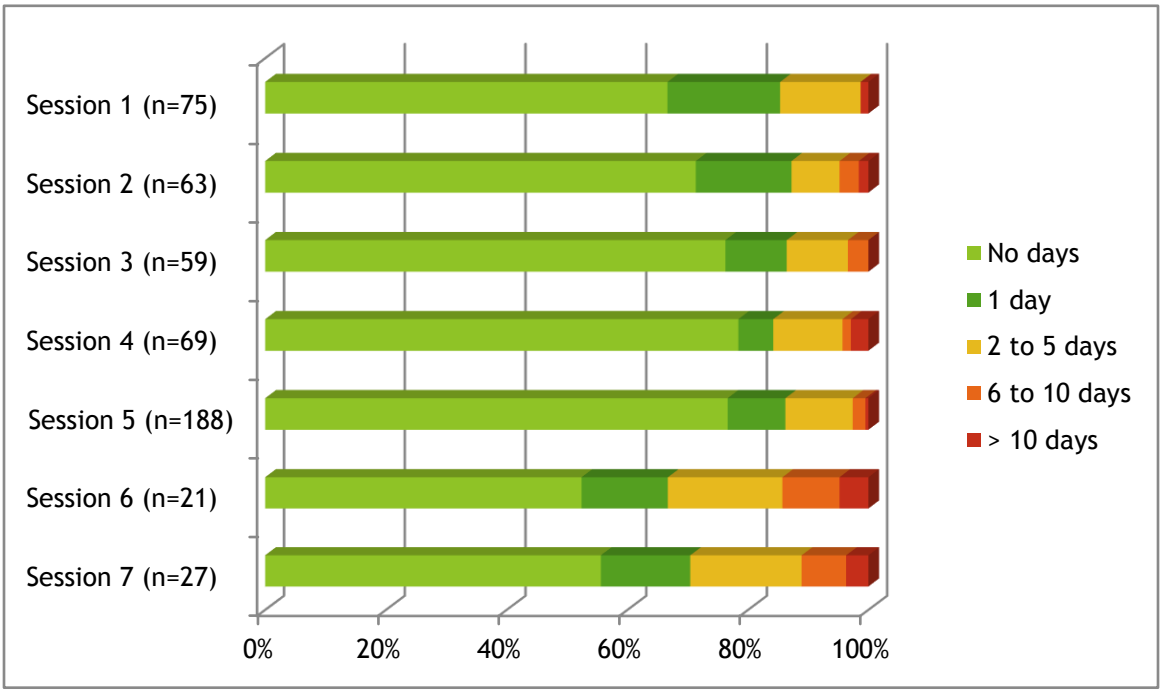
- At **tribal casinos,** clients most frequently stated that they played slot machines (47%), blackjack (28%), and poker (20%).
- At **other casinos,** clients most frequently reported playing slot machines (22%), blackjack (18%), and poker (8%).
- At **cardrooms,** clients most often reported playing poker (20%), and blackjack (18%).
- On the **Internet**, clients most often indicated playing poker (7%), slots (6%), and blackjack (5%).
- Finally, clients reported gambling on the Lottery (19%), sporting events (16%), and horse racing (5%).

Intake to End-of-Treatment Outcomes (EOT)

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

When examining recent gambling (i.e., since last treatment session), after Intake, the number of gambling days decreases during the first four outpatient sessions (**Figure 4**). Of clients who exited after Session 1, 33% report one or more days gambling; among clients who exited after Session 4, 22% report one or more days gambling. For those exiting after Session 5, there is a slight uptick to 23% of those reporting one or more days of gambling. However, for Sessions 6-7, the percentage of clients reporting one or more gambling days increases. This may be a statistical variation due to the smaller numbers of clients exiting treatment after those sessions or it may be due to greater initial severity either in gambling or in co-occurring disorders among those clients who stay in treatment longer.

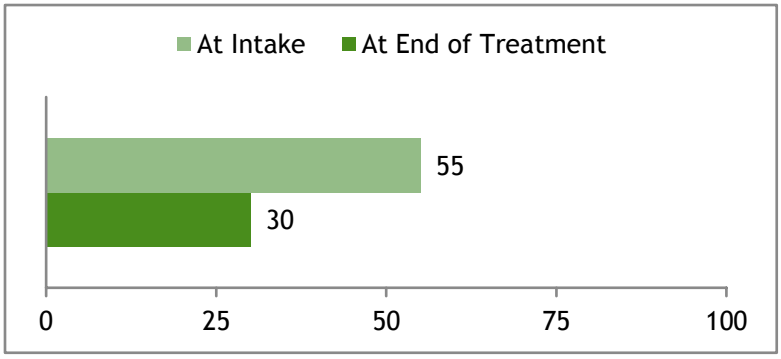
FIGURE 4. OUTPATIENT GAMBLER: PERCENTAGE OF CLIENTS BY NUMBER OF DAYS GAMBLING



Note: Each session's data only includes clients who left treatment after that session.

Outpatient clients reported less interference of gambling with their normal activities at EOT 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 25 points from Intake to EOT (**Figure 5**).

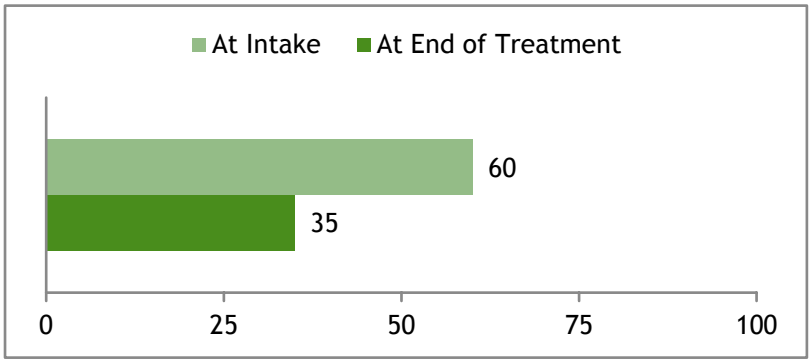
FIGURE 5. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=869, EOT N=336.

Among outpatient clients, the average intensity of the urge to gamble decreased from Intake to EOT by 25 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble after receiving outpatient services (**Figure 6**).

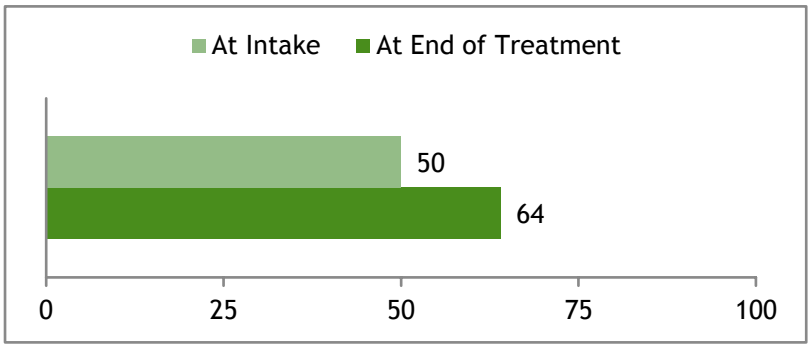
FIGURE 6. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=869, EOT N=336.

Over the course of treatment, outpatient clients reported an improvement of 14 points on average in overall life satisfaction (**Figure 7**). As above, life satisfaction was measured on a 100-point scale.

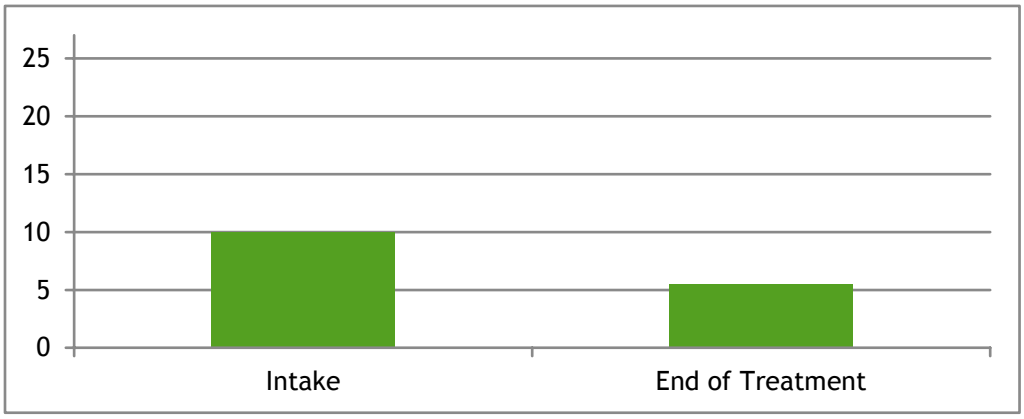
FIGURE 7. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT END OF TREATMENT



Note: Intake N=869, EOT N=336.

During FY 2016-17, treatment participants' levels of depression were measured using the PHQ-9 both at Intake and EOT. Outpatient clients showed, on average, a considerable improvement in depression from moderate depression at Intake to mild depression at EOT (**Figure 8**).

FIGURE 8. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=869, EOT N=336.

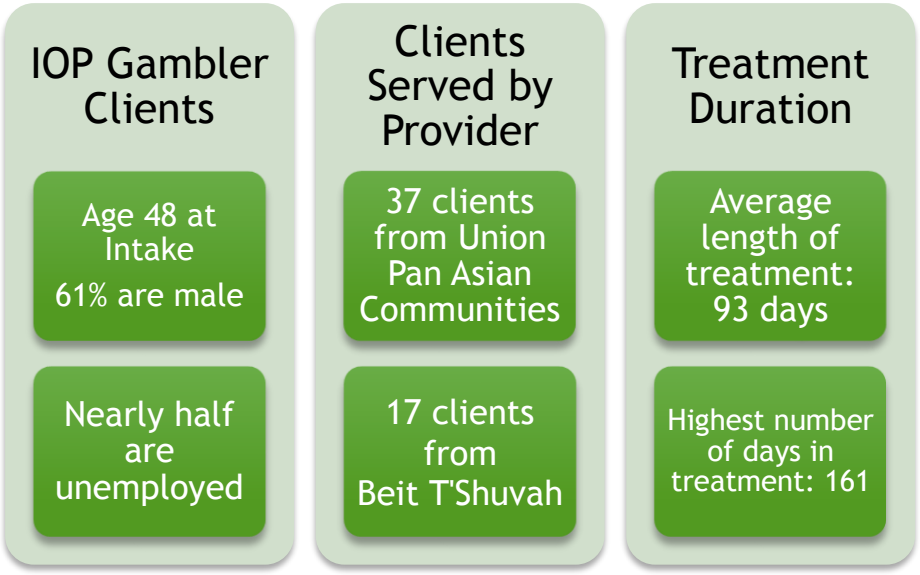
Group Outpatient

A total of 44 clients participated in group treatment in Fiscal Year 2016-17. Of these participants, 6 were affected individuals and 38 were gamblers. The average age was 49 years old and about 55% were male. The majority of group participants (89%) were referred to group by a CalGETS provider. Other referral sources included family/friends (4.5%), the 1-800-GAMBLER helpline (2.3%), and another CalGETS client (2.3%). The primary types of gambling reported at group screening were slot machines (23%), sports betting (11%), black jack (9%), video poker (7%), poker (5%), lottery (5%), roulette (2%), and bingo (2%). Tribal casinos were the most frequently reported gambling venue (21%), followed by casinos (18%), and card rooms (14%). Just under 21% of group participants reported moderately severe to severe depression at screening. Follow up data were available for 14 group participants; 9 one-year and 5 ninety-day follow-ups. All clients at both follow-up points reported no depression and had not gambled.

Intensive Outpatient Program (IOP)

Data were available from 54 clients enrolled at Intake in IOP during FY 2016-17 (**Figure 9**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=37) or Beit T'Shuvah (N=17). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

FIGURE 9. INTENSIVE OUTPATIENT PROGRAM SNAPSHOT



Demographics

A total of 54 clients entered IOP during FY 2016-17. IOP gambler clients averaged a year older than Outpatient clients. Over half (59%) of IOP clients identified as White, followed by 23% Asian/Pacific Islander, 8% African American, 8% Hispanic/Latino, and 4% as another race/ethnicity. Like the Outpatient clients, IOP clients have fairly high levels of education with 85% reporting some college education or higher. Although clients' household income varied from an income of less than $15,000 per year to $150,000, 49% of IOP clients reported that their income was less than $35,000.

Gambling Severity

With only one exception[7], the gamblers enrolled in IOP could be classified as having a gambling disorder (98%). Of these, 2% were classified with mild gambling disorder, 15% with moderate gambling disorder, and 82% with severe gambling disorder.

Gambling Behaviors

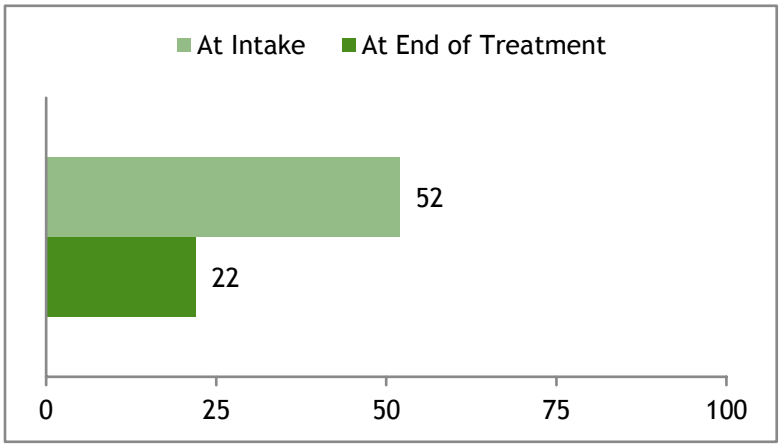
IOP clients were asked at Intake to indicate both their typical gambling locations and the types of gambling activities that they engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (91%).

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, and blackjack were the most commonly selected gambling activities. Clients who reported gambling activities at tribal casinos most frequently stated that they played slot machines (57%), blackjack (37%), and poker (26%). Clients gambling at other casinos most frequently reported playing slot machines (17%), and blackjack (22%). Clients who indicated gambling in cardrooms most often reported playing blackjack (19%) and poker (15%). Very few IOP clients reported gambling on the Internet. Among clients who reported gambling at other venues, the Lottery (21%) was the activity most frequently reported.

Intake to End of Treatment Outcomes

End of treatment data are available on 26 of the 54 clients. IOP clients' reports of interference by gambling with their normal activities showed an average decrease of 30 points from Intake to EOT (**Figure 10**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

FIGURE 10. IOP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT

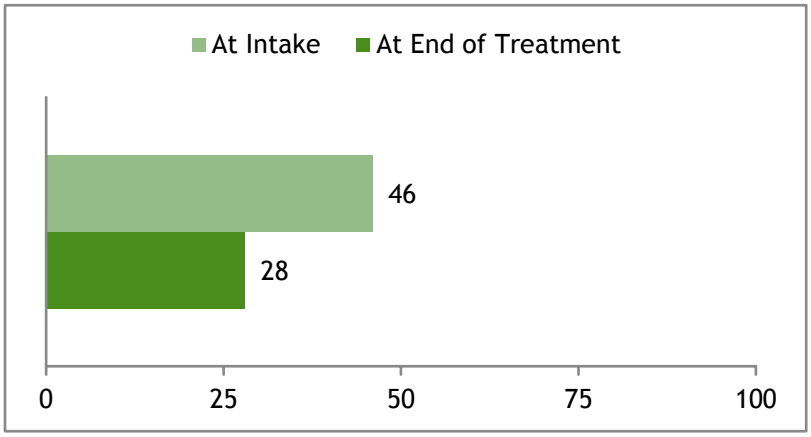


Note: Intake N=54, EOT N=26.

[7] Note: This gambler reported at least one problem gambling behavior.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to EOT by an average of 18 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble (**Figure 11**).

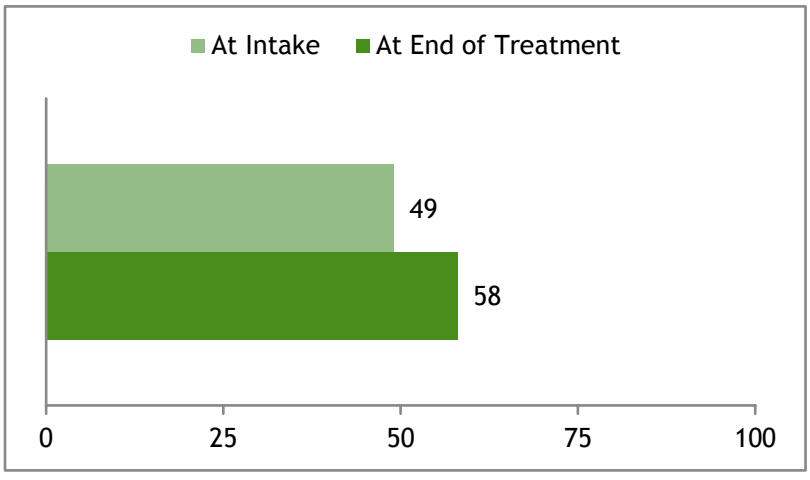
FIGURE 11. IOP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=54, EOT N=26.

IOP clients entered treatment reporting life satisfaction scores similar to Outpatient clients. Over the course of treatment, IOP clients reported an improvement of 9 points on average in overall life satisfaction (**Figure 12**). As above, life satisfaction was measured on a 100-point scale.

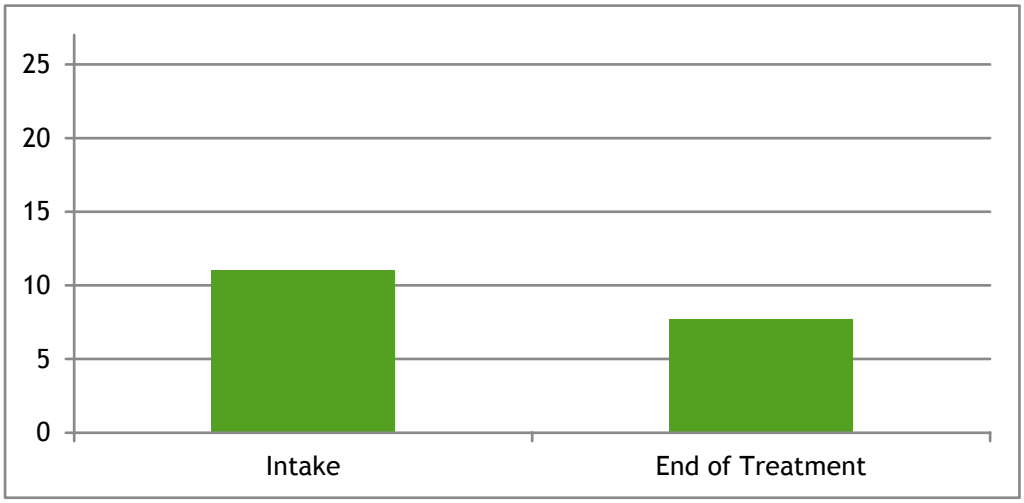
FIGURE 12. IOP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT END OF TREATMENT



Note: Intake N=54, EOT N=26.

During FY 2016-17, IOP participants' levels of depression were measured using the PHQ-9 both at Intake and EOT. They showed, on average, moderate depression at Intake and mild depression at EOT (**Figure 13**).

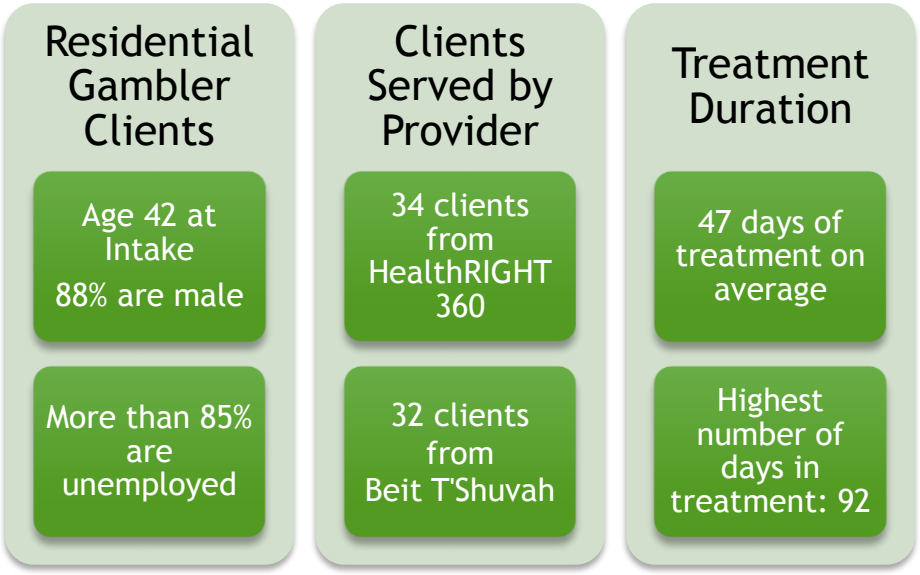
FIGURE 13. IOP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT



Residential Treatment Programs (RTP)

Data were available from 66 clients[8] enrolled at Intake in RTP during FY 2016-17 (**Figure 14**). Clients received treatment from either HealthRIGHT 360 (N=34) or Beit T'Shuvah (N=32). The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 14. RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT



[8] One client provided incomplete Intake data.

Demographics

Half (52%) of RTP clients identified as White, followed by 20% Hispanic/Latino, 12% Asian/Pacific Islander, 8% African American, 5% American Indian/Alaska Native, and 3% as another race/ethnicity. RTP clients have less education than Outpatient and IOP clients, but still have fairly high levels of education with 61% reporting some college education or higher. Similar to IOP clients, RTP clients also reported lower household income, with 77% reporting that their income was less than $35,000 and 47% reporting income less than $15,000 per year.

Gambling Severity

Of those enrolled in RTP treatment, 99% met DSM-5 criteria for gambling disorder. Of those, 6% were classified with mild gambling disorder, 12% with moderate gambling disorder, and 82% with severe gambling disorder.

Gambling Behaviors

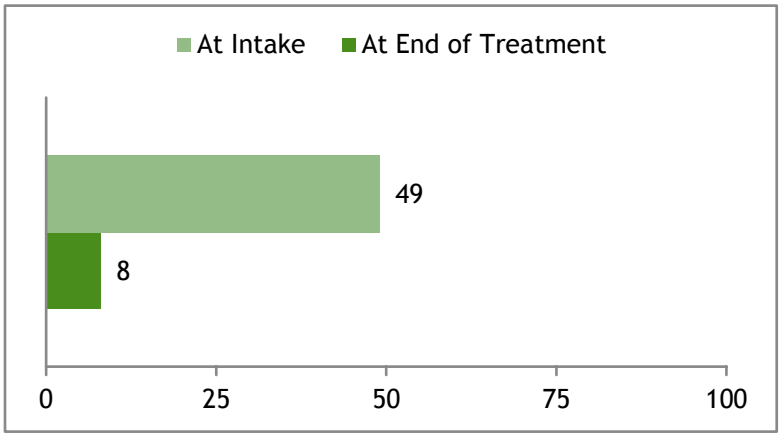
RTP clients (n=66) were asked at Intake to indicate both their typical gambling locations and the types of gambling activities that they engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (82%).

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, and the lottery were the most commonly selected gambling activities. Clients who reported gambling activities at tribal casinos most frequently stated that they played slot machines (52%), blackjack (40%), and poker (40%). Clients gambling at other casinos most frequently reported playing slot machines (28%), blackjack (29%), and poker (23%). Clients who indicated gambling in cardrooms most often reported playing blackjack (39%) and poker (39%). Of those who reported gambling on the Internet, they most often reported playing poker (14%), slots (19%), and blackjack (14%). Among clients who reported gambling at other venues, they most frequently reported the Lottery (40%), sporting events (35%), dice (15%), and bingo (11%).

Intake to End-of-Treatment Outcomes

End of treatment data are available on 47 of the 65 RTP clients for whom complete intake data are available. By the end of treatment, the average rating of interference by gambling with normal activities decreased by 41 points among RTP clients (**Figure 15**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

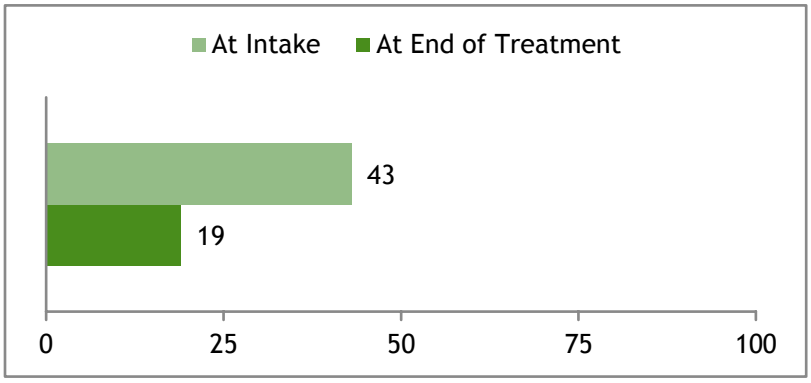
FIGURE 15. RTP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=65, EOT N=47.

Among RTP clients, the intensity of the urge to gamble, on average, decreased from Intake to EOT by 24 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble (**Figure 16**).

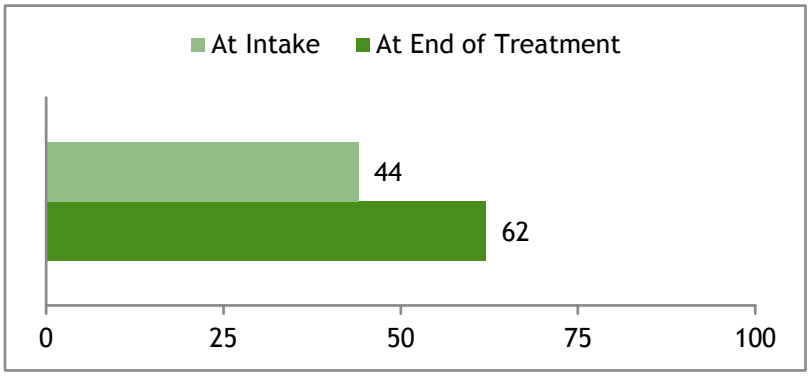
FIGURE 16. RTP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=65, EOT N=47.

RTP clients entered treatment reporting lower life satisfaction scores than Outpatient clients. Over the course of treatment, RTP clients reported an improvement of 18 points on average in overall life satisfaction (**Figure 17**). As above, life satisfaction was measured on a 100-point scale.

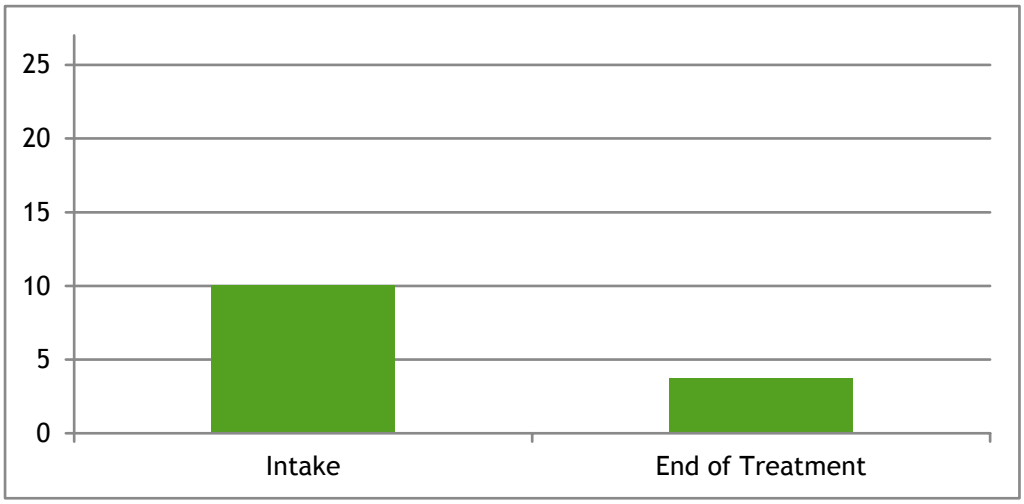
FIGURE 17. RTP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT END OF TREATMENT



Note: Intake N=65, EOT N=47.

During FY 2016-17, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and EOT. They showed, on average, a considerable improvement in depression from moderate depression at Intake to minimal depression at EOT (**Figure 18**).

FIGURE 18. RTP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT

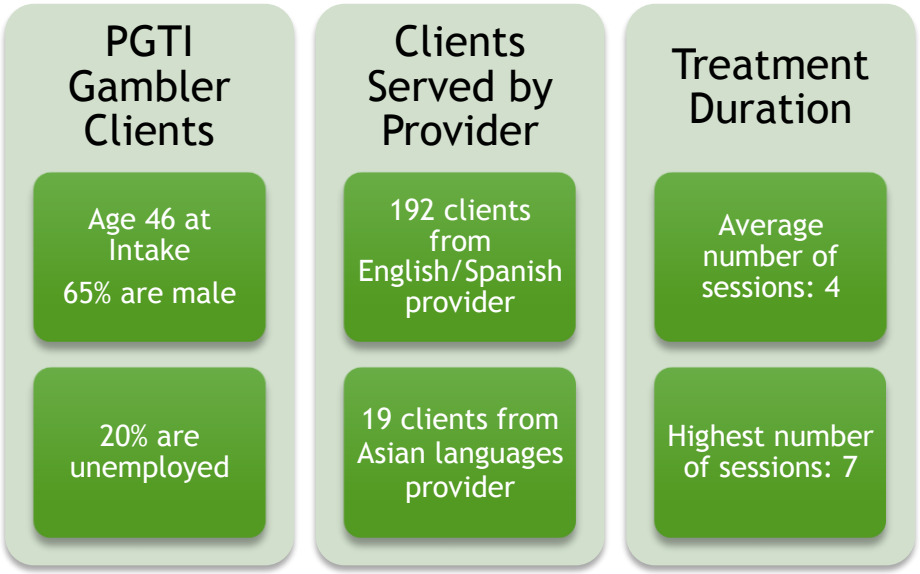


Note: Intake N=65, EOT N=47.

Problem Gambling Telephone Intervention (PGTI)

As described above, PGTI services are provided over the telephone to gamblers and affected individuals 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 and Hindi languages. Morneau Shepell (formerly called Bensinger, DuPont & Associates) provides PGTI services in English and Spanish, and NICOS Chinese Health Coalition (NICOS) provides PGTI services in Mandarin, Cantonese, Vietnamese, Korean, Tagalog and Hindi.

FIGURE 19. PGTI PROGRAMS SNAPSHOT



Note: Averages are for Morneau Shepell English and Spanish language services

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. Results are reported by language group when there are differences in the ways that data were collected or compiled across the two groups.

Within PGTI, data were available for 211 gambler clients enrolled at Intake during FY 2016-17. A total of 192 clients received services in either English or Spanish languages from Morneau Shepell, and 19 clients received services in various Asian languages from NICOS. Of the 211 total clients assessed at Intake, 159 received further treatment services (140 from Morneau Shepell, 19 from NICOS).

Clients participating in English or Spanish language sessions (n=192) most often reported being referred by tribal casinos (35%); media (e.g., television, radio, newspaper, billboards) (11%); the Lottery (9%); or by friends (6%). Some individuals (6%) indicated that they were repeat callers and were not referred by any source. Clients participating in Asian language treatment sessions (n=19) were most frequently referred by media (including TV, radio, newspaper, bill board, 47%), family or friends (16%); helplines (11%); or other sources (26%).

Clients from the English and Spanish language services (n=140) participated in four treatment sessions on average, with a maximum of seven sessions in total. Clients served through the Asian languages service provider, NICOS, participated in three sessions on average, with a maximum of 21 sessions in total.

Demographics

Gamblers who took advantage of telephone-based treatment (PGTI) reflect the diversity of California. They were, on average, 47 years old and males predominated in both groups. Among the PGTI English/Spanish clients, nearly half identified their race as White (43%), followed by Hispanic/Latino (27%), Asian/Pacific Islander (18%), African American (7%), and another race/ethnicity (5%). All of the clients receiving Asian language PGTI services identified themselves as Asian/Pacific Islander. More than 65% of PGTI English/Spanish clients reported completing some college or above, and more than 35% of

Asian language PGTI clients reported the same. The reported household income for both groups varied widely (**Table 7**).

TABLE 7. PGTI GAMBLER: DEMOGRAPHICS

FY 2016 17	English/Spanish Language PGTI (N 192)	Asian Language PGTI (N 19)
Age	(n=113)	(n=19)
Mean Age	46 years old	50 years old
Gender	(n=192)	(n=19)
Male	65%	74%
Female	35%	26%
Race/Ethnicity	(n=192)	(n=19)
White	43%	0%
Asian/Pacific Islander	18%	100%
Hispanic/Latino	27%	0%
African American	7%	0%
American Indian/Alaskan Native	0%	0%
Another race/ethnicity	5%	0%
Education	(n=125)	(n=19)
Less than High School	7%	32%
High School	26%	32%
Some College	33%	5%
Bachelor's Degree	30%	32%
Graduate/Professional Degree	4%	0%
Household Income	(n=191)	(n=16)
Less than $15,000	14%	5%
$15,000-$24,999	11%	11%
$25,000-$34,999	16%	11%
$35,000-$49,999	14%	32%
$50,000-$74,999	18%	26%
$75,000-$99,999	9%	0%
$100,000-$149,999	13%	11%
$150,000-$199,999	3%	0%
$200,000 or more	2%	5%

Gambling Severity

Of those enrolled in PGTI services, more than 93% could be classified as having mild to severe gambling disorder (**Table 8**).

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

	Severity	NODS Score	N	%
English/Spanish Language PGTI (N=191)	Problem gambling behavior	1 to 3	14	7%
	Mild gambling disorder	4 to 5	24	13%
	Moderate gambling disorder	6 to 7	61	32%
	Severe gambling disorder	8 to 9	92	48%
Asian Language PGTI (N=19)	Problem gambling behavior	1 to 3	0	0
	Mild gambling disorder	4 to 5	0	0
	Moderate gambling disorder	6 to 7	6	32%
	Severe gambling disorder	8 to 9	13	68%

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 73% of PGTI English/Spanish clients, and food/convenience stores for Lottery tickets (13%). Among Asian Language PGTI clients, 68% report gambling in casinos and 16% using the internet.

Clients were able to select multiple activities at each of the major gambling venues. Among the PGTI English/Spanish clients who reported gambling activities at tribal casinos, the most frequent activities were slot machines (44%), blackjack (21%), and poker (20%). The other major gambling activity was the Lottery (29%).

Intake to End-of-Treatment Outcomes

Outcome measures during treatment include gambling interference with daily life, intensity of gambling urges, life satisfaction, and whether a client gambled since the last treatment session (after the Intake session). Clients were asked to rate the degree to which gambling interfered with their everyday lives (PGTI English/Spanish clients, **Figure 20**). Those who attended more sessions, on average, saw decreased interference. Likewise, those who attended more sessions saw a decrease, on average, in the urge to gamble (**Figure 21**). Life satisfaction, on average, improved during treatment (**Figure 22**).

FIGURE 20. PGTI GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES

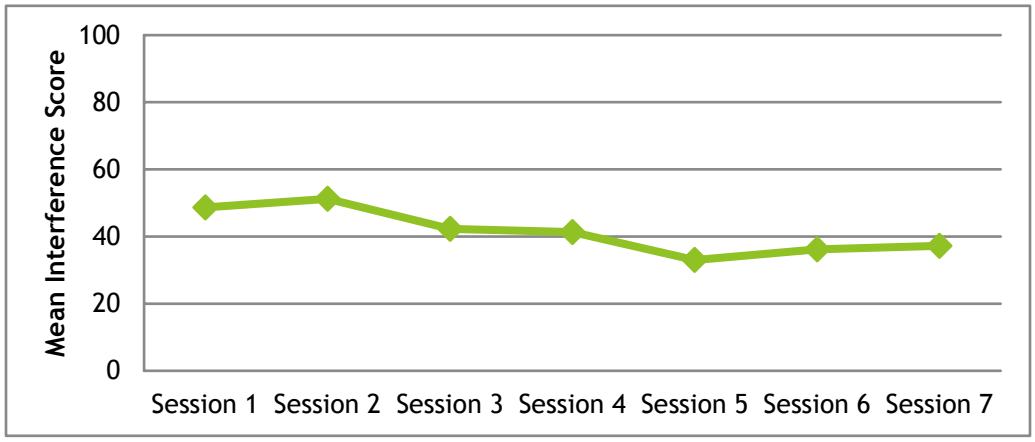


FIGURE 21. PGTI GAMBLER: INTENSITY OF GAMBLING URGE

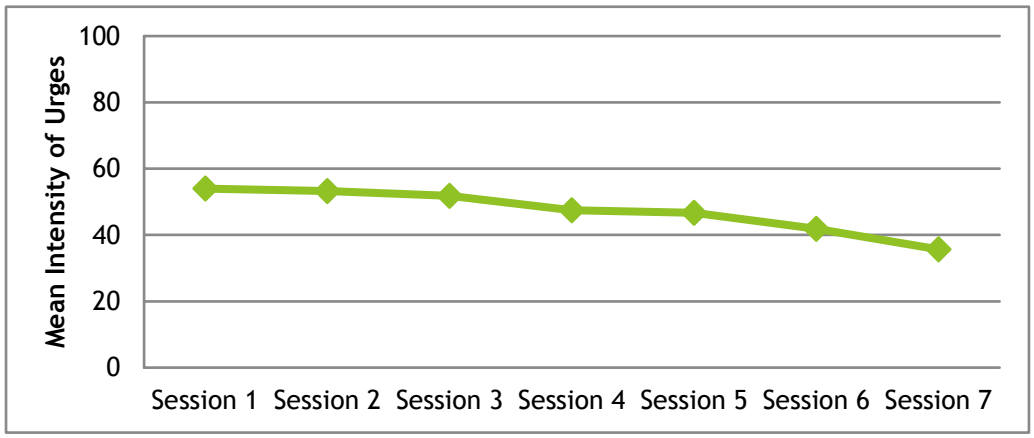
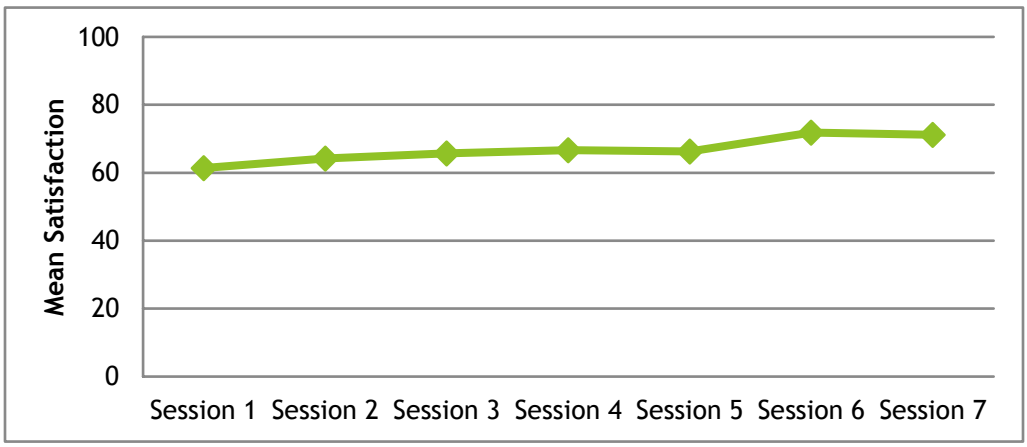
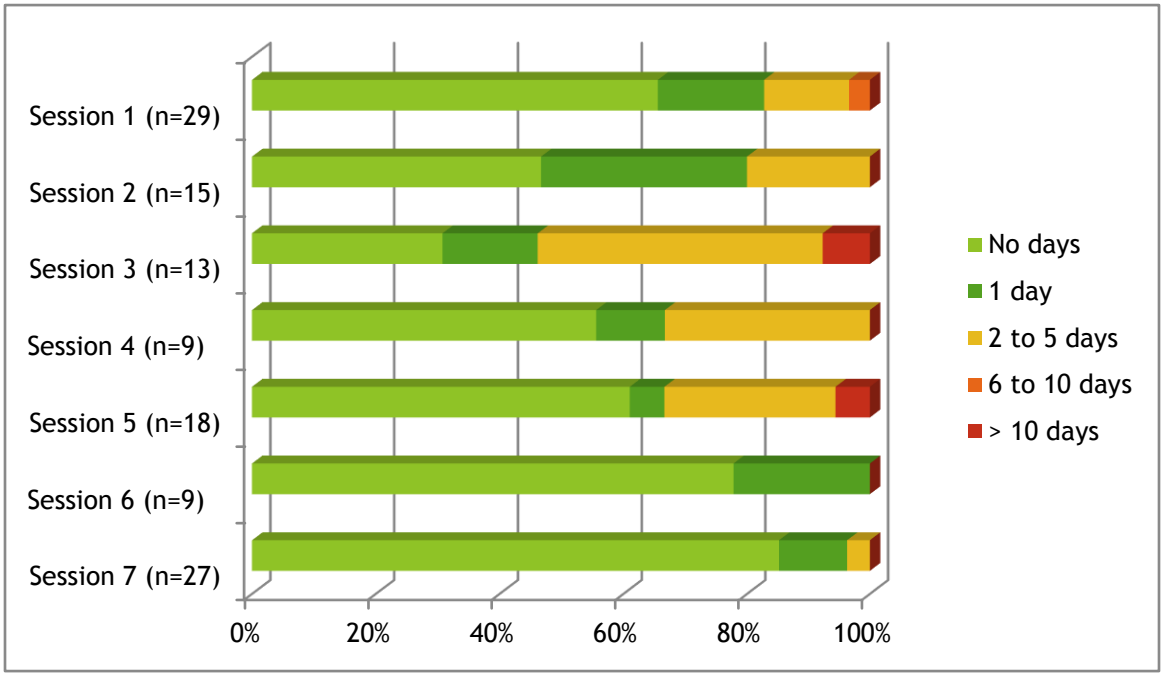


FIGURE 22. PGTI GAMBLER: OVERALL LIFE SATISFACTION SCORES



As shown in **Figure 23**, after Session 3, the greater the number of sessions a client attends, the fewer days they report gambling, on average.

FIGURE 23. PGTI GAMBLER: PERCENTAGE OF CLIENTS BY NUMBER OF DAYS GAMBLING



Note: Each session's data only includes clients who left treatment after that session.

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

	Hypertension	Diabetes	Obesity
Outpatient	13%	11%	6%
IOP	15%	13%	7%
RTP	5%	7%	3%
PGTI (English/Spanish)	7%	6%	8%
PGTI (Asian Languages)	26%	11%	0
California adults[9]	27%	8%	25%

[9] California HealthCare Foundation, California Health Care Almanac, 2015, Oakland, CA. [accessed Dec 8, 2017]. URL: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ChronicConditionsCaliforniansCHIS2015.pdf .

- The most commonly self-reported co-occurring health related conditions were hypertension, diabetes, and obesity.
- Smoking percentages were high across the treatment services network – 27% of Outpatient clients reported smoking, more than twice the state average[10]. There was a notable elevation in RTP where 55% of clients reported smoking (IOP 43%, PGTI Asian Languages 32%, and PGTI English/Spanish 29%).
- About 30% of gamblers across the treatment services network reported their health as fair or poor. This compares to 18% of adults in California reporting their health as "fair or poor" in 2015, according to the Centers for Disease Control and Prevention.[11]

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	24%	2%	11%	3%	0%	3%
IOP	46%	11%	20%	7%	2%	9%
RTP	34%	9%	26%	20%	2%	11%
PGTI (English/Spanish)	35%	4%	22%	4%	2%	5%
PGTI (Asian Languages)	16%	0%	5%	0%	0%	0%

- 24% of CalGETS outpatient clients and 29% of RTP clients scored in the moderately severe to severe depression range at intake as measured by the Patient Health Questionnaire (PHQ-9). This is a high rate compared to 14% of adult Californians reporting any diagnosis of depression.[12]
- IOP clients had relatively high levels of mood, psychotic, and anxiety disorders compared to clients in other modalities.
- RTP clients had a higher prevalence of anxiety, substance use, and ADD/ADHD disorders than clients in other modalities.

Substance Use Behaviors

- Among Outpatient clients, 55% reported that they drank alcoholic beverages. In other treatment modalities, a smaller percentage of clients reported current drinking, ranging from 46% among PGTI English/Spanish clients to 21% among PGTI Asian language clients.

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

[11] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Dec 14, 2017]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

[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]. 2015. [accessed Dec 14, 2017]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

- 30% of CalGETS Outpatient clients reported at least one binge drinking episode (more than five drinks in a single occasion) in the past year. This is comparable to the 31% of California adults reporting any binge drinking in the past year.[13]
- Marijuana was the most frequently reported substance used in the past year across the treatment services network, with 15-35% of CalGETS clients reporting use of marijuana.
- A higher percentage of RTP clients reported use of all drugs compared to clients in other types of treatment services, with 35% reporting marijuana use, 35% reporting methamphetamine use, 25% reporting use of cocaine, and 25% reporting use of narcotics. Additionally, of the RTP clients who reported drinking alcohol (29%), they averaged 11 drinks per week, twice the number of drinks in a week than 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 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 58%); therefore, they may be covered for co-occurring conditions like those identified above.

[13] California HealthCare Foundation, California Health Care Almanac, 2015, Oakland, CA. [accessed Dec 8, 2017]. URL: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ChronicConditionsCalifornians CHIS2015.pdf .

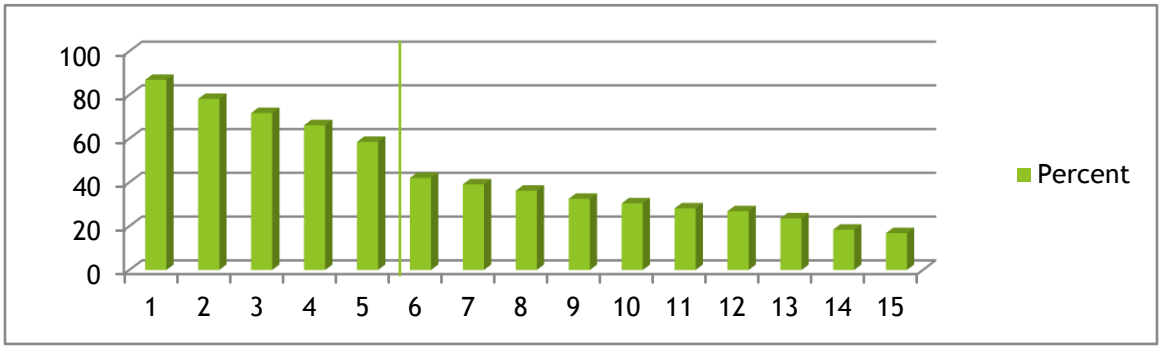
5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2016-17 data that were available from the DMS on affected individuals' (AI) demographics and treatment service outcomes. The data were collected on forms completed by clients at Intake, during treatment, and EOT.

Treatment Service Provision

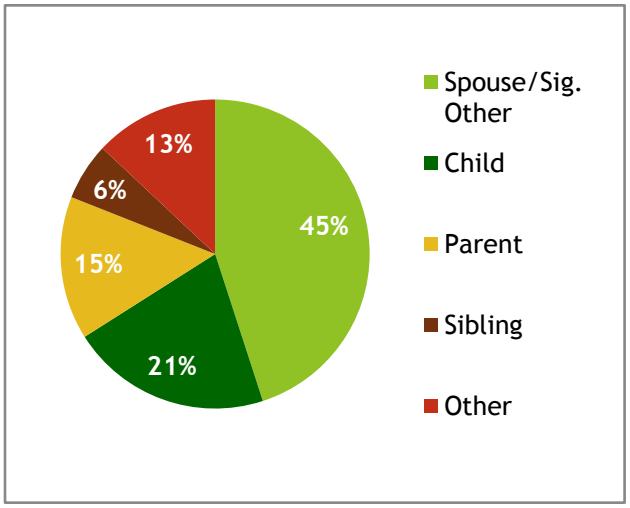
Data were available at Intake from a total of 405 AI clients. Most (94%) were served in outpatient (n=381). The remaining 6% of clients received treatment from PGTI across both English/Spanish (n=11) and Asian (n=13) language programs. The number of Outpatient treatment sessions AIs attended ranged from 0 to 21. AI attendance in Outpatient was strong during the primary treatment sessions (sessions 1-5). Forty-two percent continued treatment after session 5 (**Figure 24**).

FIGURE 24 OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Of the 381 outpatient AI clients, nearly half (45%) identified as a spouse or significant other, 21% as a child of, and 15% as a parent of a gambler (**Figure 25**).

FIGURE 25. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

The average age of Outpatient AI clients was 45 years. AIs' are mostly female (75%), whereas a majority of gambler clients are male. Nearly half of outpatient AI clients reported their race/ethnicity as White, followed by Asian/Pacific Islander (20%), Hispanic/Latino (18%), African American (6%), American Indian/Alaska Native (2%), and another race/ethnicity (10%). Outpatient AI clients reported household income in ranges similar those of Outpatient gamblers. Income ranged from less than $10,000 per year to $200,000 or more (**Table 11**).

TABLE 11. OUTPATIENT AI: DEMOGRAPHICS

FY 2016 17	(N 381)
Age	n=381
Mean Age	45 years old
Gender	n=381
Male	25%
Female	75%
Race/Ethnicity	n=380
White	45%
Asian/Pacific Islander	20%
Hispanic/Latino	18%
African American	6%
American Indian/Alaskan Native	2%
Another race/ethnicity	10%
Education	n=380
Less than High School	1%
High School	17%
Some College	38%
Bachelor's Degree	31%
Graduate/Professional Degree	13%
Household Income	n=381
Less than $15,000	10%
$15,000-$24,999	8%
$25,000-$34,999	7%
$35,000-$49,999	11%
$50,000-$74,999	17%
$75,000-$99,999	15%
$100,000-$149,999	13%
$150,000-$199,999	6%
$200,000 or more	7%
Decline to State/Missing	6%

Treatment Service Findings

Intake to End-of-Treatment Outcomes

As seen in **Table 12**, AIs, on average, have mild depression scores at Intake and lower depression scores at EOT (PHQ-9 range is 0 – 27). Average life satisfaction scores (measured on a scale from 0 to 100) are moderate at Intake and at EOT 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 EOT (both measured on a scale from 0 to 100). [14]

TABLE 12. OUTPATIENT AI: INTAKE TO END-OF-TREATMENT OUTCOMES

	Intake Mean	End of Treatment Mean
Depression (PHQ-9) score	9	5
Life satisfaction	54	65
Degree to which problem gambler's behaviors have interfered with normal activities	58	35
Feel responsible for gambler's treatment and recovery	43	27

Note: Intake N=377, EOT N=146.

Health Information on Affected Individuals

Co-occurring health diagnoses were less common among affected individuals than gamblers; however, some affected individuals participating in the outpatient program reported health-related issues. Health problems reported by five percent or more of Outpatient AI clients were obesity and hypertension. The percentage of Outpatient AIs reporting smoking continued a steady decline in the current fiscal year: from 17% in FY 2012-13 to 8% in FY 2016-17.

Also of note was the lower percentage of Outpatient AIs who reported current drinking (45%) relative to Outpatient gamblers (54%). However, both groups saw a 2% increase in current drinking compared to the past fiscal year. Marijuana use in the past year was reported by 12% of Outpatient AIs, while less than 1% reported use of any other drug. Similar to past years, in FY 2016-17 nearly 75% of Outpatient AIs rated their health as good to excellent at intake.

In regard to co-occurring psychiatric disorders reported at intake, 16% of Outpatient AI clients reported treatment in the past year for mood disorders, 10% for anxiety disorders, 1% for psychotic disorders, 1% for attention deficit disorders, and 1% reported treatment for substance abuse disorders. Using the Patient Health Questionnaire (PHQ-9) criteria, 36% reported moderate to severe depression symptoms.

[14] It should be noted that the 146 clients assessed at EOT are a subset of the 377 clients assessed at Intake, and as a result, the scores cannot be statistically compared.

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 data management system (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 2016-17, therefore, three follow-up attempts were made for each client at each wave from July through December 2016, and five attempts were made from January through June 2017. Although the increase in staff resources began half-way through the fiscal year, compared to FY 2015-16 the number of follow-up attempts tripled and the number of completed interviews doubled.

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 3-5 attempts) for the gamblers and AIs' who agreed to follow-up during FY 2016-17. The numbers differ slightly from DMS data because they are based on call logs. UGSP made over 4,200 attempts to reach clients for follow-up interviews; completing 552 interviews, and ultimately closing 804 cases when clients were unable to be reached. It should be noted that cases are closed after 3-5 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	787	231	**1017**	1378	341	**1719**	1185	354	**1539**	3350	926	**4276**
Completed	122	39	**161**	182	42	**224**	122	45	**167**	426	126	**552**
Closed	127	37	**164**	243	76	**319**	238	83	**321**	608	196	**804**

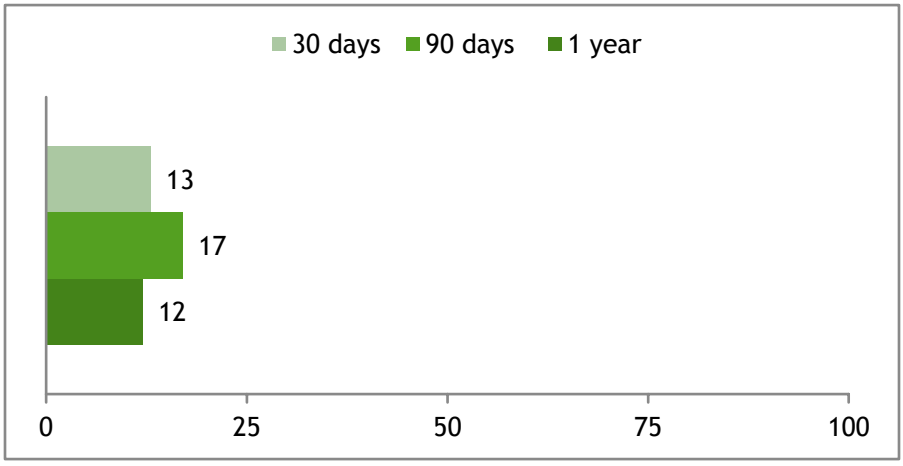
Note: G = Gamblers, AI = Affected individuals

Follow-up results are presented below for the two largest groups of gamblers receiving treatment: Outpatient gamblers and English/Spanish PGTI gamblers. During FY 2016-17, Morneau Shepell, the English/Spanish PGTI provider, had not yet made the transition to DMS. Therefore, these data are presented separately because they vary from the data collected in the DMS.

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 26**).

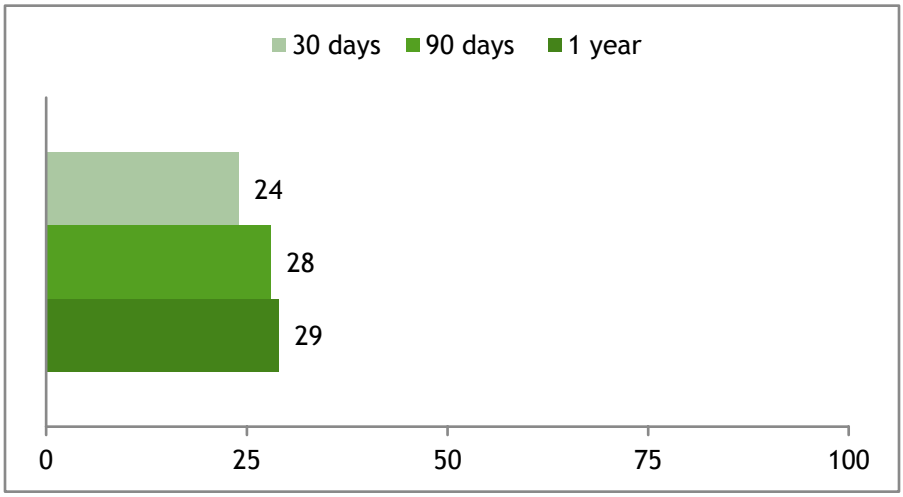
FIGURE 26. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT FOLLOW-UP



Note: 30 days N=104, 90 days N=170, 1 year N=118.

Likewise, the intensity of the urge to gamble, on average, was low during the post-treatment period, remaining below 30 points on the 100-point scale (**Figure 27**).

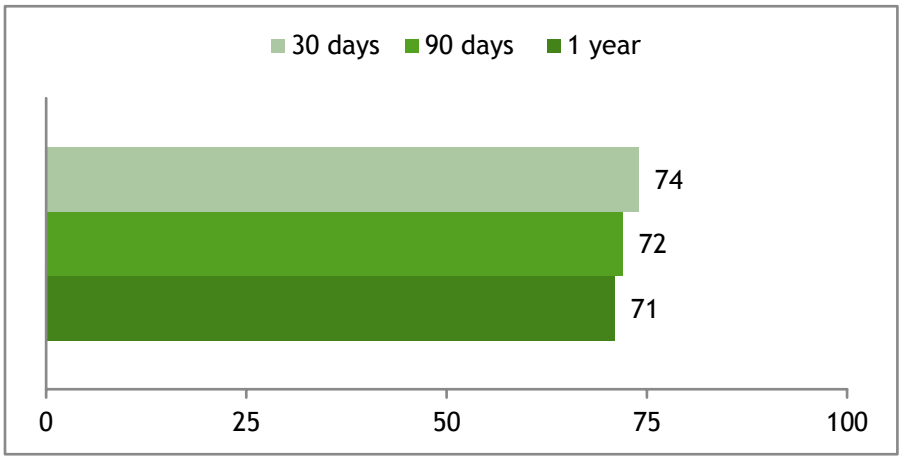
FIGURE 27. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT FOLLOW-UP



Note: 30 days N=104, 90 days N=170, 1 year N=118.

Clients' average overall life satisfaction remained relatively unchanged (**Figure 28**). As above, life satisfaction was measured on a 100-point scale.

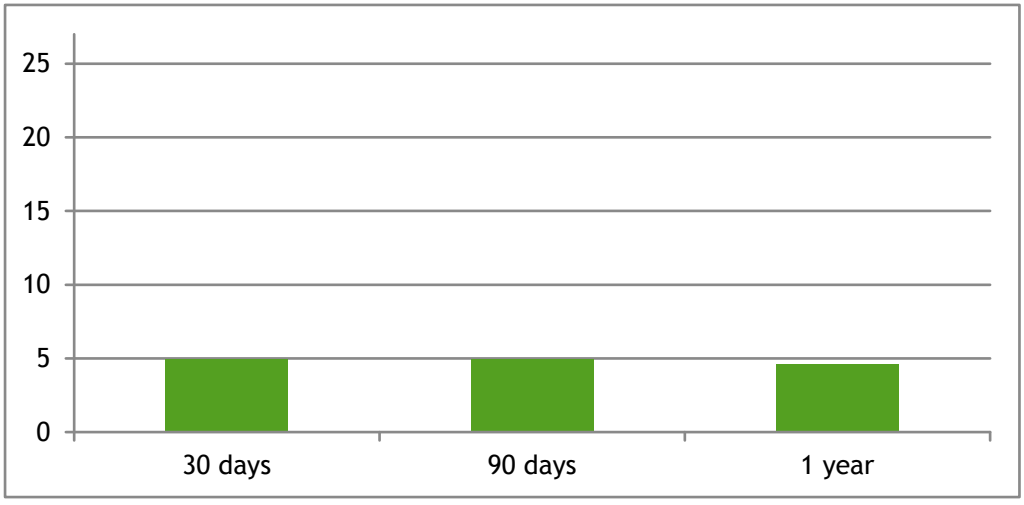
FIGURE 28. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT FOLLOW-UP



Note: 30 days N=104, 90 days N=170, 1 year N=118.

As shown in **Figure 29**, the average depression (PHQ-9) score was 5 at 30 days post-treatment, indicating mild depression. At the 90-day and one-year follow-ups, the depression score remained at 5, still within the mild depression range.

FIGURE 29. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT FOLLOW-UP



Note: 30 days N=104, 90 days N=170, 1 year N=118.

Gamblers: English/Spanish PGTI Follow-up Results

Morneau Shepell conducted follow-up interviews with their English/Spanish language PGTI clients. Figures on the number of attempts made to contact participants were not available; however, results on those contacted are presented below.

- 30-day interviews: Of the 22 people interviewed, 59% had not gambled in the past 30 days.
- 90-day interviews: Of the 19 people interviewed, 47% had not gambled in the past 30 days.
- 1-year interviews: Of the 12 people interviewed, 42% had not gambled in the past 30 days.

As shown in **Table 14**, average quality of life scores showed some fluctuations over time, but it is difficult to know if these differences reflect actual trends among the clients because the scores are from such a small sample.

TABLE 14. ENGLISH/SPANISH PGTI GAMBLER (MORNEAU SHEPELL): MEAN SCORES FOR QUALITY OF LIFE VARIABLES BY FOLLOW-UP POINT

	30 Day (N=22)	90 Day (N=19)	1 Year (N 12)
Overall life satisfaction	74	58	66
Craving strength	50	56	63
Amount of control over gambling	68	53	56

Note: Each quality of life variable was measured on a scale from 0-100, with 0 representing none and 100 representing the greatest.

By one year from the end of treatment, we see a slight erosion in clients' ratings on all the quality-of-life measures presented above. More research is needed to determine how this can be addressed.

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 142 gambler clients offering comments on their treatment experiences, 109 (77%) had positive comments, 18 (11%) had negative comments, and 15 (10%) had neutral or mixed comments. In general, clients who had positive comments praised 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 or mixed comments were either non-committal or mentioned both positive and negative experiences.

Of the 50 affected individuals who provided feedback on their treatment experiences, 42 (84%) offered positive comments, 5 (10%) offered neutral or mixed comments, and 3 (6%) offered negative comments. 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 weren't fully met by the program. Two participants commented that they did not find the treatment provider helpful.

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 2016-17 the ongoing 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 which bans the gambler from gambling establishments. There is a paucity of research examining the effectiveness of self-exclusion and UCLA Gambling Studies Program is currently investigating 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 seek further 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. Our research questions include: What motivates a gambler to self-exclude? How did they hear about self-exclusion? How did the gambler experience the self-exclusion process? Was self-exclusion helpful? Overall, our goal is to develop a more comprehensive understanding about whether self-exclusion is effective. By the end FY 2016-17, the study had been approved by the UCLA Institutional Review Board, site visits had taken place with multiple casinos and card clubs, and the first participants had been enrolled. The study will continue into FY 2017-18.

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