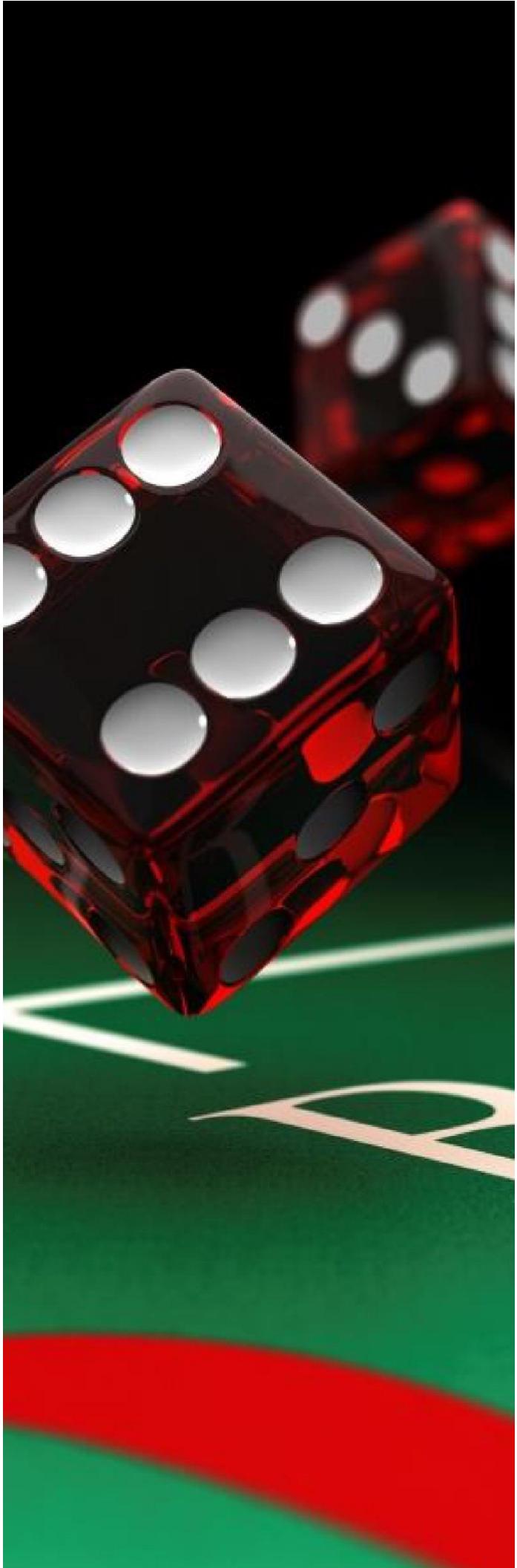


ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2015-16

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 2015-2016

Contents

EXECUTIVE SUMMARY

Overview

California Gambling Education and Treatment Services (CalGETS) is a statewide program for clients with gambling disorder (also known as gambling addiction) and affected individuals (family members and friends affected by someone with a gambling disorder). Over 1,600 individuals received treatment through CalGETS in FY 2015-16. 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 UCLA Gambling Studies Program (UGSP). Since the beginning of CalGETS in 2009, over 9,250 individuals have received treatment through the program to address the harmful impact of problem gambling behavior.

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 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 presents 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, supervises and oversees 219 licensed mental health providers (with an average of 5 years of experience treating gambling), as well as 6 treatment programs, all engaged in delivering evidenced-based treatment to problem gamblers and affected individuals.
- Treatment services are available in 30 languages/dialects.

CalGETS Treatment Outcomes (FY 2015-16)

Gamblers:

- 1,218 gamblers received treatment across the treatment network. Three quarters (74%) received outpatient services, 15% were served in PGTI (14% in English/Spanish and 1% in Asian languages), 4% were served in IOP, 6% were served in RTP and 1% were served in group treatment.
- Data collected from CalGETS clients show decreased intensity of their gambling urges and increased overall life satisfaction at the conclusion of treatment. Life satisfaction as measured by a self-reported 100-point scale has increased from intake to end of treatment across the treatment network by 12 points or more.
- The percentage of time lost due to gambling interfering with normal activities showed a marked decrease between intake and end of treatment for all treatment formats.

- The mean score at intake for all CalGETS clients falls into the range of moderate depression (10). By the end of CalGETS, the mean score had fallen to 5 (mild depression) and only 8% of the respondents were classified with moderate to severe depression.

CalGETS GAMBLER CHARACTERISTICS: 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, 31% currently smoke. This is three times the state average. In the residential treatment setting, the prevalence rate of smoking is 60%.
Alcohol Use	CalGETS clients report a heavy drinking episode (more than five drinks in a single occasion) occurring, on average, every 20 days.
Marijuana	According to the National Survey on Drug Use and Health, 14.7% of the population of California self-reported using marijuana within the last 12 months. Across the treatment network, 16%-45% of CalGETS clients use marijuana.
State of Health	30% of gamblers across the treatment network reported their health as "fair or poor".
Health Insurance	78% 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	70% of CalGETS clients reported they currently have a physician they can access for primary care needs.
Depression	45% of CalGETS clients scored in the moderate to severe depression range at intake as measured by the Patient Health Questionnaire (PHQ-9).

Affected Individuals:

- 436 affected individuals received treatment across the treatment network.
- Affected individuals are significant others (52%), children of gamblers (17%) or parents (13%).
- Significant improvements in life satisfaction, decreased negative impact of someone else's gambling and decreased sense of responsibility for the gambler's treatment and recovery were reported.

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

Client Follow-up

UGSP completed 263 post-treatment telephone interviews for program evaluation and to assess the impact of treatment. Results show that both gamblers' and affected individuals' quality of life remains improved 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. Significant program accomplishments include the creation of: *Suicide Prevention and Gambling Prevention* - a training video for use by lay persons, para-professionals and CalGETS providers; and, *Sleep Hygiene and Gambling Disorders* – a handout for use by clients and providers.

1. CalGETS PROGRAM STRUCTURE

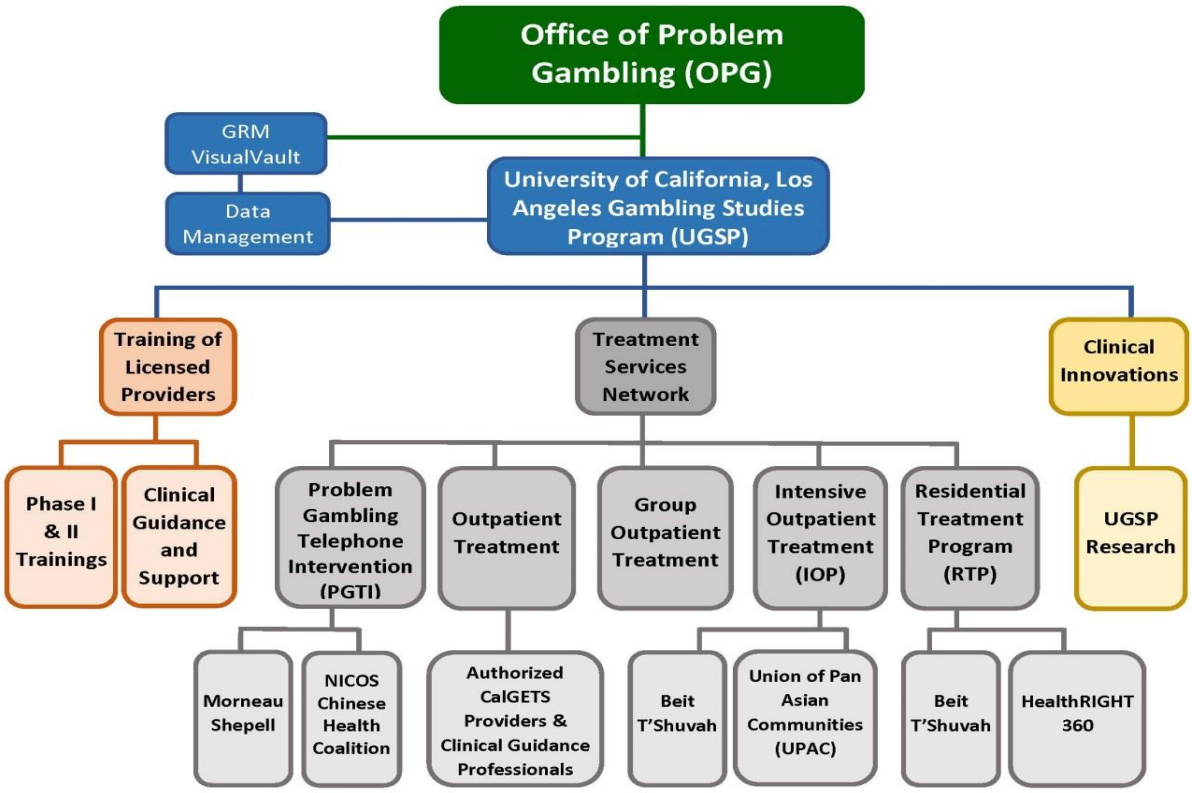
Introduction

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 gambling disorder in California.
- Establish a broad spectrum of treatment services using a stepped-care approach to address diverse multi-cultural treatment needs for those with a gambling disorder or affected individuals.
- Establish training events that will enhance the knowledge and therapeutic skills of licensed health providers for both newly eligible and authorized providers.
- Disseminate screening tools and methods about the availability of treatment services.
- Ensure that all eligible clients have access to care in selection of treatment providers capable of addressing unique individual needs and preferences.
- Empower clients to be involved in the recovery process by being informed about 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 and Outpatient (Individual and Group) for gamblers and affected individuals, as well as, Intensive Outpatient and Residential treatment for gamblers only. Participant follow-up is 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 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 a year of completing CalGETS provider authorization, providers are required to participate in 10 hours of CalGETS Clinical Guidance and Support.[1] The 10 hours of required 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.

CalGETS authorized providers are given the opportunity to participate in Phase II training, which consists of a five hour, single-day training. Phase II training is intended to deliver advanced study and current information on gambling disorder treatments. 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. Additionally, UGSP and OPG staff members conduct in-person compliance monitoring reviews of active providers to ensure compliance with CalGETS policies and procedures.

[1] This requirement has been adjusted to two years for FY 2016-17, with 5 hours required in the first year.

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 are 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 2015-16, there were 219 active, authorized CalGETS providers, offering services in over 30 languages and dialects. Gamblers and affected individuals may also receive six group treatment sessions within one year[2]. This does not include the mandatory individual screening prior to attending group 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 severe gambler clients. Services include individual, group, and family counseling.

Residential Treatment Programs (RTP). Individuals with severe 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 BDA 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 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. Participants are queried on satisfaction with treatment, current gambling behaviors, and quality of life. CalGETS clients who consent to follow-up are contacted at 30,

[2] Starting in FY 2016-17, three blocks of 8 group sessions became available to clients in outpatient treatment.

90, and 365 days after treatment exit and 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 2015-16 TREATMENT REPORT DATA SOURCES AND METHODS

Data sources

Data is obtained from the CalGETS client forms, Version 2.0, which for FY 2015-16 had a new measure, the PHQ-9 (described below). 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 stored on 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. All providers, except BDA Morneau Shepell, enter their data into the DMS. BDA Morneau Shepell enters their data into Filemaker Pro and export 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 diagnosis.[3] 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' lifetime gambling problems. The Modified NODS combines questions to produce the 10 items needed to calculate a NODS score. It uses a true/false format and results in scores ranging from 0 to 10 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 2 indicates an at-risk gambler, 3 to 4 indicates a problem gambler and 5 or higher indicates a pathological gambler.

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

[3] Clients who endorse thoughts of self-harm or suicide 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

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?" Replies are rated using a 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 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 2015-16 some issues may have impacted data collection and/or reporting. These issues include:

- Transition from Excel-based data capture to the DMS among one of the CalGETS PGTI providers was not accomplished in FY 2015-16.
- UGSP's assessment of the DMS reporting and data exporting processes revealed technical issues (i.e., missing or limited data available when data exports were retrieved).

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 sessions are offered in blocks of eight (i.e., Intake, treatment sessions one through six, with an end of treatment session), and Intensive Outpatient (IOP) is 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 23.

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), UGSP or OPG websites, healthcare 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 (i.e., including 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/services if clinically indicated, and providing culturally and linguistically appropriate services).

The Phase I training for FY 2015-16 was held August 19-21, 2015 in Sacramento, California. From October 2015 to May 2016, three Phase II training events were conducted throughout the state (i.e., in Sacramento, San Diego, and Orange County).

Shortly after the close of FY 2015-16, UGSP conducted a survey with all active providers to obtain information on provider characteristics and experiences with CalGETS (2016 Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2016, unless given an exemption. The 2016 Provider Survey indicates that at the end of FY 2015-16, the Treatment Services Network had 219 licensed providers who were authorized to provide services to gamblers and affected individuals. **Table 1** details the number of clinicians and providers who completed Phase I and II training during FY 2015-16. Additionally, UGSP provided 26 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

TABLE 1. CalGETS TRAINING

	FY 2015-16
Training	
Licensed mental health clinicians who completed Phase I	36
Licensed clinicians who completed Phase I and became authorized providers	28
Licensed providers who completed Phase II	61

Providers' demographic information is provided below (**Table 2**). Providers were primarily female, and reported their race/ethnicity as: 69% White, 13% Asian, 8% Hispanic/Latino, and 6% Black/African American.

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

	FY 2015-16
Gender	n=212
Female	73%
Male	27%

Race/Ethnicity	n=212
White	69%
Asian	13%
Hispanic/Latino	8%
Black/African American	6%
Multicultural	2%
Native Hawaiian/Pacific Islander	0%
Choose not to designate	2%

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 just over five years. In FY 2015-16, 71.2% of providers were Licensed Marriage and Family Therapists, 13.7% were Licensed Clinical Social Workers, 8% were Psychologists, and 9% were Licensed Professional Social Workers. Of those providers, 20.8% reported providing treatment services in languages other than English: 45.5% providing services in Spanish, 40.9% providing services in an Asian language, and 13.6% providing services in other languages. Over half (53%) 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 (84.9%)
- Phase II Training (63.7%)
- Clinical Guidance and Support (51.9%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 99.5% planned to continue as authorized CalGETS providers into the following 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. FY 2015-16 is the first full year that providers offered outpatient group treatment, as only a few sessions had been conducted at the end of FY 2014-15.

Treatment Service Provision

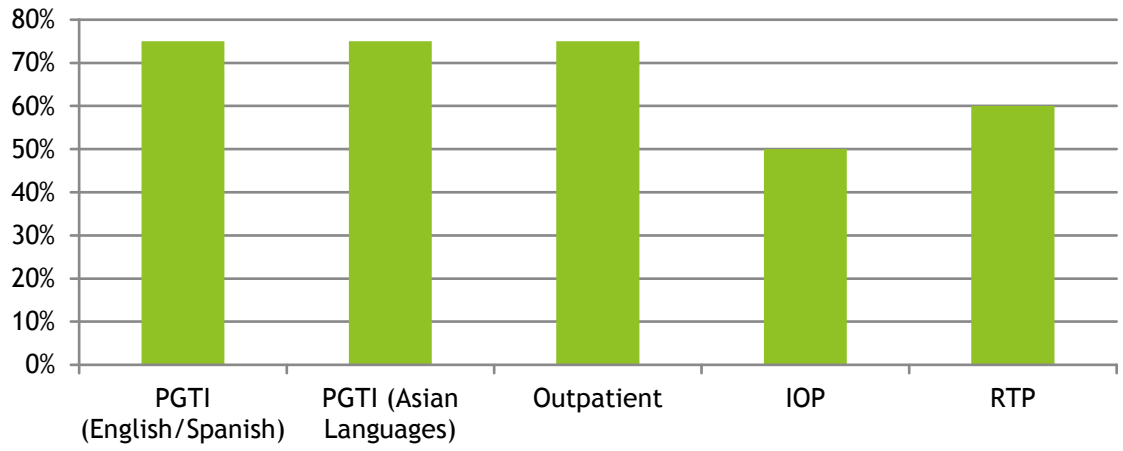
In FY 2015-16, a total of 1,221 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (74%) enrolled in Outpatient, followed by Problem Gambling Telephone Intervention (PGTI) (15%), Residential Treatment Programs (6%), Intensive Outpatient (4%), and 1% in Outpatient Group.

TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED

	N	Percentage
Outpatient	907	74%
Outpatient Group	13	1%
Intensive Outpatient Program (IOP)	50	4%
Residential Treatment Programs (RTP)	67	6%
Problem Gambling Telephone Intervention (PGTI) (English/Spanish languages)	167	14%
PGTI (Asian languages)	17	1%
Total	1,221	100%

The provider network offers rapid entry into treatment from the time of first contact with a provider (**Table 4**). The vast majority of clients enter treatment within one week.

TABLE 4. TREATMENT SERVICES: PERCENTAGE OF CLIENTS ENTERING TREATMENT WITHIN 7 DAYS OF FIRST CONTACT



Treatment Service Findings

Outpatient

Individual Outpatient

As shown in Table 3,[4] outpatient has, by far, the largest number of clients. Intake data are available from 907 clients who enrolled in outpatient. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2015-16, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (36%), family/friends (14%), healthcare professionals (9%), Gamblers Anonymous/Gam-Anon (8%), and former clients (8%).

The number of sessions completed by outpatient gambler clients (n=907) varied:

- 14% of clients had only an intake session
- 65% received 1-8 treatment sessions
- 21% received 9-16 treatment sessions

Some individuals may be continuing treatment into FY 2016-17, but these additional sessions are not counted in the percentages above.

Demographics

Outpatient clients had an average age of 47 years and two-thirds (66%) were male. Less than half of the clients identified their race as White (44%), followed by Asian/Pacific Islander (19%), Hispanic (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 2015-16	(N=907)
Age	n=907
Mean Age	47 years old
Gender	n=907
Male	66%
Female	34%
Race/Ethnicity	n=886
White	46%
Asian/Pacific Islander	19%
Hispanic/Latino	17%
African American	10%
American Indian/Alaskan Native	1%
Another race/ethnicity	7%

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

Education	n=897
Less than High School	5%
High School	17%
Some College	38%
Bachelor's Degree	30%
Graduate/Professional Degree	10%
Household Income	n=897
Less than $10,000	7%
$10,000-$14,999	7%
$15,000-$24,999	11%
$25,000-$34,999	11%
$35,000-$49,999	14%
$50,000-$74,999	16%
$75,000-$99,999	11%
$100,000-$149,999	11%
$150,000-$199,999	4%
$200,000 or more	4%
Decline to State	4%

Gambling Severity

An overwhelming proportion of gamblers who sought outpatient treatment through CalGETS had a pathological level of gambling severity (**Table 6**).

TABLE 6. OUTPATIENT GAMBLER: GAMBLING SEVERITY (NODS) CLASSIFICATION

Severity	NODS Score	N	%
At-Risk	1 to 2	8	1%
Problem	3 to 4	28	3%
Pathological	5 or More	852	94%

Note: Nineteen (2.1%) outpatient gamblers had incomplete NODS data.

Gambling Behaviors

At Intake, outpatient clients (n=907) were asked to indicate both their typical gambling locations and the types of gambling activities that they have engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (85%).

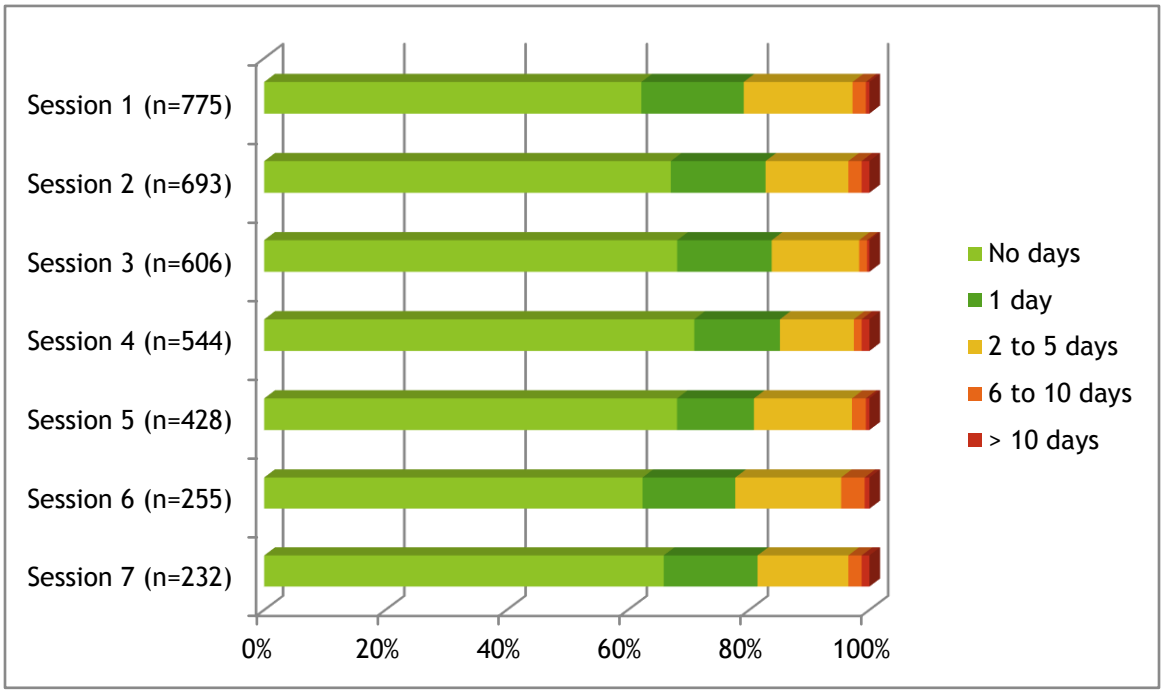
Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines, poker, and blackjack were the most commonly selected gambling activities. Clients who reported gambling activities at tribal casinos most frequently stated that they played slot machines (48%), blackjack (26%), and poker (18%). Clients gambling at other casinos most frequently reported playing slot machines (20%), blackjack (19%), and poker (14%). Clients who indicated gambling in cardrooms most often reported playing poker (20%), and blackjack (18%). Clients who reported gambling on the Internet most often indicated playing poker (6%). Among clients who reported gambling at other venues, activities such as the lottery (23%) and sporting events (15%) were most frequently reported.

Intake to End-of-Treatment Outcomes

In order to measure the impact of treatment, recent gambling, perceived negative impact of gambling, perceived control over gambling, urge to gamble, and depression were assessed at Intake and EOT. At Intake, nearly 100% of clients report gambling disorder in the past year.

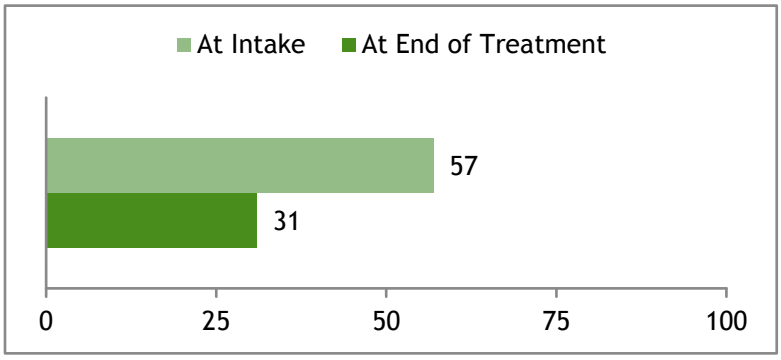
When examining recent gambling (i.e., since last treatment session), after Intake, the number of gambling days decreases (Figure 2) during the first four outpatient sessions (38% report one or more days gambling at Session 1; 29% report one or more days gambling at Session 4). However, in Sessions 5-7, the percentage of clients reporting one or more gambling days increases. This may be due to greater initial severity either in gambling or in co-occurring disorders among those clients who stay in treatment longer, but more research is needed to determine if that is the case.

FIGURE 2. OUTPATIENT GAMBLER: PERCENTAGE OF CLIENTS BY NUMBER OF DAYS GAMBLING



Outpatient clients reported less interference by 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 26 points from Intake to EOT (**Figure 3**).

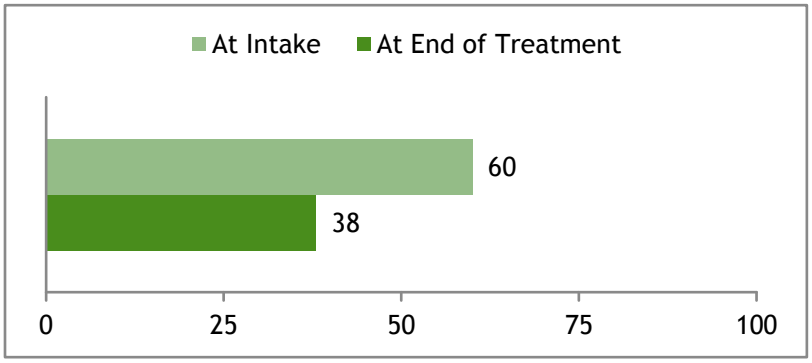
FIGURE 3. OUTPATIENT GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=888, EOT N=394.

Among outpatient clients, the average intensity of the urge to gamble decreased from Intake to EOT by 22 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble after receiving outpatient services (**Figure 4**).

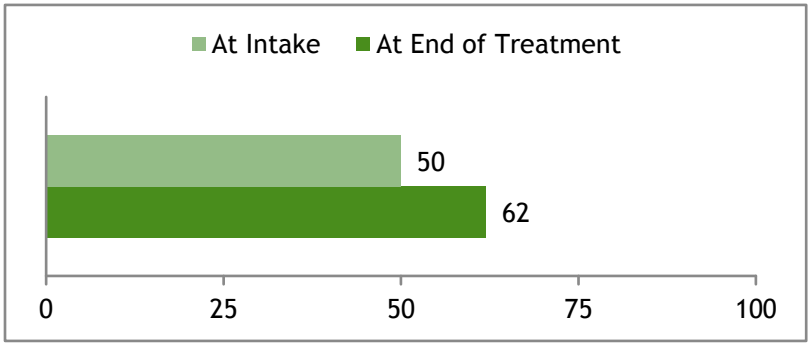
FIGURE 4. OUTPATIENT GAMBLER: INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=888, EOT N=394.

Over the course of treatment, outpatient clients reported an improvement of 12 points on average in overall life satisfaction (**Figure 5**). As above, life satisfaction was measured on a 100-point scale.

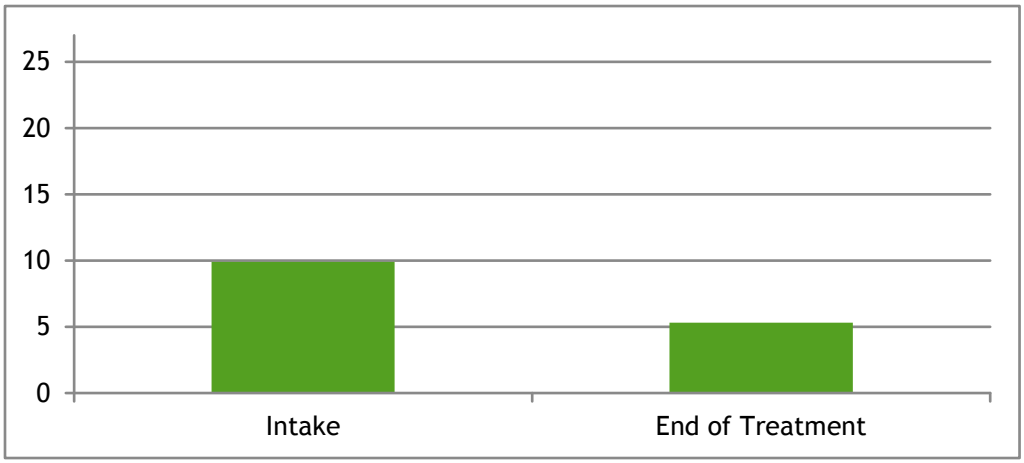
FIGURE 5. OUTPATIENT GAMBLER: OVERALL LIFE SATISFACTION SCORES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=888, EOT N=394.

During FY 2015-16, 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 6**).

FIGURE 6. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT



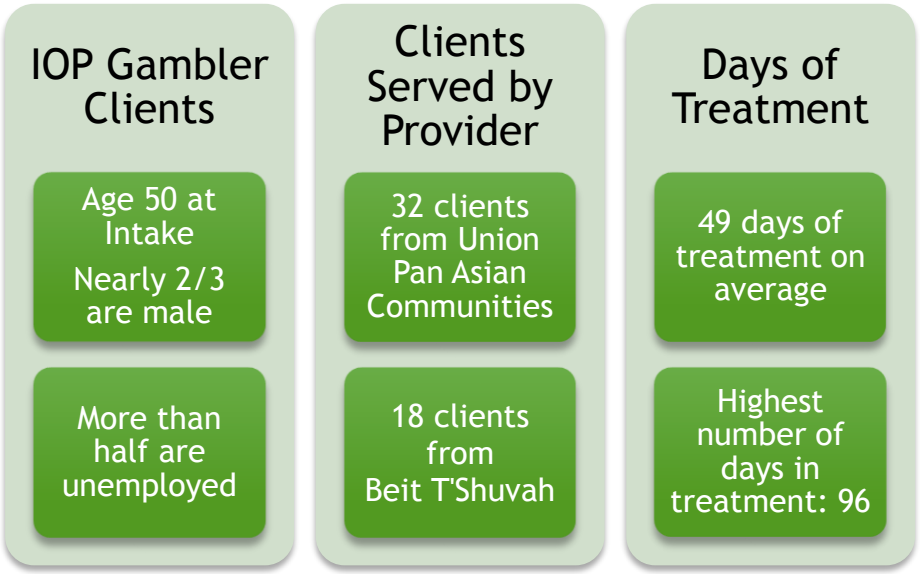
Group Outpatient

The 13 clients who participated in outpatient treatment groups had an average age of 53 years and slightly more than half were male. Their main referral source for group treatment was from a CalGETS provider. Group Outpatient participants were predominantly slots players who gambled primarily at tribal casinos and other casinos. Roughly half reported moderate to severe depression at intake, while the rest reported mild depression. Of the four patients for whom EOT data are available, all reported moderate to severe depression. Of the twelve for whom 30-day follow-up data are available, none reported gambling in the past 30 days.

Intensive Outpatient Program (IOP)

Data were available from 50 clients enrolled at Intake in IOP during FY 2015-16 (**Figure 7**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=32) or Beit T'Shuvah (N=18). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

FIGURE 7. IOP SNAPSHOT[5]



Demographics

IOP gambler clients were slightly older than Outpatient clients. Over half (59%) of IOP clients identified as White, followed by 16% Asian/Pacific Islander, 16% African American, 4% Hispanic/Latino, and 4% as another race/ethnicity. Like the Outpatient clients, IOP clients have fairly high levels of education with 82% reporting some college education or higher. Although clients' household income varied from an income of less than $10,000 per year to $200,000 or more, 56% of IOP clients reported that their income was less than $35,000.

Gambling Severity

With only one exception, the gamblers enrolled in IOP had a pathological level of gambling severity (98%).

Gambling Behaviors

IOP clients (n=50) 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%).

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 (51%), blackjack (36%), and poker (19%). Clients gambling at other casinos most frequently reported playing slot machines (19%), and blackjack (15%). Clients who indicated gambling in cardrooms most often reported playing blackjack (26%) and poker (15%). Very few IOP clients reported

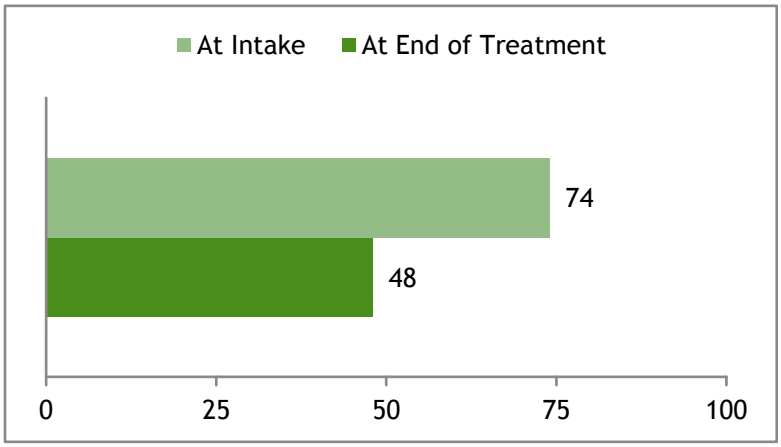
[5] Note: Seven individuals with intermittent, but ongoing attendance at UPAC were excluded in calculating days in treatment for IOP.

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 is available on 37 of the 50 clients. IOP clients' reports of interference by gambling with their normal activities showed an average decrease of 26 points from Intake to EOT (**Figure 8**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

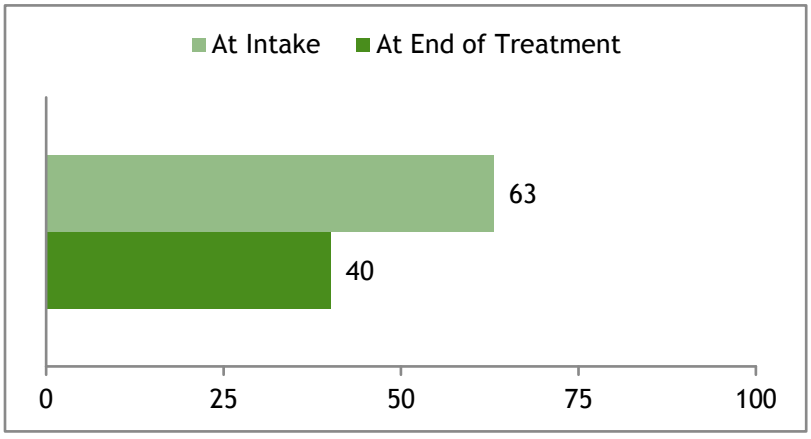
FIGURE 8. IOP GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=50, EOT N=37.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to EOT by an average of 23 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble (**Figure 9**).

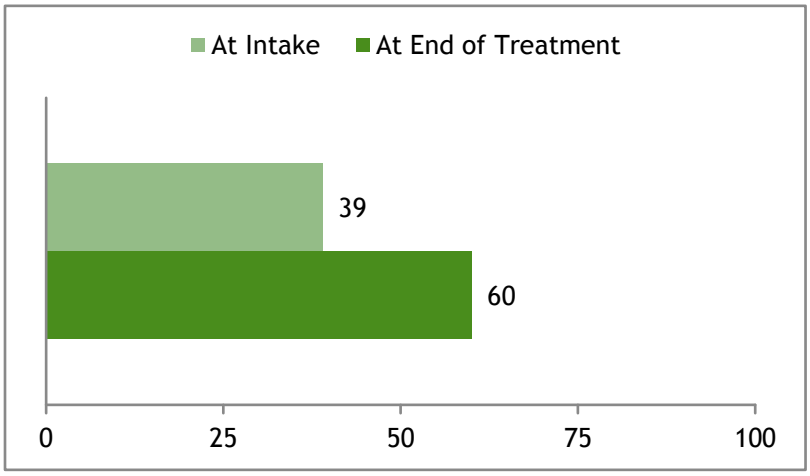
FIGURE 9. IOP GAMBLER: INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=50, EOT N=37.

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

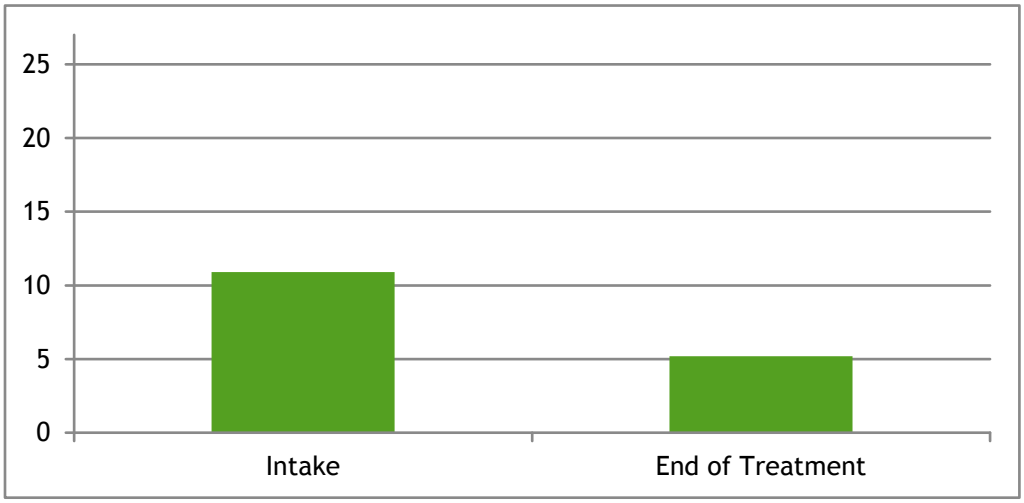
FIGURE 10. IOP GAMBLER: OVERALL LIFE SATISFACTION SCORES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=50, EOT N=37.

During FY 2015-16, IOP 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 mild depression at EOT (**Figure 11**).

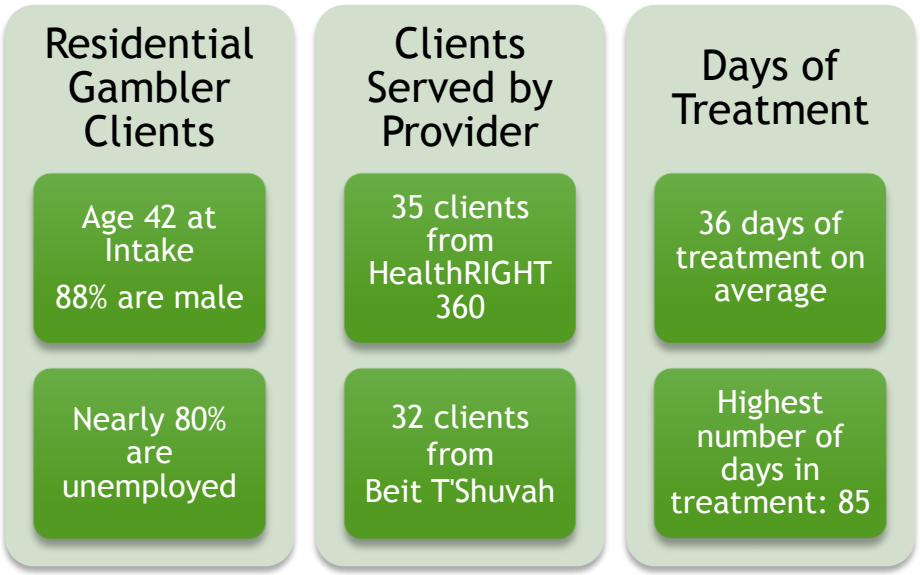
FIGURE 11. IOP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT



Residential Treatment Programs (RTP)

Data were available from 67 clients enrolled at Intake in RTP during FY 2015-16 (**Figure 12**). Clients received treatment from either HealthRIGHT 360 (N=35) or Beit T'Shuvah (N=32). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 12 RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT



Demographics

Nearly half (48%) of RTP clients identified as White, followed by 24% African American, 16% Hispanic/Latino, 5% Asian/Pacific Islander, 2% American Indian/Alaska Native, and 6% as another race/ethnicity. RTP clients have less education than Outpatient and IOP clients, but still have fairly high levels of education with 57% reporting some college education or higher. Similar to IOP clients, RTP clients also reported lower household income, with 79% reporting that their income was less than $35,000 and nearly 40% reporting income less than $10,000 per year.

Gambling Severity

Of those enrolled in RTP treatment, 94% reported gambling severity at a pathological level, while 3% reported problem and 3% reported at-risk gambling severity.

Gambling Behaviors

RTP clients (n=67) were asked at Intake to indicate both their typical gambling locations and the types of gambling activities that they engaged in over the last 12 months. Of the specific gambling locations (i.e., bingo halls, casinos, Internet, lottery stores, and other gambling locations), casinos were the most frequently selected gambling venue from the options provided (87%).

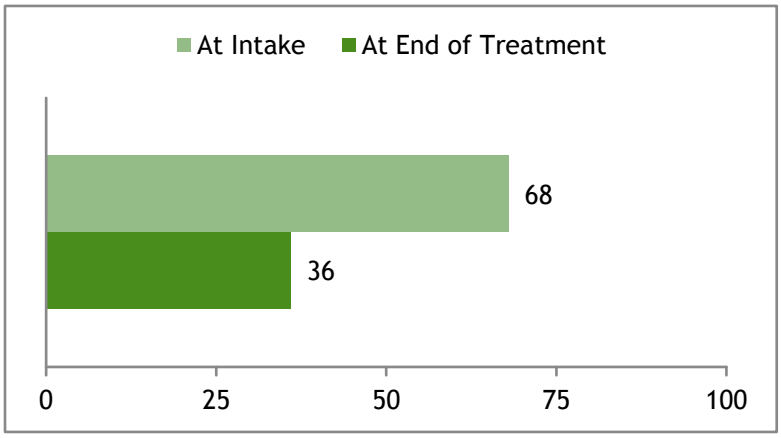
Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, slot machines, poker, blackjack, and the lottery were the most commonly selected gambling activities. Clients who reported gambling activities at tribal casinos most frequently stated that they played slot machines (49%), blackjack (43%), and poker (39%). Clients gambling at other casinos most frequently reported playing slot machines (55%), blackjack (52%), poker (34%), and craps (19%).

Clients who indicated gambling in cardrooms most often reported playing blackjack (58%) and poker (45%). Of those who reported gambling on the Internet, they most often reported playing poker (30%), slots (22%), and blackjack (21%). Among clients who reported gambling at other venues, they most frequently reported the lottery (46%), sporting events (28%), and horse racing (22%).

Intake to End-of-Treatment Outcomes

End of treatment data is available on all 67 clients. RTP clients' reports at Intake and EOT of interference by gambling with their normal activities showed, on average, a decrease of 32 points (**Figure 13**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

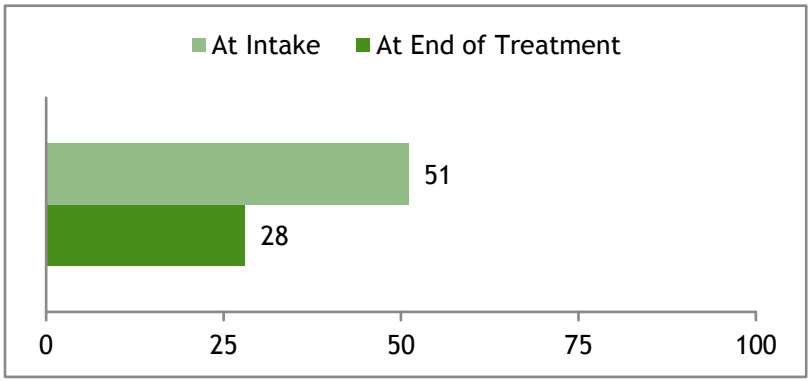
FIGURE 13. RTP GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=67, EOT N=67.

Among RTP clients, the intensity of the urge to gamble, on average, decreased from Intake to EOT by 23 points on the 100-point scale. Lower scores at EOT indicated a less intense urge to gamble (**Figure 14**).

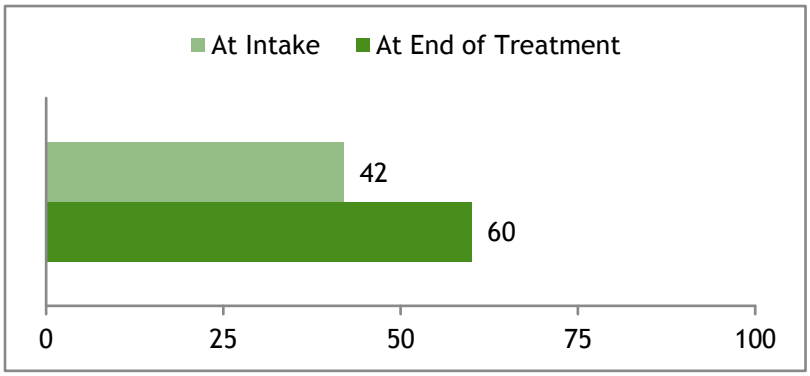
FIGURE 14. RTP GAMBLER: INTENSITY OF GAMBLING URGE AT INTAKE AND AT END OF TREATMENT



Note: Intake N=67, EOT N=67.

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 15**). As above, life satisfaction was measured on a 100-point scale.

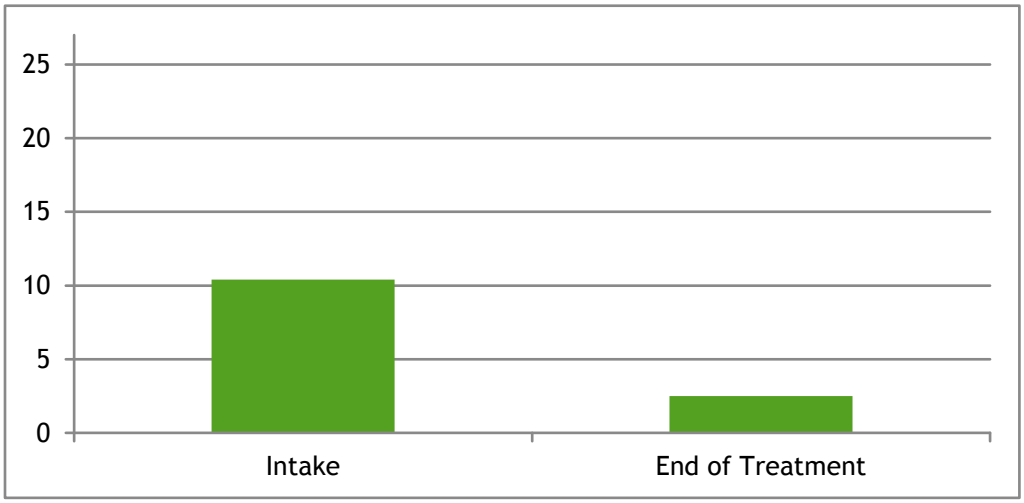
FIGURE 15. RTP GAMBLER: OVERALL LIFE SATISFACTION SCORES AT INTAKE AND AT END OF TREATMENT



Note: Intake N=67, EOT N=67.

During FY 2015-16, 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 16**).

FIGURE 16. RTP GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT INTAKE AND AT END OF TREATMENT



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. BDA 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.

The following section summarizes frequency tables and includes 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 184 gambler clients enrolled at Intake during FY 2015-16. A total of 167 clients received services in either English or Spanish languages from BDA Morneau Shepell, and 17 clients received services in various Asian languages from NICOS. Of the 184 total clients assessed at Intake, 144 received further treatment services (131 from BDA Morneau Shepell, 13 from NICOS).

Clients participating in English or Spanish language sessions (n=167) most often reported being referred by tribal casinos (30%); media (e.g., television, radio, newspaper, billboards) (14%); or by friends (9%). Some individuals (9%) indicated that they were repeat callers and were not referred by any source. Clients participating in Asian language treatment sessions (n=17) were most frequently referred by family or friends (24%); helplines (18%); or other sources (41%).

Clients from the English and Spanish language services (n=131) 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 13 sessions in total.

Demographics

Gamblers who took advantage of telephone-based treatment (PGTI) reflect the diversity of California. They were, on average, 46 years old and males predominated in both groups. Among the PGTI English/Spanish clients, nearly half identified their race as White (45%), followed by Hispanic/Latino (19%), African American (17%), Asian/Pacific Islander (15%), and another race/ethnicity (4%). All of the clients receiving Asian language PGTI services identified themselves as Asian/Pacific Islander. More than 50% of PGTI English/Spanish clients reported completing some college or above, and more than 40% 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 2015-16	English/Spanish Language PGTI (N=167)	Asian Language PGTI (N=17)	All PGTI Clients (N=184)
Age	(n=131)	(n=17)	(n=148)
Mean Age	46 years old	46 years old	46 years old
Gender	(n=167)	(n=17)	(n=184)
Male	59%	71%	60%
Female	41%	29%	40%

Race/Ethnicity	(n=162)	(n=16)	(n=178)
White	44%	0%	40%
Asian/Pacific Islander	15%	100%	23%
Hispanic/Latino	20%	0%	18%
African American	17%	0%	16%
American Indian/Alaskan Native	0%	0%	0%
Another race/ethnicity	4%	0%	3%
Education	(n=160)	(n=16)	(n=176)
Less than High School	9%	25%	11%
High School	24%	31%	25%
Some College	38%	25%	36%
Bachelor's Degree	21%	13%	21%
Graduate/Professional Degree	8%	6%	7%
Household Income	(n=156)	(n=16)	(n=172)
Less than $10,000	3%	6%	3%
$10,000-$14,999	6%	0%	5%
$15,000-$24,999	10%	19%	11%
$25,000-$34,999	12%	19%	13%
$35,000-$49,999	17%	0%	16%
$50,000-$74,999	26%	31%	26%
$75,000-$99,999	10%	13%	10%
$100,000-$149,999	11%	6%	10%
$150,000-$199,999	3%	6%	3%
$200,000 or more	3%	0%	3%

Gambling Severity

Of those enrolled in PGTI services, more than 90% reported gambling severity at a pathological level.

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

	Severity	NODS Score	N	%
	At-Risk	1 to 2	5	3%
	Problem	3 to 4	6	4%
	Pathological	5 or More	156	93%
	At-Risk	1 to 2	0	0
	Problem	3 to 4	1	6%
	Pathological	5 or More	15	94%

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 64% of clients, and food/convenience stores for lottery tickets (14%).

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 (52%), blackjack (19%), and poker (17%). The other major gambling activity was the Lottery (30%). Among Asian Language PGTI clients, 29% played baccarat at a casino. Otherwise, there was no predominant gambling activity among this group.

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, N = 131, **Figure 17**). 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 18**). Life satisfaction remained relatively unchanged during treatment (**Figure 19**).

FIGURE 17. PGTI GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES

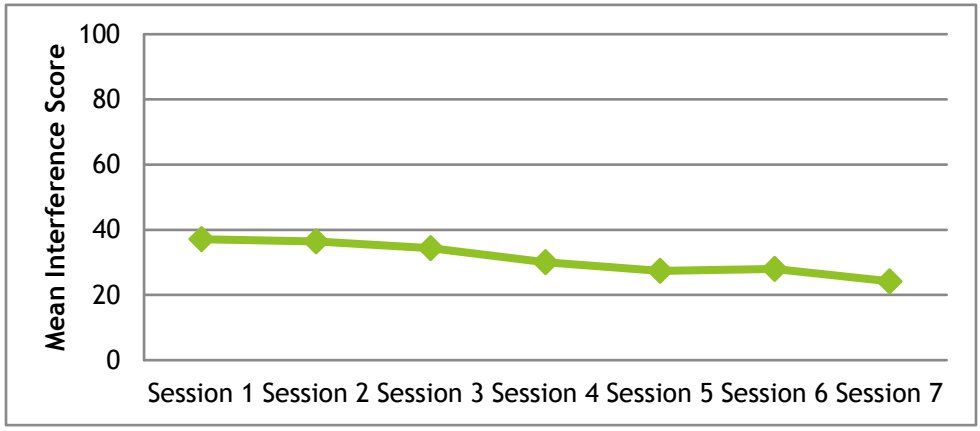


FIGURE 18. PGTI GAMBLER: INTENSITY OF GAMBLING URGE

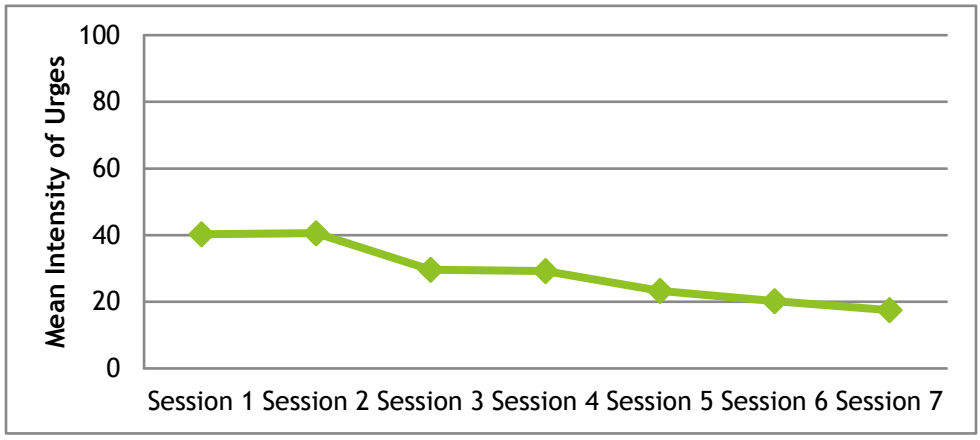
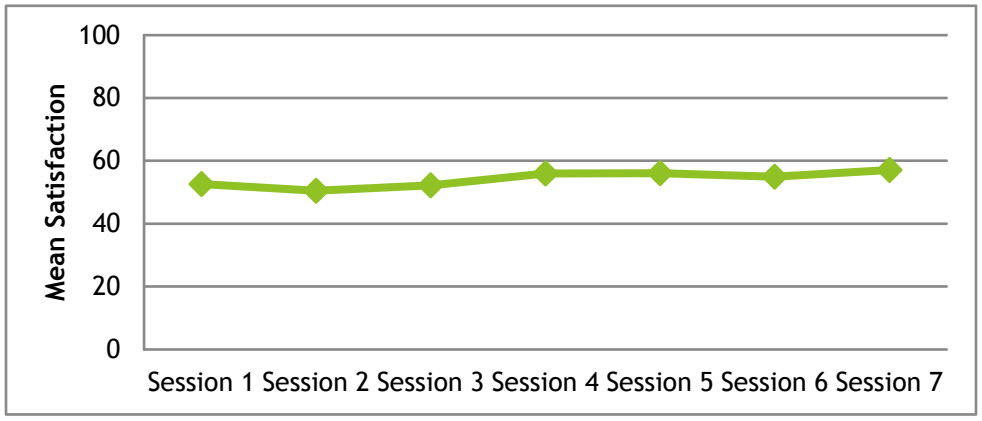
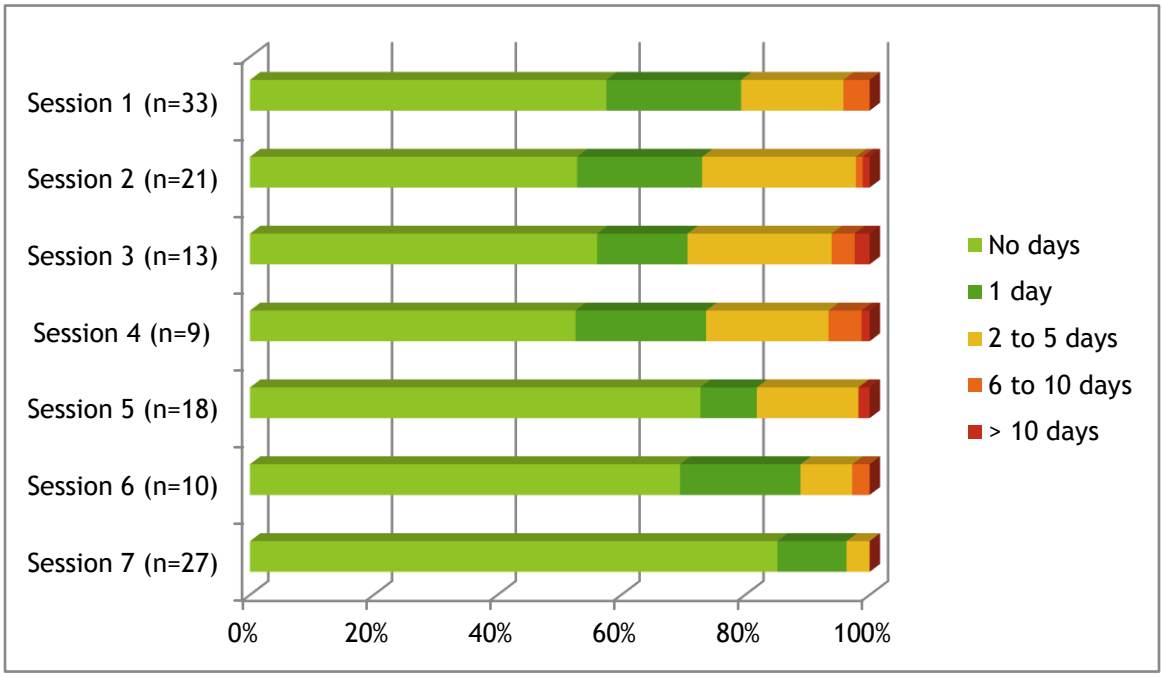


FIGURE 19. PGTI GAMBLER: OVERALL LIFE SATISFACTION SCORES



As shown in **Figure 20**, after Session 4, the greater the number of sessions a client attends, the fewer days they report gambling, on average (PGTI English/Spanish clients, N = 131).

FIGURE 20. PGTI GAMBLER: PERCENTAGE OF CLIENTS BY NUMBER OF DAYS GAMBLING



Health Information on Gamblers

Co-Occurring Health Conditions

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

- The most commonly reported co-occurring health related conditions were hypertension, diabetes, and obesity (occurring at 6-19%).

- Smoking percentages were high across the treatment services network, with a notable elevation in RTP where over 60% of clients reported smoking.
- About 30% of gamblers across the treatment services network reported their health as fair or poor.

Co-Occurring Psychiatric Disorders

Anxiety and mood disorders were the most common co-occurring mental health conditions reported (**Table 9**).

TABLE 9. 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%	14%	3%	1%	3%
IOP	40%	17%	15%	9%	0%	0%
RTP	42%	9%	25%	43%	6%	9%
PGTI (English/Spanish)	29%	4%	17%	2%	0%	1%
PGTI (Asian Languages)	6%	0%	0%	0%	0%	0%

- 45% of CalGETS clients scored in the moderate to severe depression range at intake as measured by the Patient Health Questionnaire (PHQ-9).
- RTP clients had a higher prevalence of all co-occurring psychiatric disorders than clients in any other modality, with the exception of psychotic disorders.

Substance Use Behaviors

- Among Outpatient clients, 52% reported that they were current drinkers. In other types of treatment services a smaller percentage of clients reported current drinking, ranging from 44% among PGTI English/Spanish clients to 18% among PGTI Asian language clients.
- CalGETS clients report a heavy drinking episode (more than five drinks in a single occasion) occurring, on average, every 20 days.
- Marijuana was the most frequently reported substance used in the past year across the treatment services network, with 16%-45% 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 45% reporting marijuana use, and about a third reporting use of cocaine and methamphetamines. Additionally, of the RTP clients who reported drinking alcohol (30%), they reported drinking three times 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 a significant portion of CalGETS clients in residential treatment who have co-occurring substance abuse issues. The high incidence of mental health need, in addition to the gambling-related problems experienced by CalGETS clients, validates the use of licensed mental health professionals as the primary source of our workforce. At least 78% of all clients reported having health insurance and 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.

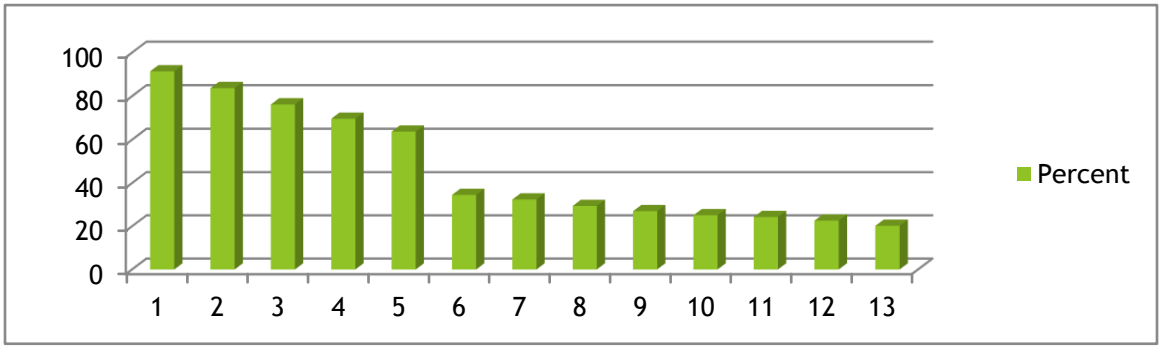
5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2015-16 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

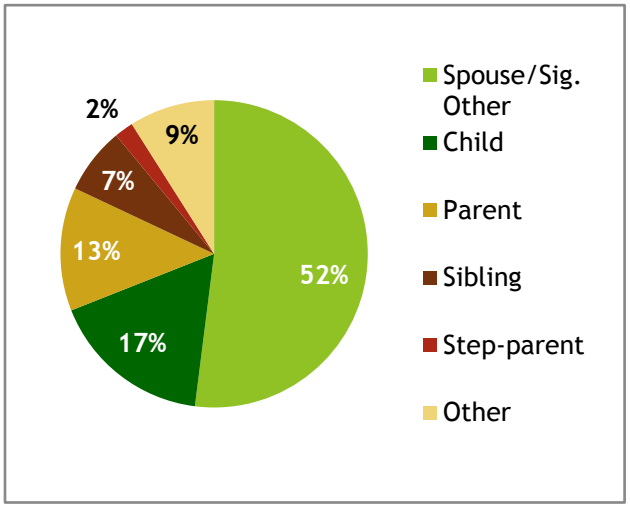
Data were available at Intake from a total of 436 AI clients. Most (94%) were served in outpatient (n=411). The remaining 6% of clients received treatment from PGTI across both English/Spanish (n=14) and Asian (n=11) language programs. The number of Outpatient treatment sessions AIs attended ranged from 0 to 13. AI attendance in Outpatient was strong during the primary treatment sessions (sessions 1-5). For those who needed additional treatment (35%), additional treatment was available after session 5 (**Figure 21**).

FIGURE 21 OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Of the 411 outpatient AI clients, over half (52%) identified as a spouse or significant other, 17% as a child of, and 13% as a parent of a gambler (**Figure 22**).

FIGURE 22. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

The average age of Outpatient AI clients was 47 years. Affected individuals are mostly female (74%), whereas a majority of gambler clients are male. Half of outpatient AI clients reported their race/ethnicity as White, followed by Hispanic/Latino (20%), Asian/Pacific Islander (18%), African American (4%), American Indian/Alaska Native (2%), and another race/ethnicity (6%). 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 10**).

TABLE 10. OUTPATIENT AI: DEMOGRAPHICS

FY 2015-16	(N=411)
Age	n=411
Mean Age	47 years old
Gender	n=411
Male	26%
Female	74%
Race/Ethnicity	n=400
White	50%
Asian/Pacific Islander	18%
Hispanic/Latino	20%
African American	4%
American Indian/Alaskan Native	2%
Another race/ethnicity	6%
Education	n=408
Less than High School	5%
High School	16%
Some College	35%
Bachelor's Degree	25%
Graduate/Professional Degree	19%
Household Income	n=408
Less than $10,000	8%
$10,000-$14,999	2%
$15,000-$24,999	9%
$25,000-$34,999	10%
$35,000-$49,999	12%
$50,000-$74,999	17%
$75,000-$99,999	12%
$100,000-$149,999	14%
$150,000-$199,999	7%
$200,000 or more	4%
Decline to State	5%

Treatment Service Findings

Intake to End-of-Treatment Outcomes

As seen in **Table 11**, 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). [6]

TABLE 11 OUTPATIENT AI: INTAKE TO END-OF-TREATMENT OUTCOMES

	Intake Mean	End of Treatment Mean
Depression (PHQ-9) score	8	5
Life satisfaction	56	61
Degree to which problem gambler's behaviors have interfered with normal activities	53	35
Feel responsible for gambler's treatment and recovery	36	25

Note: Intake N=406, EOT N=187.

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 AIs included: obesity, hypertension, and diabetes. The percentage of Outpatient AIs reporting smoking continued a steady decline in the current fiscal year: from 17% in FY 2012-13 to 9% in FY 2015-16.

Also of note was the lower percentage of Outpatient AIs who reported current smoking (43%) relative to Outpatient gamblers (52%). Similar to past years, in FY 2015-16 nearly 75% of outpatient affected individuals rated their health as good to excellent at intake.

In regard to co-occurring psychiatric disorders, 24% of Outpatient AI clients reported mood disorders, 14% reported anxiety disorders, 3% reported attention deficit disorders, and 3% reported substance abuse disorders.

[6] It should be noted that the 187 clients assessed at EOT are a subset of the 406 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.

Table 12, 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 attempts) for the 549 gamblers who agreed to follow-up during FY 2015-16. The numbers differ slightly from DMS data because they are based on call logs. UGSP made over 1,400 attempts to reach clients for follow-up interviews; completing 263 interviews, and ultimately closing 253 cases when clients were unable to be reached. It should be noted that cases are closed after 3 attempts at a particular follow-up point, but attempts to reach an individual begin anew at the next time point.

TABLE 12. 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
Attempted	344	149	**493**	388	124	**512**	315	97	**412**	1047	370	**1417**
Completed	82	26	**108**	73	23	**96**	44	15	**59**	199	64	**263**
Closed	47	23	**70**	73	19	**92**	67	24	**91**	187	66	**253**

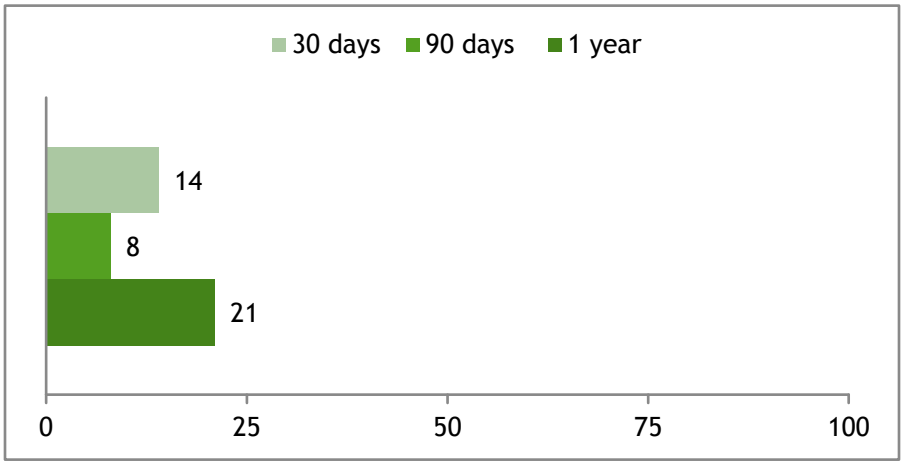
Note: G = Gamblers, AI = Affected individuals

Follow-up results are presented below for the two largest groups of gamblers receiving treatment: Outpatient gamblers and English/Spanish PGTI gamblers. During FY 2015-16, BDA 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, the intensity of their urges to gamble, their overall life satisfaction, and their level of depression. During the post-treatment period, the degree to which gambling interfered with clients' normal activities, on average, remained low (**Figure 23**).

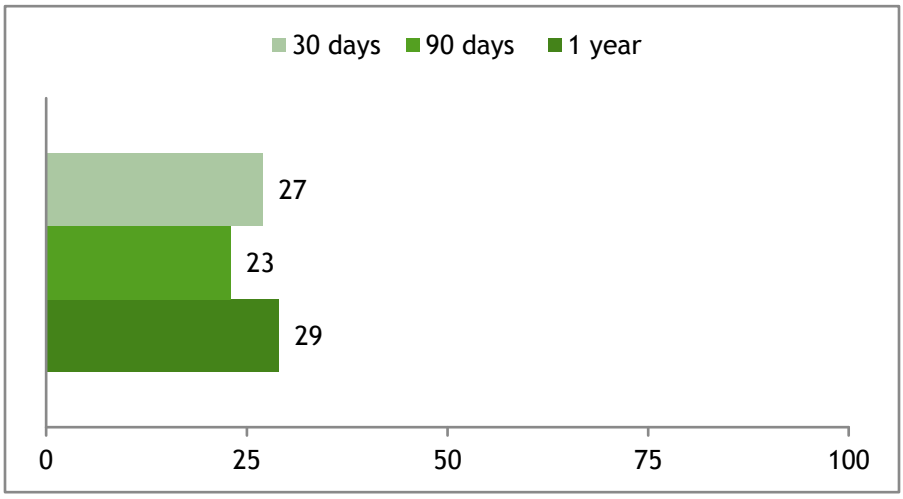
FIGURE 23. OUTPATIENT GAMBLER: GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT FOLLOW-UP



Note: 30 days N=80, 90 days N=57, 1 year N=39.

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 24**).

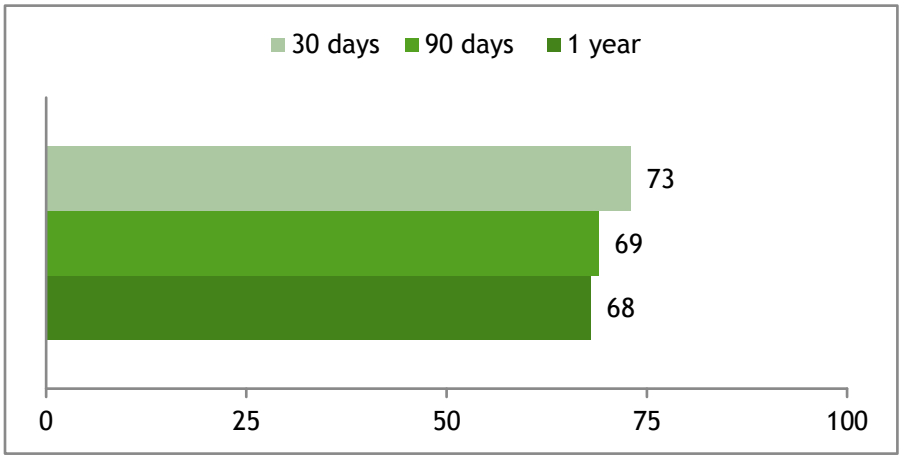
FIGURE 24. OUTPATIENT GAMBLER: INTENSITY OF GAMBLING URGE AT FOLLOW-UP



Note: 30 days N=80, 90 days N=57, 1 year N=39.

Clients' average overall life satisfaction remained relatively unchanged (**Figure 25**). As above, life satisfaction was measured on a 100-point scale.

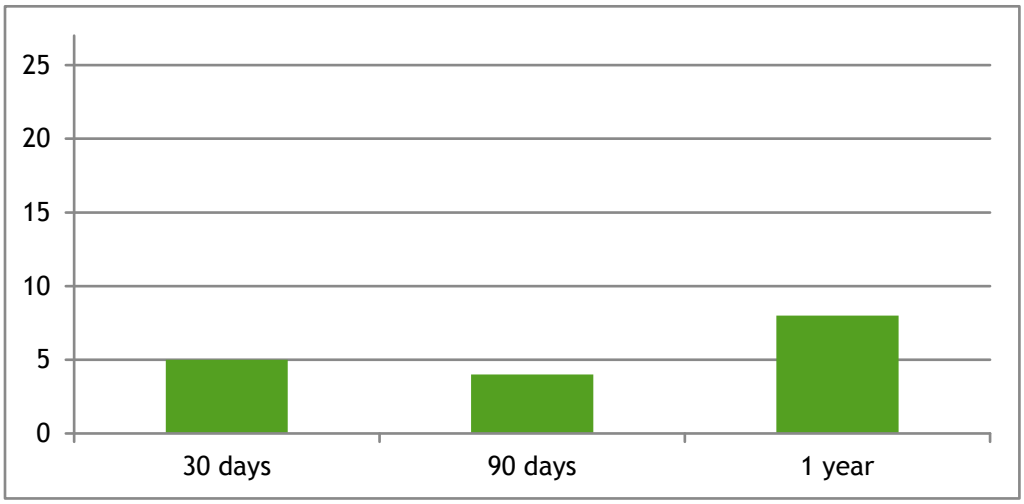
FIGURE 25. OUTPATIENT GAMBLER: OVERALL LIFE SATISFACTION SCORES AT FOLLOW-UP



Note: 30 days N=80, 90 days N=57, 1 year N=39.

As shown in **Figure 26**, the average depression (PHQ-9) score was 5 at 30 days post-treatment, indicating mild depression. At the one-year follow-up, the depression score was 8, still within the mild depression range.

FIGURE 26. OUTPATIENT GAMBLER: MEAN PHQ-9 DEPRESSION SCORE AT FOLLOW-UP



Gamblers: English/Spanish PGTI Follow-up Results

BDA 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 17 people interviewed, 47% had not gambled in the past 30 days.
- 90-day interviews: Of the 26 people interviewed, 23% had not gambled in the past 30 days.
- 1-year interviews: Of the 14 people interviewed, 43% had not gambled in the past 30 days.

As shown in **Table 13**, 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 13. ENGLISH/SPANISH PGTI GAMBLER (BDA MORNEAU SHEPELL): MEAN SCORES FOR QUALITY OF LIFE VARIABLES BY FOLLOW-UP POINT

	30 Day (N=17)	90 Day (N=25)	1 Year (N=13)
Overall life satisfaction	65	71	62
Craving strength	58	57	48
Amount of control over gambling	78	63	67

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 67 gambler clients offering comments on their treatment program, 53 had positive comments, 13 had negative comments, and 1 was neutral. 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.

Of the 27 affected individuals who provided feedback, 25 offered positive and 2 offered negative comments about their treatment experiences. In general, those with positive comments found the services helpful, particularly in understanding problem gambling. Many also had positive comments about the therapists. Two participants commented that they did not find the treatment 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.

Engaging Healthcare Paraprofessionals in Screening and Referring Problem Gamblers

During FY 2015-16, this clinical innovations project involved work with paraprofessionals such as sober coaches, suicide prevention specialists, and psychiatric technicians. The goals of this project were to: (a) raise awareness of the CalGETS program; (b) increase referrals to CalGETS; and, (c) develop ongoing professional relationships with healthcare paraprofessionals. After determining that psychiatric technicians were not appropriate to work with due to their limited scope of practice, work moved forward on collaborations with sober companions and suicide-prevention specialists.

Sober Companions

Three focus groups with sober companions were held in FY 2015-16. These sober companions were recruited from Connections in Recovery, a service providing addiction and mental health consulting and support services. Each focus group involved eight individuals, for a total of 24 focus group participants. The focus groups were designed to gather information about sober companions' knowledge about problem gambling and awareness of treatment resources for problem gambling. After the focus groups, sober companions were provided with a one-hour overview of gambling disorder and CalGETS programming and were also encouraged to attend the OPG's Problem Gambling Training Summit. Four key themes emerged from the focus groups: (a) gambling disorder is an addictive disorder yet training among substance abuse programs is lacking; (b) there should be standardized training to increase understanding and to facilitate working with behavioral addictions for sober companions; (c) there is a need for training in handling "real-world" situations (e.g., what if a gambler wants to buy a lottery ticket, what if a gambler asks the sober companion to hold their paycheck to prevent them from gambling with it, etc.); and, (d) none of the sober companions had experience working with gambling disorder.

Suicide-prevention Paraprofessionals

Suicide prevention helpline programs were interested in providing links to training videos on suicide and gambling problems for their personnel; however, it was determined that a one-hour in person training on gambling disorder was not feasible given less than 1.5% of suicide prevention helpline callers reported their suicidal ideation was due to a gambling problem. During FY 2015-16, UGSP developed a training video on suicide prevention and gambling disorder for use by lay-persons, paraprofessionals (e.g., suicide help-line workers), and CalGETS providers.

Sleep Hygiene

Also during FY 2015-16, in response to providers' requests for a tool to address clients' sleep problems, UGSP developed a handout on sleep hygiene (good sleep habits) and gambling disorders for use by clients and CalGETS providers. UGSP researched and summarized current sleep hygiene best practices. The relationship between sleep hygiene and gambling disorder is an example of the relationship between gambling disorder and physical health, in general, and the importance of addressing both mental health and physical health in while working with clients.

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