# ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2017-18

*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 2017-18

## Contents

# EXECUTIVE SUMMARY

## Overview

California Gambling Education and Treatment Services (CalGETS) is a statewide program for clients with problem gambling and affected individuals (AIs) (family members and friends affected by someone with problem gambling). Over 1,600 individuals received treatment through CalGETS in fiscal year (FY) 2017-18. 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 13,900 individuals have received treatment through the program to address the harmful impacts of problem gambling. CalGETS provides treatment to a broad spectrum of gamblers and AIs. Treatment is provided via a range of treatment modalities in the Treatment Services Network and is available in a variety of languages. At follow-up, CalGETS clients report improved quality of life and satisfaction with the treatment services.

## Provider Treatment Services Network

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

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

## CalGETS Providers: A Diverse and Skilled Workforce

- CalGETS trains, authorizes, provides clinical guidance, and oversees 260 licensed mental health providers (with an average of 6.8 years of experience treating gambling), as well as oversees six treatment programs, all engaged in delivering evidenced-based treatment to gamblers and AIs.
- Treatment services are available in 30 languages/dialects.

## CalGETS Treatment Outcomes (FY 2017-18)

### *Gamblers:*

- 1181 gamblers received treatment across the treatment network. Three-quarters (74%) received outpatient services, 16% were served in PGTI (15% in English/Spanish and 1% 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 last treatment contact decreased by an average of 15 to 27 points (depending on treatment modality) on a self-reported 100-point scale.

- The degree to which clients perceived that gambling interfered with normal activities decreased on a 100-point scale by an average of 16 to 44 points (depending on treatment modality) between Intake and last treatment contact.
- Life satisfaction as measured by a self-reported 100-point scale increased from Intake to last treatment contact by an average of 12 to 27 points (depending on treatment modality).
- By the end of CalGETS treatment client levels of depression, on average, improved substantially.

**CalGETS GAMBLER CHARACTERISTICS AT INTAKE: HEALTH AND WELLNESS**

| | |
|---|---|
| **Medical problems** | The most common co-occurring health conditions of CalGETS clients are hypertension, obesity, and diabetes. |
| **Smoking** | Among CalGETS outpatient clients, 24% currently smoke. This percentage is down from last year, but is more than twice the state average. In the residential treatment setting, the prevalence rate of smoking is 42%. |
| **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 binge drinking in the past month (Centers for Disease Control and Prevention [CDC]). |
| **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, 13-48% of CalGETS clients use marijuana. |
| **State of Health** | According to the CDC, 18% of adults in California reported their health as "fair or poor" in 2015. In comparison, about 34% of gamblers across the treatment network reported their health as "fair or poor." |
| **Health Insurance** | About 80% of all CalGETS clients reported having health insurance, but less is known about their costs to maintain insurance, including premiums and deductibles. |
| **Access to Health care** | At least 70% of CalGETS clients (except RTP clients at 63%) reported they currently have a physician they can access for primary care needs. |
| **Depression** | 26% of CalGETS outpatient clients scored in the moderately severe to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 17% of adult Californians reporting any depression diagnosis (CDC). |

### *Affected Individuals:*

- 364 AIs received treatment across the treatment network.
- AIs are spouses/significant others (51%), children (20%) or parents (10%) of gamblers; and 79% of AIs are female.
- During treatment, the degree to which AIs report that the problem gambler's behaviors interfered with normal activities and the degree to which they feel responsible for the gambler's treatment and recovery both improved (decreased), depression decreased, and life satisfaction increased.

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

## Client Follow-up

Post-treatment follow-up interviews are designed for program evaluation and to assess the impact of treatment. UGSP added staff and completed 512 post-treatment telephone interviews. Results show that both gamblers' and AIs' improved quality of life sustained over time and that treatment participants are generally satisfied with treatment providers.

## Clinical Innovations

Housed within UGSP, these projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. 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 during FY 2017-18.

# 1. CalGETS PROGRAM STRUCTURE

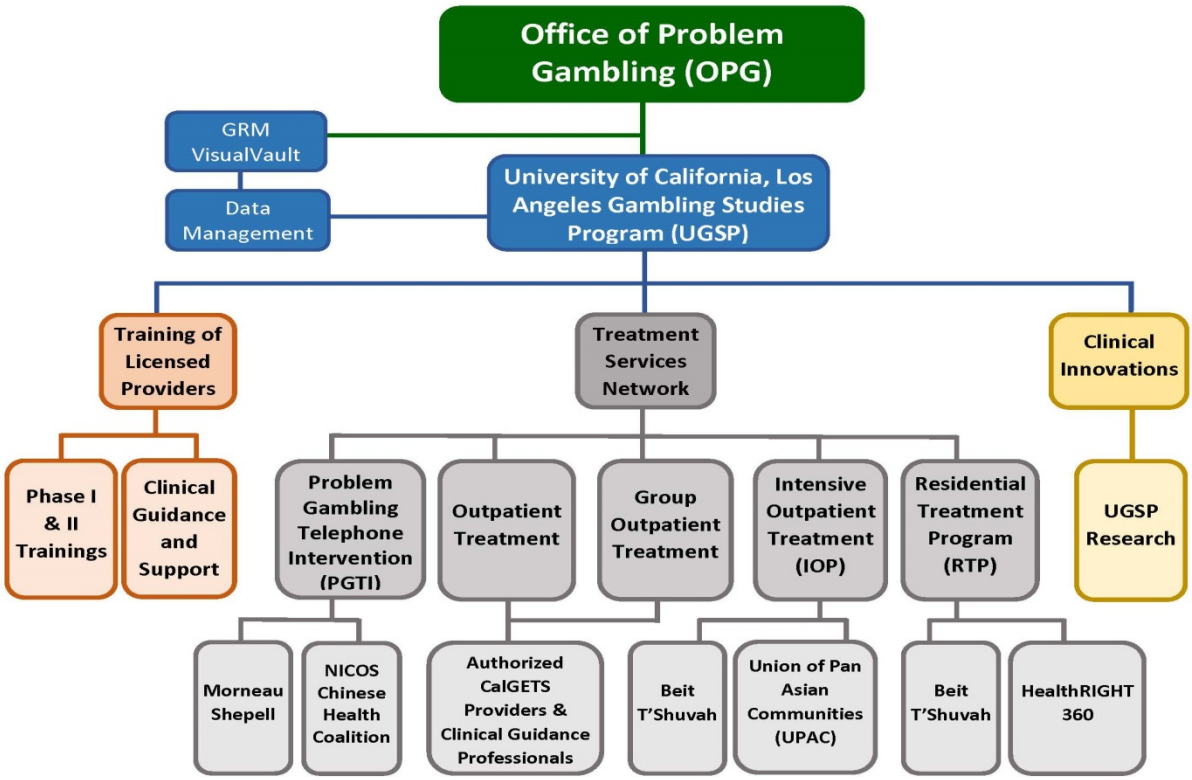
## Introduction

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

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

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

**FIGURE 1. CalGETS COLLABORATIVE MODEL**




## Training of Licensed Providers

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

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

## Treatment Services Network

The Treatment Services Network offers a continuum of evidenced-based services to individuals with gambling disorders and to those affected by someone with gambling disorder. These services are offered at no cost to California residents and treatment is available in 30 languages/dialects. Within the Treatment Services Network, the following treatment services are offered:

**Outpatient (Individual and Group).** Gamblers and AIs may receive up to three treatment blocks of eight face-to-face sessions from the authorized CalGETS provider network. Licensed providers use their own clinical experience and treatment philosophies, along with CalGETS training to provide evidence-based services. During FY 2017-18, there were 260 active, authorized CalGETS providers, offering services in over 30 languages and dialects. Gamblers and AIs may also receive 24 in-treatment group sessions. This does not include the mandatory individual screening prior to attending group in-treatment sessions or the individual end-of-group session. Group treatment sessions may be comprised of a mixture of gamblers and AIs, and must include 3-10 participants. 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 IOP care. Beit T'Shuvah Right Action Gambling Program in Los Angeles and Union of Pan Asian Communities (UPAC) in San Diego currently provide IOP services three hours per day, three times per week to clients requiring more intensive services. Services include individual, group, and family counseling.

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

**Problem Gambling Telephone Intervention (PGTI).** Gamblers and AIs may receive up to three treatment blocks of eight sessions in the PGTI program. Telephone intervention allows access to treatment services for clients who may be disabled, lack transportation, or live in rural areas of the state where outpatient services are not available. 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 AIs throughout California.

# 2. FY 2017-18 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 Information Management Services/VisualVault servers and are available to designated analysts at GRM, OPG, and UGSP to run reporting functions on the data in the system. During FY 2017-18, all providers entered their data into the DMS.

## Instruments

### *Gamblers*

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

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

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

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

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

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

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

### *Affected Individuals (AIs)*

**PHQ-9**: See Above.

**Life Satisfaction**: See Above.

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

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

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

## Analyses

It should be noted that during FY 2017-18 some issues may have impacted data collection and/or reporting. These issues include:

- 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) that have been addressed in analysis, but, due to the complexity of the database programming cannot be completely resolved.

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

Outpatient treatment is offered in blocks of eight sessions, and IOP and RTP are offered in 30-day treatment blocks. Clients may discontinue treatment at any time, not just at the end of a scheduled treatment block. This means the "dose" of treatment a client receives may vary not only by the type of treatment they participate in, but also in how long they chose to participate. To ensure we capture data about clients as they leave treatment (Last Treatment Contact), we utilize data from the End of Treatment (EOT) form, or, from the client's last In-Treatment form when an EOT form is not available. It should be noted that 90 Outpatient cases had an Intake as their only treatment visit and were eliminated from the Intake to Last-Treatment-Contact comparisons. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Version 24. Data distributions were examined and, if necessary, extreme outliers were trimmed to reduce the effect of possibly spurious values.

# 3. CalGETS PROVIDERS AND TRAINING

Trained CalGETS providers deliver treatment services through the Treatment Services Network. Clients are referred to the network from a number of sources including problem gambling helplines (1-800-GAMBLER and, specifically serving Asian languages, 1-888-968-7888[2]), UGSP or OPG websites, health care professionals, outreach campaigns, providers' websites, information provided at gambling venues, and other sources. CalGETS providers are mental health professionals who are trained to ensure that high quality services are available for individuals seeking treatment. In addition to clinical training on the treatment of gambling disorder, CalGETS providers receive training on program quality assurance (i.e., specifying timelines for providers to make contact and meet with referrals, determining client eligibility according to CalGETS criteria, collecting and completing all required forms, referring clients to other programs and services if clinically indicated, and providing culturally and linguistically appropriate services).

In FY 2017-18, UGSP and OPG conducted Phase II trainings in August and September of 2017, and April and May of 2018.

Shortly after the close of FY 2017-18, UGSP conducted a survey with all active CalGETS providers to obtain information on provider characteristics and experiences with CalGETS (2018 Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2018, unless given an exemption. The Treatment Services Network had 260 licensed providers who were authorized to provide services to gamblers and AIs at some point during the 2017-18 fiscal year; the responses of 221 of these providers who remained active or decided to participate after suspension or termination are included in the 2018 Provider Survey. **Table 1** details the number of clinicians and providers who completed Phase II training during FY 2017-18. Additionally, CalGETS clinical supervisors delivered 49 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

**TABLE 1. CalGETS TRAINING**

| | FY 2017-18 |
|---|---|
| Training | |
| Licensed mental health clinicians who completed Phase I | N/A |
| Licensed mental health clinicians who completed Phase I and became authorized providers | N/A |
| Authorized providers who completed Phase II | 78 |

Providers' demographic information is provided below (**Table 2**). Providers were primarily female, and reported their race/ethnicity as: 66% White, 13% Asian, 8% Hispanic/Latino, and 7% Black/African American.

[2] Now discontinued, as of July 1, 2018, Asian language services are provided through 1-800-GAMBLER.

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

| | FY 2017-18 |
|---|---|
| Gender | n=221 |
| Female | 76% |
| Male | 24% |
| Race/Ethnicity | n=221 |
| White | 66% |
| Asian | 13% |
| Hispanic/Latino | 8% |
| Black/African American | 7% |
| Multiracial | 2% |
| Native Hawaiian/Pacific Islander | <1% |
| Choose not to designate or Other | 5% |

The data on CalGETS providers indicates that they are experienced mental health providers. On average, providers who completed the survey had been licensed for 14.5 years and had treated individuals with gambling disorder for an average of 6.8 years. In FY 2017-18, 72% of providers were Licensed Marriage and Family Therapists (LMFT), 15% were Licensed Clinical Social Workers (LCSW), 9% were Psychologists (PhD), 4% were Clinical Psychologists (PsyD), and 1% had other clinical degrees (Licensed Professional Clinical Counselor, Research Psychologists). CalGETS providers reach clients for whom English is not their primary language - 23% reported providing treatment services in languages other than English. Of those, 47% indicated that they provided services in Spanish, 39% provided services in an Asian language, and 18% provided services in other languages; including Arabic, Armenian, Hebrew, Persian, and Russian (these total over 100% because some providers offered services in multiple languages in addition to English). Almost two-thirds (62%) of CalGETS providers offered educational materials in languages other than English.

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

- Phase I Training (81%)
- Phase II Training (70%)
- Clinical Guidance and Support (52%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 96% 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 2017-18.

## Treatment Service Provision

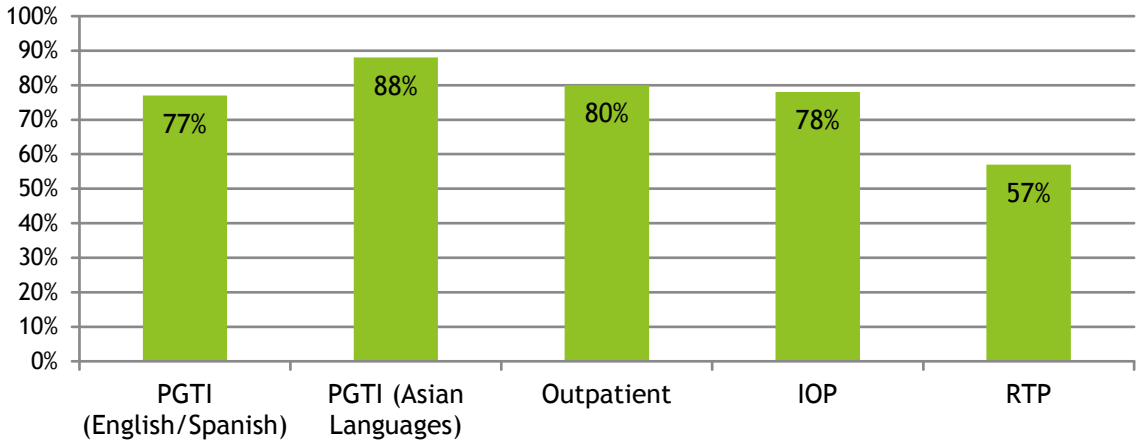
In FY 2017-18, a total of 1,181 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (74%) enrolled in Outpatient, followed by PGTI (16%), RTPs (5%), and IOPs (4%). Of these clients, 3% also participated in Outpatient Group services.

**TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED**

| | N | Percentage |
|---|---|---|
| Outpatient | 876 | 74% |
| *Outpatient Group* | *39* | *3%* |
| Intensive Outpatient Program (IOP) | 49 | 4% |
| Residential Treatment Programs (RTP) | 61 | 5% |
| Problem Gambling Telephone Intervention (PGTI) (English/Spanish languages) | 179 | 15% |
| PGTI (Asian languages) | 16 | 1% |
| Total[3] | 1,181 | 99% |

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. Compared to the California population, White, Non-Hispanics are over-represented and 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 (for those reporting a single category only) | Outpatient N = 872[4] | IOP N = 49 | RTP N = 61 | PGTI English/ Spanish N = 178[5 6] | Total N = 1176 | CA Population[7] N = 39,536,653 |
|---|---|---|---|---|---|---|
| White, Non-Hispanic only[8] | 46% | 49% | 57% | 44% | 45% | 27% |
| Black or African American only | 10% | 6% | 16% | 10% | 10% | 7% |
| American Indian/Alaskan Native only | 1% | 0% | 3% | 0% | 1% | 2% |
| Asian/Pacific Islander only | 17% | 16% | 3% | 17% | 17% | 16% |
| Hispanic or Latino only | 15% | 10% | 7% | 22% | 16% | 39% |
| Other race/ethnicity only | 5% | 4% | 3% | 3% | 5% | - |
| Multiracial or Multi-ethnic[9] | 7% | 14% | 10% | 4% | 7% | - |
| **Race/Ethnicity (for those reporting single AND multiple categories)** | | | | | | |
| White, Non-Hispanic only or with another race/ethnicity[10] | 49% | 55% | 62% | 46% | 49% | |
| Black or African American only or with another race/ethnicity | 11% | 10% | 18% | 11% | 11% | |
| American Indian/Alaskan Native only or with another race/ethnicity | 2% | 0% | 3% | 0% | 1% | |
| Asian/Pacific Islander only or with another race/ethnicity | 19% | 27% | 5% | 17% | 19% | |
| Hispanic or Latino only or with another race/ethnicity | 19% | 18% | 15% | 25% | 19% | |
| Other race/ethnicity only or with another race/ethnicity | 7% | 4% | 7% | 5% | 7% | |

[4] Four cases from the Outpatient program for gamblers were missing race/ethnicity data.

[5] One case from the PGTI English/Spanish program for gamblers was missing race/ethnicity data.

[6] Only PGTI English/Spanish is reported in this table because all clients served in the PGTI Asian Language program (N=16) reported Asian or Pacific Islander ethnicity. The 16 NICOS PGTI clients were included in the count for total API individuals served during the 2017-18 fiscal year.

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

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

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

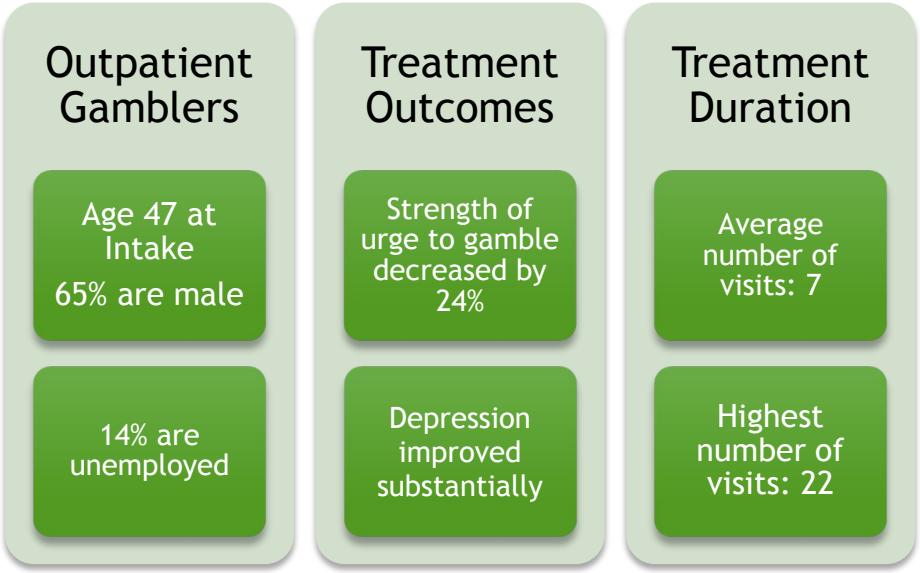
[10] "Only or with another race/ethnicity" categories specify the percentage of respondents who identify with each ethnic or racial designation, whether alone or in combination with other ethnic or racial designations.

## Treatment Service Findings

### Outpatient

*Individual Outpatient*

**FIGURE 3. OUTPATIENT SNAPSHOT**




As shown earlier in Table 3,[11] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 876 clients who enrolled in outpatient. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2017-18, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (33%), family/friends (13%), Gamblers Anonymous/Gam-Anon (11%), former clients (8%), health care professionals (7%), the OPG website (5%), and the California Council on Problem Gambling (4%). In addition, 15% cited other sources including Internet searches that yielded the CalGETS website, treatment providers' websites, or the Psychology Today referral website. The number of sessions completed by outpatient gambler clients (n=876) varied:

- 14% of clients had only an Intake session
- 58% received 1-8 treatment sessions
- 17% received 9-16 treatment sessions
- 12% received 17-22 treatment sessions

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

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

### *Demographics*

Outpatient clients had an average age of 47 years and two-thirds (65%) were male. Less than half of clients identified their race as White, Non-Hispanic only (46%), or with another race/ethnicity (49%); followed by 17% reporting Asian/Pacific Islander only, or 19% with another race/ethnicity; 15% Hispanic/Latino only, or 25% with another race/ethnicity; 10% African American only, or 11% with another race/ethnicity; 5% another race/ethnicity only, or 7% with an additional race/ethnicity; 7% Multiracial/Multi-ethnic; and 1% American Indian/Alaskan Native or 2% with an additional race/ethnicity. Clients are, for the most part, well-educated – more than three-quarters reported completing some college or above. The reported household income varied widely from less than $15,000 per year to over $200,000 (**Table 5**).

**TABLE 5. OUTPATIENT GAMBLER: DEMOGRAPHICS**

| FY 2017-18 | (N=876) |
|---|---|
| Age | n=876 |
| Mean Age | 47 years old |
| Gender | n=876 |
| Male | 65% |
| Female | 35% |
| Race/Ethnicity (for those reporting a single category only) | n=872 |
| White, Non-Hispanic only | 46% |
| Asian/Pacific Islander only | 17% |
| Hispanic or Latino only | 15% |
| Black or African American only | 10% |
| American Indian/Alaskan Native only | 1% |
| Other race/ethnicity only | 5% |
| Multiracial or Multi-ethnic | 7% |
| Race/Ethnicity (for those reporting single AND multiple categories) | |
| White, Non-Hispanic only or with another race/ethnicity | 49% |
| Asian/Pacific Islander only or with another race/ethnicity | 19% |
| Hispanic or Latino only or with another race/ethnicity | 19% |
| Black or African American only or with another race/ethnicity | 11% |
| American Indian/Alaskan Native only or with another race/ethnicity | 2% |
| Other race/ethnicity only or with another race/ethnicity | 7% |
| Education | n=874 |
| Less than High School | 4% |
| High School | 18% |
| Some College | 38% |
| Bachelor's Degree | 31% |
| Graduate/Professional Degree | 9% |
| Household Income | n=874 |
| Less than $15,000 | 9% |
| $15,000-$24,999 | 8% |
| $25,000-$34,999 | 9% |
| $35,000-$49,999 | 14% |
| $50,000-$74,999 | 17% |
| $75,000-$99,999 | 13% |
| $100,000-$149,999 | 14% |
| $150,000-$199,999 | 7% |
| $200,000 or more | 6% |
| Decline to state | 5% |

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

### *Gambling Severity*

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

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

| Severity | NODS Score | N | % |
|---|---|---|---|
| Problem gambling behavior | 1 to 3 | 20 | 2% |
| Mild gambling disorder | 4 to 5 | 58 | 7% |
| Moderate gambling disorder | 6 to 7 | 201 | 24% |
| Severe gambling disorder | 8 to 9 | 577 | 67% |

**Note:** Twenty outpatient gamblers had incomplete NODS data.

### *Gambling Behaviors*

At Intake, outpatient clients (n=876) 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 (84%).

Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines (51%), poker (41%), and blackjack (30%) were the most commonly selected gambling activities.

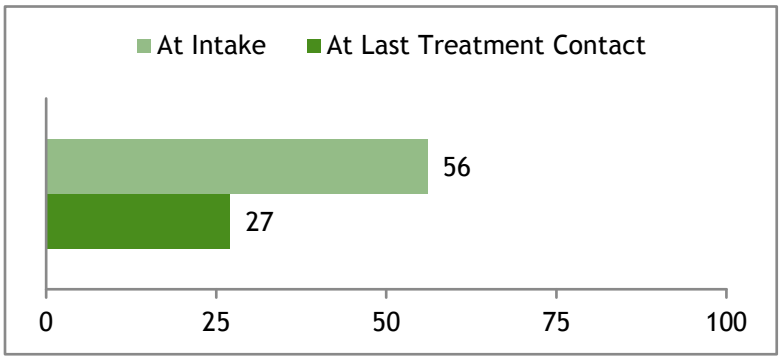
- At **tribal casinos,** clients most frequently stated that they played slot machines (46%), blackjack (29%), and poker (16%).
- At **other casinos,** clients most frequently reported playing slot machines (23%), blackjack (18%), and poker (12%).
- At **cardrooms,** clients most often reported playing poker (20%), and blackjack (19%).
- On the **Internet**, clients most often indicated playing poker (6%), slots (6%), and blackjack (4%).
- Finally, clients reported gambling on the Lottery (21%), sporting events (17%), and horse racing (6%).

### *Intake to Last Treatment Contact Outcomes (LTC)*

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

Outpatient clients reported less interference of gambling with their normal activities at last treatment contact compared to Intake. On a scale from 0-100, where higher scores indicate a greater impact of gambling on other activities, average scores decreased by 29 points from Intake to last treatment contact (**Figure 4**).

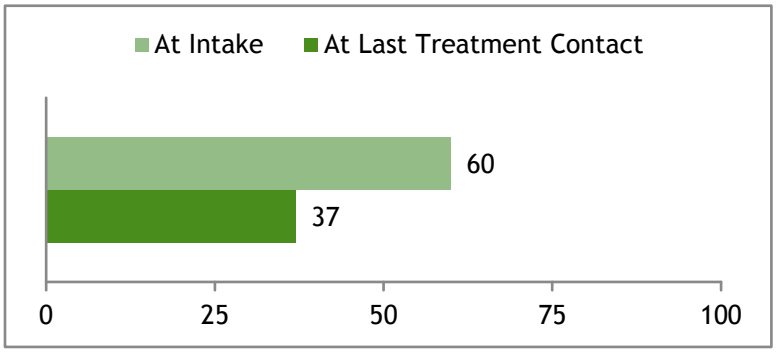
**FIGURE 4. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=851, LTC N=786.

Among outpatient clients, the average intensity of the urge to gamble from Intake to last treatment contact decreased by 23 points on the 100-point scale. Lower scores at last treatment contact indicated a less intense urge to gamble after receiving outpatient services (**Figure 5**).

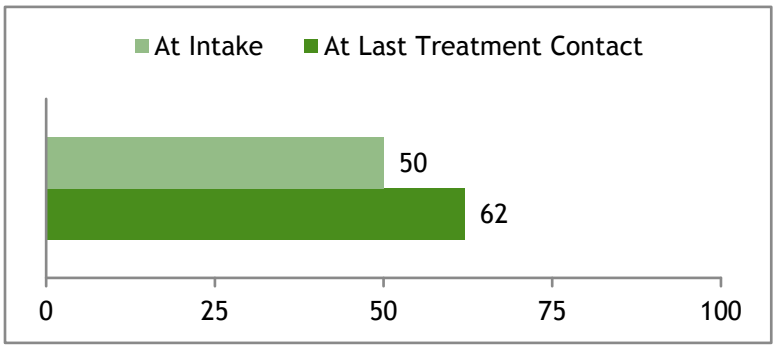
**FIGURE 5. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=855, LTC N=786.

Over the course of treatment, outpatient clients reported an improvement of 12 points on average in overall life satisfaction (**Figure 6**). As above, life satisfaction was measured on a 100-point scale.

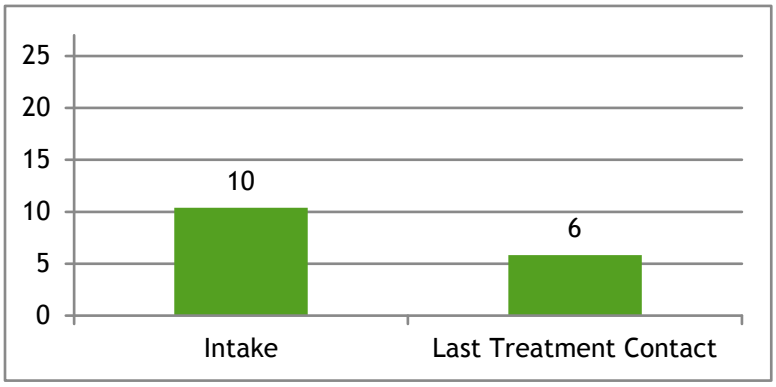
**FIGURE 6. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=857, LTC N=784.

During FY 2017-18, treatment participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment episode. Outpatient clients showed, on average, a considerable improvement in depression from moderate depression at Intake to mild depression at their last treatment session (**Figure 7**).

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




**Note:** Intake N=853, LTC N=786.

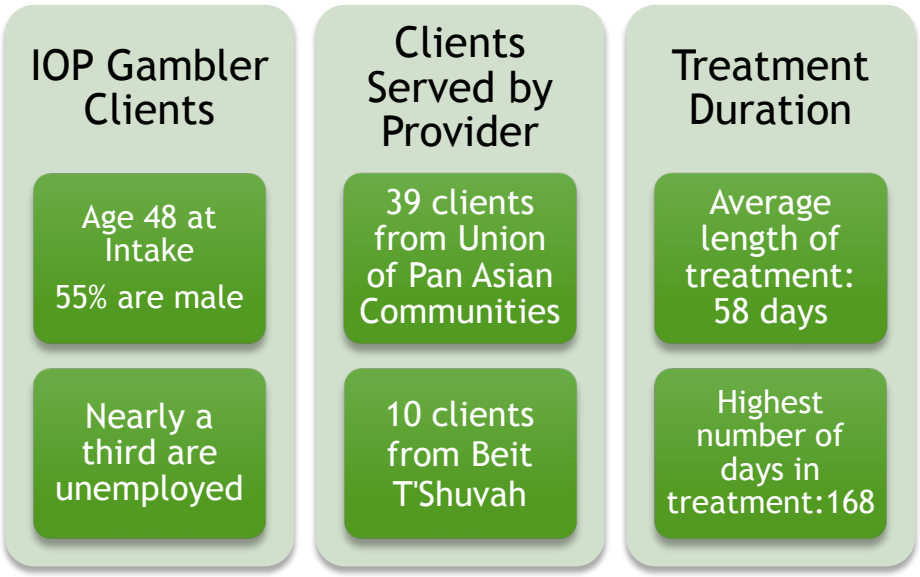
### *Group Outpatient*

A total of 54 clients participated in group treatment in FY 2017-18. Of these participants, 15 were AIs and 39 were gamblers. The average age was 44 years old and about 63% were male. The majority of group participants (70%) were referred to group by a CalGETS provider. Other referral sources included former CalGETS clients (22%), Gamblers Anonymous (6%), family/friends (4%), and health care professionals (4%). The primary types of gambling reported at group screening were black jack (43%), slot machines (28%), sports betting (10%), poker (8%), and roulette (3%). Casinos were the most frequently reported gambling venue (28%), followed by Tribal casinos (17%), and card rooms (13%). Twenty-two percent of group participants reported moderately severe to severe depression at screening. Follow up data were available for 14 group participants; 7 thirty-day surveys were completed, 6 ninety-day surveys, and 1 one-year follow-up. All group outpatient clients at each follow-up point reported no depression and had not gambled.

## Intensive Outpatient Program (IOP)

Data were available from 49 clients enrolled at Intake in IOP during FY 2017-18 (**Figure 8**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=39) or Beit T'Shuvah (N=10). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

**FIGURE 8. INTENSIVE OUTPATIENT PROGRAM SNAPSHOT**




### *Demographics*

A total of 49 clients entered IOP during FY 2017-18. IOP clients' average age was 48. About half (49%) identified as White, Non-Hispanic only, followed by 16% Asian/Pacific Islander only, 10% Hispanic/Latino only, 6% African American only, 4% as another race/ethnicity only, and 14% as Multiracial or Multi-ethnic. About half (55%) identified as White, Non-Hispanic only or with another race/ethnicity, followed by 27% Asian/Pacific Islander only or with another race/ethnicity, 18% Hispanic/Latino only or with another race/ethnicity, 10% African American only or with another race/ethnicity, and 4% as another race/ethnicity only or with an additional race/ethnicity. Like Outpatient clients, IOP clients have fairly high levels of education with 82% reporting some college education or higher. Although clients' household income varied from less than $15,000 per year to $200,000 or higher, 26% of IOP clients reported an income less than $35,000 and a quarter declined to state their household income.

### *Gambling Severity*

All IOP clients met criteria established in the DSM-5 for gambling disorder (100%). Specifically, 2% were classified with mild gambling disorder (endorsing 4-5 criteria), 14% with moderate gambling disorder (endorsing 6-7 criteria), and 84% with severe gambling disorder (endorsing 8-9 criteria).

### *Gambling Behaviors*

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

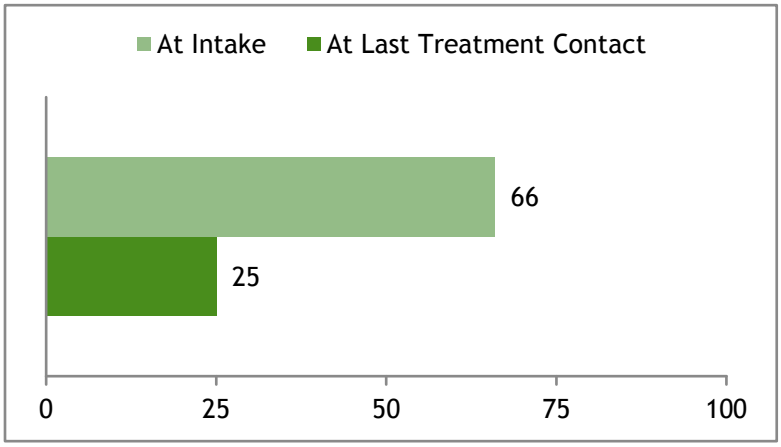
Across all venues the most commonly selected gambling activities were slot machines (61%), blackjack (35%), and poker (14%).

- At **tribal casinos,** IOP clients most frequently stated that they played slot machines (61%), blackjack (31%), and video poker (16%).
- At **other casinos,** clients most frequently reported playing slot machines (12%), blackjack (8%), and video poker (8%).
- At **cardrooms,** clients most often reported playing blackjack (6%) and poker (2%).
- On the **Internet**, clients most often indicated playing blackjack (6%) and poker (2%).
- Finally, clients reported gambling on sporting events (16%), the Lottery (12%), and stocks (4%).

### *Intake to Last Treatment Contact Outcomes*

Last treatment contact data are available on 45 of the 49 clients. IOP clients' reports of interference by gambling with their normal activities showed an average decrease of 41 points from Intake to last treatment contact (**Figure 9**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

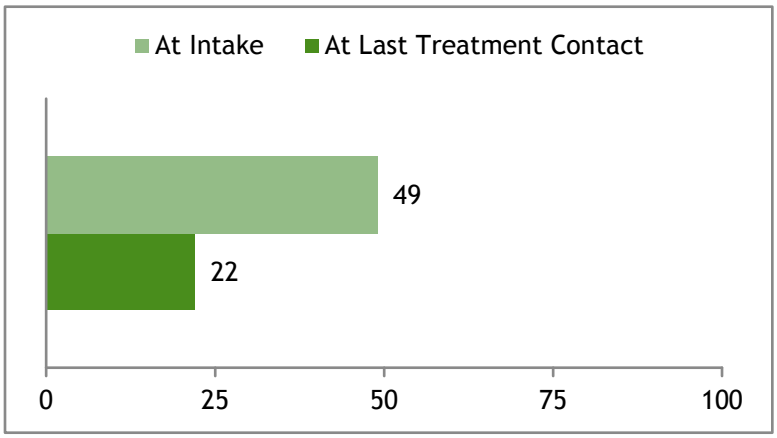
**FIGURE 9. IOP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=49, LTC N=45.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to last treatment contact by an average of 27 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble (**Figure 10**).

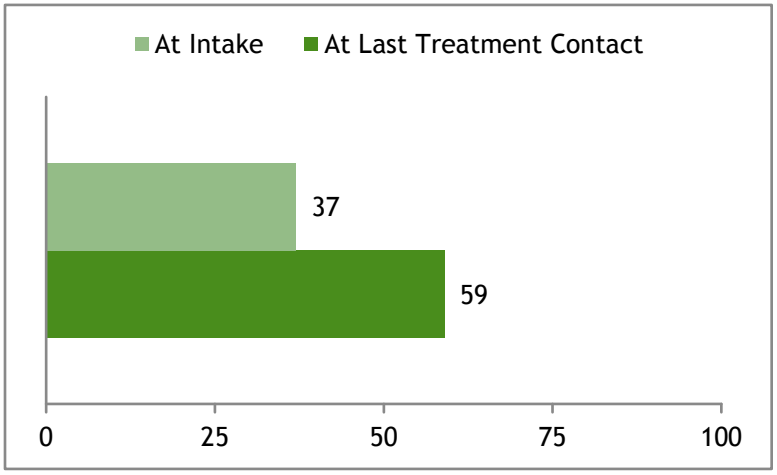
**FIGURE 10. IOP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=49, LTC N=45.

IOP clients entered treatment reporting life satisfaction scores similar to Outpatient clients. Over the course of treatment, IOP clients reported an improvement of 22 points on average in overall life satisfaction (**Figure 11**). As above, life satisfaction was measured on a 100-point scale.

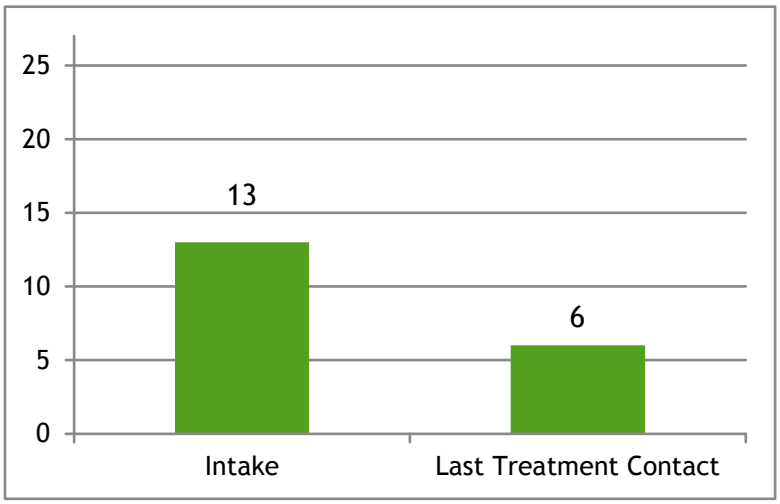
**FIGURE 11. IOP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=49, LTC N=45.

During FY 2017-18, IOP participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. They showed, on average, moderate depression at Intake and mild depression at their last treatment session (**Figure 12**).

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

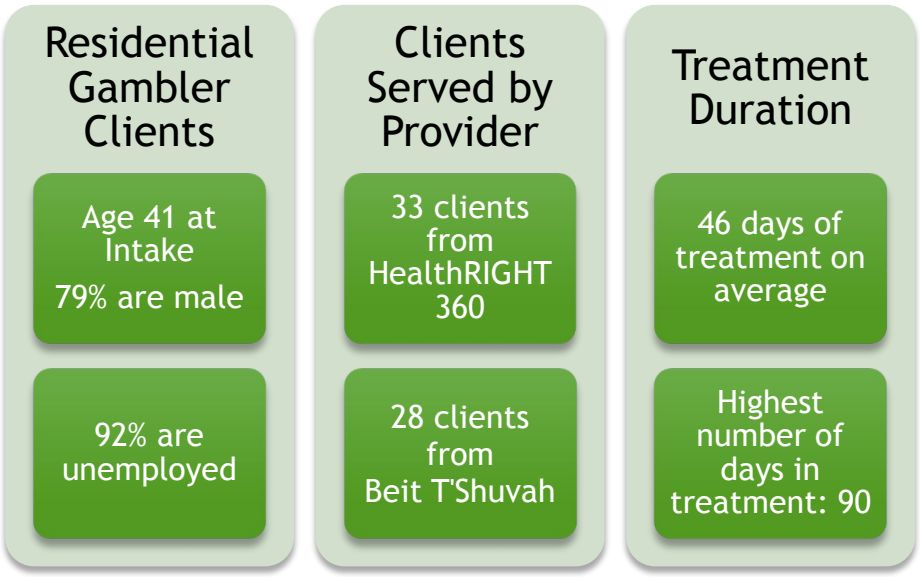



**Note:** Intake N=49, LTC N=45.

## Residential Treatment Programs (RTP)

Data were available from 61 clients enrolled at Intake in RTP during FY 2017-18 (**Figure 13**). Clients received treatment from either HealthRIGHT 360 (N=33) or Beit T'Shuvah (N=28). The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

**FIGURE 13. RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT**




### *Demographics*

About half (57%) identified as White, Non-Hispanic only, followed by 16% African American only, 7% Hispanic/Latino only, 3% Asian/Pacific Islander only, 3% American Indian or Alaskan Native only, 3% as another race/ethnicity only, and 10% as Multiracial or Multi-ethnic. About half (62%) identified as White, Non-Hispanic only or with another race/ethnicity, followed by 18% African American only or with another race/ethnicity, 15% Hispanic/Latino only or with another race/ethnicity, 7% as another race/ethnicity only or with an additional race/ethnicity, 5% Asian/Pacific Islander only or with another race/ethnicity, and 3% American Indian or Alaskan Native only or with 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 80% reporting that their income was less than $35,000 and 39% reporting income less than $15,000 per year.

### *Gambling Severity*

All clients enrolled in RTP treatment met DSM-5 criteria for gambling disorder.[12] Specifically, 8% were classified with moderate gambling disorder, and 92% with severe gambling disorder.

[12] One client had missing gambling severity data.

### *Gambling Behaviors*

RTP clients (n=61) 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 (88%).

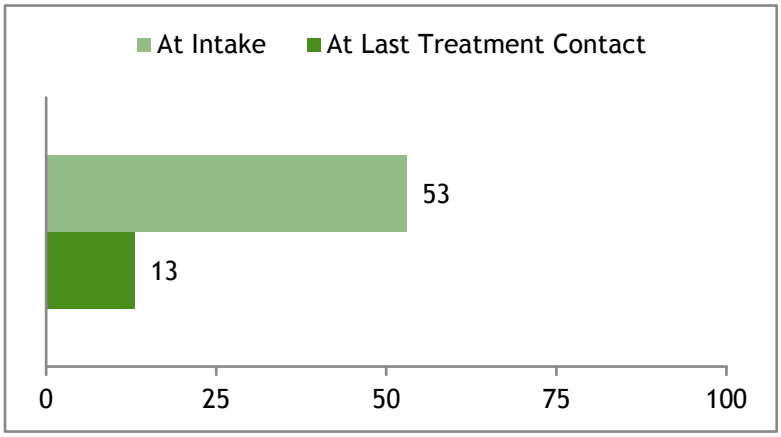
Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, slot machines, poker, blackjack, and the lottery were the most commonly selected gambling activities.

- At **tribal casinos,** clients most frequently stated that they played blackjack (47%), slot machines (43%), and poker (35%).
- At **other casinos,** clients most frequently reported playing blackjack (37%), slot machines (30%), and poker (22%).
- At **cardrooms,** clients most often reported playing blackjack (52%) and poker (39%).
- On the **Internet**, clients most often indicated playing slots (25%), blackjack (20%), and poker (18%).
- Finally, clients reported gambling on the Lottery (33%), sporting events (23%), horse racing (12%), and dice (12%).

### *Intake to Last Treatment Contact Outcomes*

Last treatment contact data are available on 60 of the 61 clients who entered residential treatment in FY 2017-18. By the end of treatment, the average rating of interference by gambling with normal activities decreased by 40 points among RTP clients (**Figure 14**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

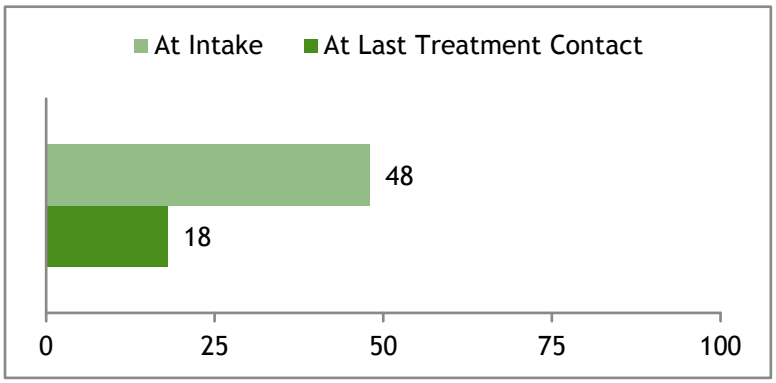
**FIGURE 144. RTP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=60, LTC N=60.

Among RTP clients, the intensity of the urge to gamble, on average, decreased from Intake to last treatment contact by 30 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble (**Figure 15**).

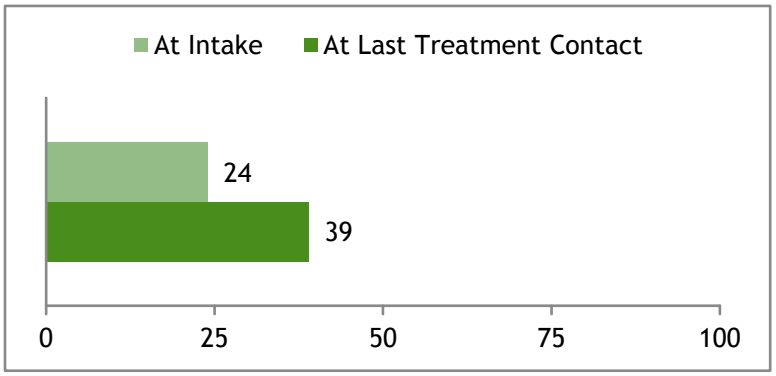
**FIGURE 15. RTP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=60, LTC N=60.

RTP clients entered treatment reporting lower life satisfaction scores than Outpatient clients. Over the course of treatment, RTP clients reported an improvement of 15 points on average in overall life satisfaction (**Figure 16**). As above, life satisfaction was measured on a 100-point scale.

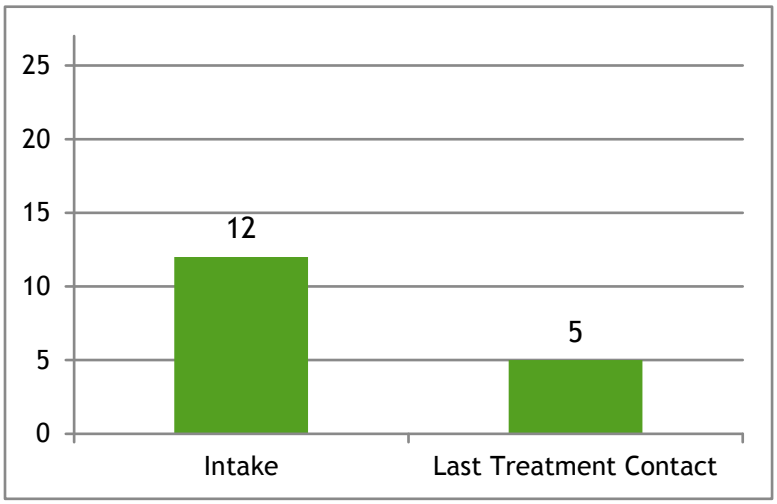
**FIGURE 16. RTP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** Intake N=60, LTC N=60.

During FY 2017-18, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and LTC. They showed, on average, a considerable improvement in depression from moderate depression at Intake to mild depression at last treatment contact (**Figure 17**).

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

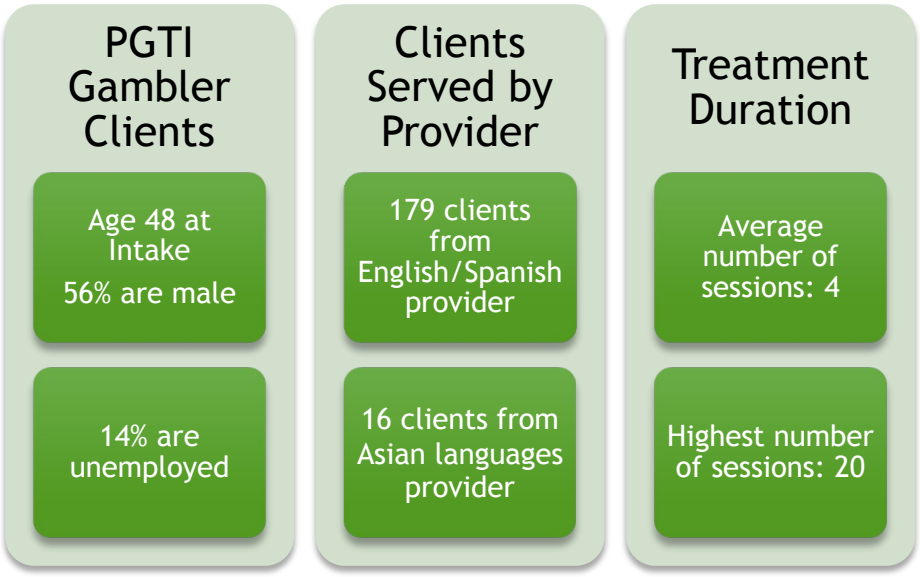



**Note:** Intake N=59, LTC N=59.

## Problem Gambling Telephone Intervention (PGTI)

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

**FIGURE 18. PGTI PROGRAMS SNAPSHOT**




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

Within PGTI, data were available for 195 gambler clients enrolled at Intake during FY 2017-18. A total of 179 clients received services in either English or Spanish languages from Morneau Shepell, and 16 clients received services in various Asian languages from NICOS. Of the 195 total clients assessed at Intake, 141 received further treatment services (126 from Morneau Shepell, 15 from NICOS).

Clients participating in English or Spanish language services (n=179) most often reported being referred by the Helpline (1-800-GAMBLER) (44%); the California Council on Problem Gambling (36%); family or friends (7%); or by casino signage (5%). Clients participating in Asian language services (n=16) were most frequently referred by media (including TV, radio, newspaper, bill board, 25%); family or friends (25%); the Helpline (13%); or by a former CalGETS client (13%).

Clients from the English and Spanish language services (n=126) participated in three treatment sessions on average, with a maximum of eight sessions in total. Clients served through the Asian languages service provider (n=15), NICOS, participated in 6 sessions on average, with a maximum of 20 sessions in total.

### *Demographics*

Gamblers in PGTI treatment were, on average, 48 years old and predominately male, with varying household incomes. Of English/Spanish clients, 44% were White, Non-Hispanic only, or 46% with another race/ethnicity; followed by 22% Hispanic/Latino only, or 25% with another race/ethnicity; 17% Asian/Pacific Islander only, or with another race/ethnicity; 10% African American only, or 11% with another race/ethnicity; 3% another race/ethnicity only, or 5% with an additional race/ethnicity; and 4% Multiracial/Multi-ethnic. All Asian language clients identified as Asian/Pacific Islander only and 38% had completed some college or more, compared to 65% of English/Spanish clients. (**Table 7**).

**TABLE 7. PGTI GAMBLER: DEMOGRAPHICS**

| FY 2017-18 | English/Spanish Language (N=179) | Asian Language (N=16) |
|---|---|---|
| Age | (n=179) | (n=16) |
| Mean Age | 48 years old | 48 years old |
| Gender | (n=179) | (n=16) |
| Male | 56% | 63% |
| Female | 44% | 38% |
| Race/Ethnicity (for those reporting a single category only) | (n=178) | (n=16) |
| White, Non-Hispanic only | 44% | 0% |
| Asian/Pacific Islander only | 17% | 100% |
| Hispanic or Latino only | 22% | 0% |
| Black or African American only | 10% | 0% |
| American Indian/Alaskan Native only | 0% | 0% |
| Other race/ethnicity only | 3% | 0% |
| Multiracial or Multi-ethnic | 4% | 0% |
| Race/Ethnicity (for those reporting single AND multiple categories) | | |
| White, Non-Hispanic only or with another race/ethnicity | 46% | 0% |
| Asian/Pacific Islander only or with another race/ethnicity | 17% | 100% |
| Hispanic or Latino only or with another race/ethnicity | 25% | 0% |
| Black or African American only or with another race/ethnicity | 11% | 0% |
| American Indian/Alaskan Native only or with another race/ethnicity | 0% | 0% |
| Other race/ethnicity only or with another race/ethnicity | 5% | 0% |
| Education | (n=178) | (n=16) |
| Less than High School | 3% | 25% |
| High School | 33% | 38% |
| Some College | 33% | 19% |
| Bachelor's Degree | 24% | 19% |
| Graduate/Professional Degree | 7% | 0% |
| Household Income | (n=178) | (n=16) |
| Less than $15,000 | 10% | 13% |
| $15,000-$24,999 | 9% | 6% |
| $25,000-$34,999 | 10% | 6% |
| $35,000-$49,999 | 15% | 44% |
| $50,000-$74,999 | 20% | 6% |
| $75,000-$99,999 | 12% | 19% |
| $100,000-$149,999 | 11% | 6% |
| $150,000-$199,999 | 3% | 0% |
| $200,000 or more | 6% | 0% |
| Decline to state | 3% | 0% |

### *Gambling Severity*

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

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

| | Severity | NODS Score | N | % |
|---|---|---|---|---|
| **English/Spanish Language PGTI (N=174)** | Problem gambling behavior | 1 to 3 | 13 | 8% |
| | Mild gambling disorder | 4 to 5 | 41 | 24% |
| | Moderate gambling disorder | 6 to 7 | 59 | 34% |
| | Severe gambling disorder | 8 to 9 | 61 | 35% |
| **Asian Language PGTI (N=16)** | Problem gambling behavior | 1 to 3 | 0 | 0% |
| | Mild gambling disorder | 4 to 5 | 0 | 0% |
| | Moderate gambling disorder | 6 to 7 | 6 | 38% |
| | Severe gambling disorder | 8 to 9 | 10 | 63% |

### *Gambling Behaviors*

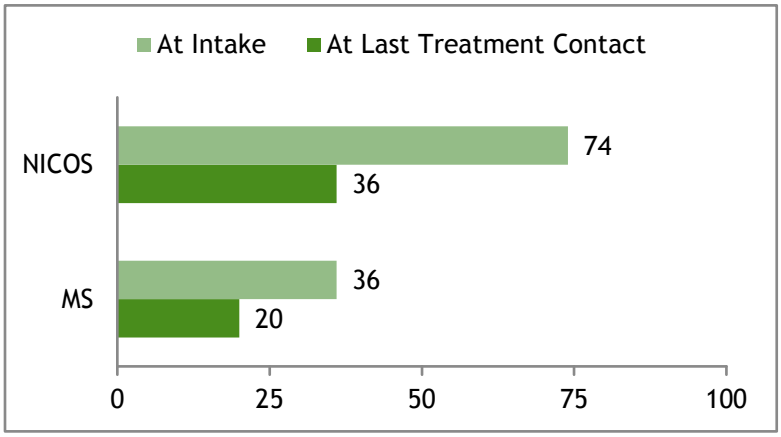
PGTI clients were asked at Intake to describe their gambling behaviors and the types of gambling activities they have engaged in over the last 12 months. Typical gambling locations included casinos, mentioned by 82% of PGTI English/Spanish clients, and food/convenience stores for Lottery tickets (14%). Among Asian Language PGTI clients, 88% report gambling in casinos and 19% using the Internet.

Clients were able to select multiple activities at each of the major gambling venues. PGTI English/Spanish clients reported gambling activities at tribal casinos most often and the most frequent activities were slot machines (50%), blackjack (22%), and poker (16%). The other major gambling activity was the Lottery (22%).

### *Intake to Last Treatment Contact Outcomes*

Data from the last treatment contact or from the End of Treatment form are available on 37 of the 61 PGTI clients who participated in treatment in FY 2017-18. By the end of treatment, the average rating of interference by gambling with normal activities decreased by 16-38 points among PGTI clients (**Figure 19**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities

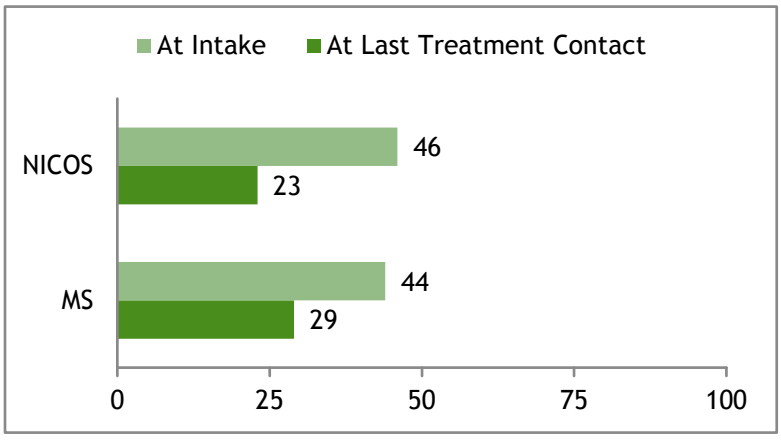
**FIGURE 19. PGTI GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** NICOS Intake N=16, LTC N=15; MS Intake N=174, LTC N=126

Among PGTI clients, the intensity of the urge to gamble, on average, decreased from Intake to their last treatment contact by 15-23 points on the 100-point scale. Lower scores at clients' last treatment contact indicated a less intense urge to gamble (**Figure 20**).

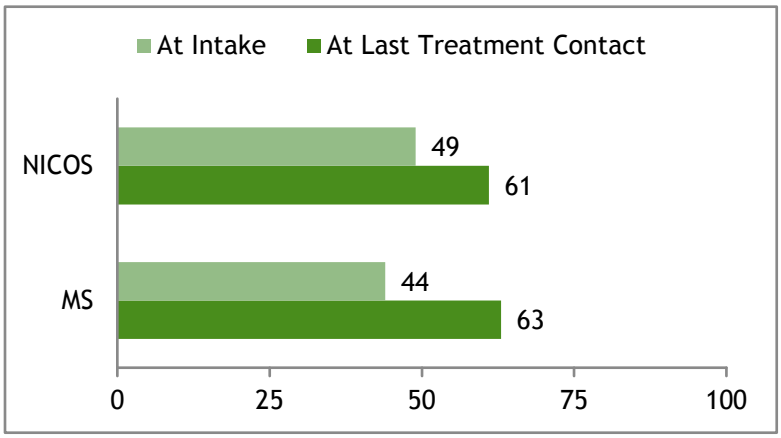
**FIGURE 20. PGTI GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** NICOS Intake N=16, LTC N=15; MS Intake N=174, LTC N=126

PGTI clients entered treatment reporting lower life satisfaction scores than Outpatient clients. Over the course of treatment, PGTI clients reported an improvement of 12-19 points on average in overall life satisfaction (**Figure 21**). As above, life satisfaction was measured on a 100-point scale.

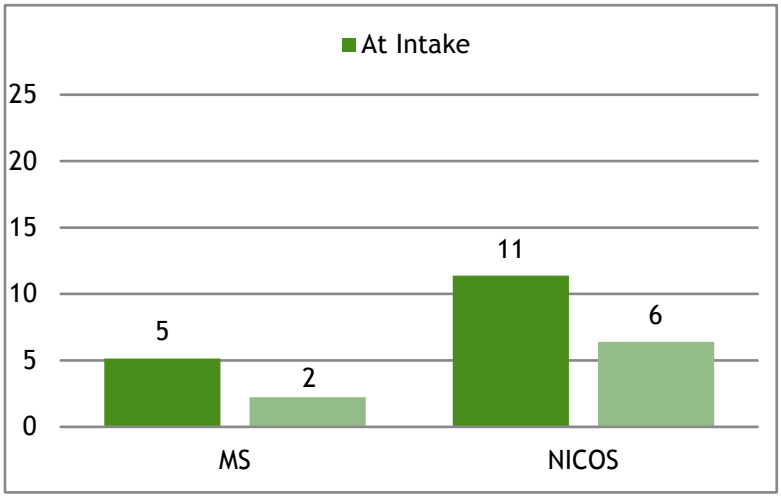
**FIGURE 21. PGTI GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT**




**Note:** NICOS Intake N=16, LTC N=15; MS Intake N=174, LTC N=126

During FY 2017-18, PGTI participants' levels of depression were measured using the PHQ-9 both at Intake and at the last treatment contact. English- and Spanish-speaking Morneau Shepell clients showed, on average, a considerable improvement in depression from mild depression at Intake to subclinical levels of depression at the last treatment contact (**Figure 22**). Asian-language-speaking clients (NICOS) also showed considerable improvement from moderate to mild depression.

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




**Note:** MS Intake N=174, LTC N=126; NICOS Intake N=16, LTC N=15

## Health Information on Gamblers

### Co-Occurring Health Conditions

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

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

| | Self-Reported Hypertension | Self-Reported Diabetes | Self-Reported Obesity | Obesity Calculated from BMI |
|---|---|---|---|---|
| Outpatient (N = 857) | 14% | 11% | 7% | 29% |
| IOP (N = 49) | 16% | 14% | 10% | 41% |
| RTP (N = 60) | 8% | 5% | 7% | 27% |
| PGTI (English/Spanish) (N = 174) | 13% | 10% | 6% | 33% |
| PGTI (Asian Languages) (N = 16) | 19% | 25% | 6% | -- |
| California adults[13] (N =9,341; 9,347; 8,475) | 28% | 11% | -- | 25% |

- The most commonly self-reported co-occurring health related conditions were hypertension, diabetes, and obesity.
- Smoking percentages were high across the treatment services network – 24% of Outpatient clients reported smoking, more than twice the state average.[14] There was a notable elevation in RTP where 42% of clients reported smoking (IOP 31%, PGTI Asian Languages 25%, and PGTI English/Spanish 20%). Rates of smoking decreased in all treatment modalities over the past year.
- About 34% of gamblers across the treatment services network (ranging from 24 - 45% depending on type of treatment attended) reported their health as fair or poor. This compares to 18% of adults in California reporting their health as "fair or poor" in 2017, according to the Centers for Disease Control and Prevention.[15]

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

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

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

## Co-Occurring Psychiatric Disorders

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

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

| | Mood Disorders | Psychotic Disorders | Anxiety Disorders | Substance Use Disorders | Personality Disorder | ADD/ ADHD |
|---|---|---|---|---|---|---|
| Outpatient (N = 857) | 24% | 2% | 11% | 2% | 1% | 3% |
| IOP (N = 49) | 43% | 2% | 18% | 8% | 4% | 4% |
| RTP (N = 60) | 47% | 7% | 20% | 23% | 0% | 2% |
| PGTI (English/Spanish) (N = 174) | 21% | 5% | 14% | 1% | 1% | 2% |
| PGTI (Asian Languages) (N = 16) | 6% | 6% | 6% | 0% | 0% | 0% |

- 26% of CalGETS outpatient clients and 28% of RTP clients scored in the moderately severe to severe depression range at Intake as measured by the PHQ-9. This is a high rate compared to 17% of adult Californians reporting any diagnosis of depression.[16]
- IOP clients had the highest prevalence of personality disorders and ADD/ADHD among the treatment network and had relatively high levels of mood, anxiety, and substance use disorders compared to clients in other modalities.
- RTP clients had the highest prevalence of mood, psychotic, anxiety, and substance use disorders across the treatment system.

## Substance Use Behaviors

- Among Outpatient clients, 54% reported that they drank alcoholic beverages. In other treatment modalities, a smaller percentage of clients reported current drinking, ranging from 25% among PGTI Asian language clients to 37% among PGTI English/Spanish clients.
- 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 similar to the 31% of California adults reporting any binge drinking in the past month.[17]
- Marijuana was the most frequently reported substance used in the past year across the treatment services network, with 13-48% 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 48% reporting marijuana use, 23% reporting methamphetamine use, 18% reporting use of cocaine, and 27% reporting use of narcotics. Additionally, of the RTP clients who reported drinking alcohol (28%), they averaged 15 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

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

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

of the CalGETS clients in residential treatment who have co-occurring substance abuse issues. The high incidence of mental health issues among CalGETS clients, in addition to their gambling-related problems, validates the use of licensed mental health professionals as the primary source of our workforce. At least 80% of all clients in all treatment modalities reported having health insurance and at least 70% report that they currently have a physician that they can access for primary care needs (except RTP clients at 78% and 63%, respectively); therefore, they may be covered for co-occurring conditions like those identified above.

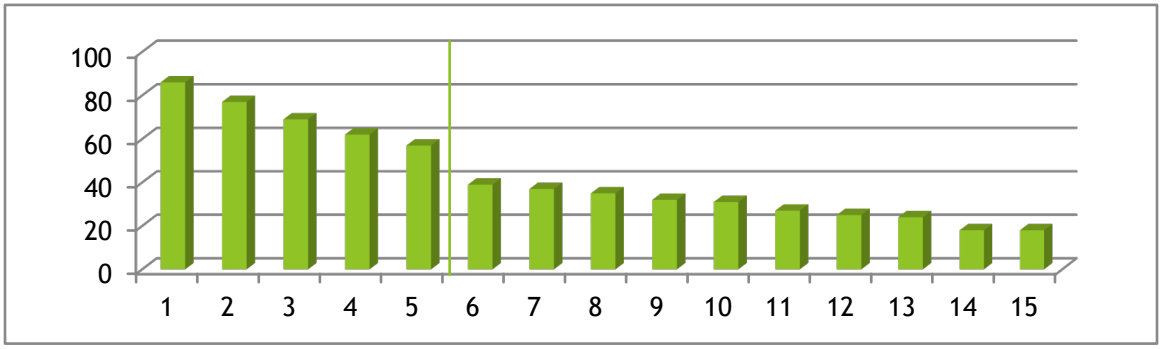
# 5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2017-18 data that were available from the DMS on AIs' demographics and treatment service outcomes. The data were collected on forms completed by clients at Intake, during treatment, and at the last treatment contact or from the End of Treatment form.

## Treatment Service Provision

Data were available at Intake from a total of 364 AI clients. Most (96%) were served as outpatients (n=348). The remaining 4% of clients received treatment from PGTI across both English/Spanish (n=8) and Asian (n=8) 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 23**).

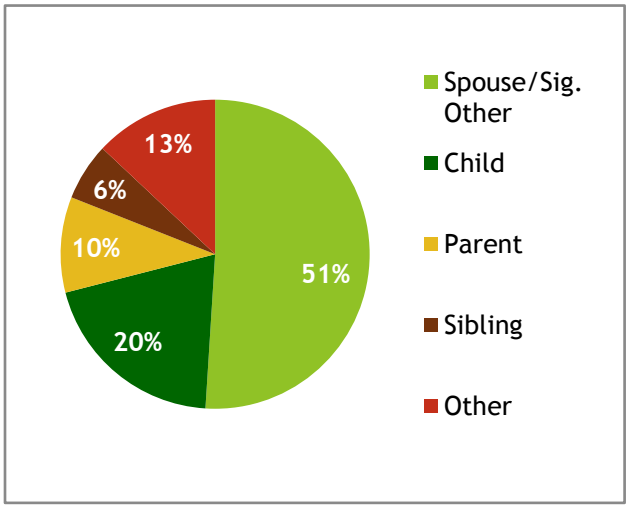
**FIGURE 23. OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION**




**Note:** N=348

Of the 348 outpatient AI clients, about half (51%) identified as a spouse or significant other, 20% as a child of, and 10% as a parent of a gambler (**Figure 24**).

**FIGURE 24. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER**



### *Demographics*

AIs in Outpatient treatment were 44 years old, on average, and predominately female (79%), whereas a majority of gambler clients are male. About half were White, Non-Hispanic only or with another race/ethnicity; followed by 18% Hispanic/Latino only, or 21% with another race/ethnicity; 17% Asian/Pacific Islander only, or 20% with another race/ethnicity; 5% African American only, or 6% with another race/ethnicity; 7% another race/ethnicity only, or 8% with an additional race/ethnicity; 5% Multiracial/Multi-ethnic; and 1% American Indian/Alaskan Native only or with another race/ethnicity. Similar to Outpatient gamblers, Outpatient AIs have widely varying household incomes and high education levels, with even more (86 vs. 78%) attending some college or higher (**Table 11**).

**TABLE 11. OUTPATIENT AI: DEMOGRAPHICS**

| **FY 2017-18** | (N=348) |
|---|---|
| Age | n=348 |
| Mean Age | 44 years old |
| Gender | n=348 |
| Male | 21% |
| Female | 79% |
| Race/Ethnicity (for those reporting a single category only) | n=348 |
| White, Non-Hispanic only | 48% |
| Asian/Pacific Islander only | 17% |
| Hispanic or Latino only | 18% |
| Black or African American only | 5% |
| American Indian/Alaskan Native only | 0% |
| Other race/ethnicity only | 7% |
| Multiracial or Multi-ethnic | 5% |
| Race/Ethnicity (for those reporting single AND multiple categories) | |
| White, Non-Hispanic only or with another race/ethnicity | 50% |
| Asian/Pacific Islander only or with another race/ethnicity | 20% |
| Hispanic or Latino only or with another race/ethnicity | 21% |
| Black or African American only or with another race/ethnicity | 6% |
| American Indian/Alaskan Native only or with another race/ethnicity | 1% |
| Other race/ethnicity only or with another race/ethnicity | 8% |
| Education | n=348 |
| Less than High School | 1% |
| High School | 14% |
| Some College | 36% |
| Bachelor's Degree | 31% |
| Graduate/Professional Degree | 19% |
| Household Income | n=348 |
| Less than $15,000 | 7% |
| $15,000-$24,999 | 7% |
| $25,000-$34,999 | 9% |
| $35,000-$49,999 | 13% |
| $50,000-$74,999 | 18% |
| $75,000-$99,999 | 13% |
| $100,000-$149,999 | 14% |
| $150,000-$199,999 | 6% |
| $200,000 or more | 8% |
| Decline to State | 6% |

## Treatment Service Findings

### *Intake to Last Treatment Contact Outcomes*

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

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

| | Intake Mean | Last Treatment Contact Mean |
|---|---|---|
| Depression (PHQ-9) score | 9 | 6 |
| Life satisfaction | 53 | 60 |
| Degree to which problem gambler's behaviors have interfered with normal activities | 57 | 37 |
| Feel responsible for gambler's treatment and recovery | 35 | 22 |

**Note:** Intake N=346, LTC N=310.

## Health Information on Affected Individuals

Co-occurring health diagnoses were less common among AIs than gamblers; however, some AIs participating in the outpatient program reported health-related issues. Health problems reported by 5% or more of Outpatient AI clients were hypertension, obesity, and diabetes. Twenty percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking continued a steady decline in the current fiscal year: from 17% in FY 2012-13 to 5% in FY 2017-18.

Also of note was the lower percentage of Outpatient AIs who reported current drinking (50%) relative to Outpatient gamblers (54%). However, AIs saw a 5% increase in current drinking compared to the past fiscal year, while outpatient gamblers saw a 1% decrease. Marijuana use in the past year was reported by 15% of Outpatient AIs, while 1% reported use of cocaine, narcotics, and tranquilizers. Similar to past years, in FY 2017-18 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, 11% for anxiety disorders, 2% for attention deficit disorders, and 1% reported treatment for psychotic disorders, personality disorders, and substance abuse disorders. Using the PHQ-9 criteria, 42% reported moderate to severe depression symptoms.

# 6. FOLLOW-UP OF TREATMENT PARTICIPANTS

UGSP staff members collect follow-up data from clients served within Outpatient, IOP, and RTP modalities using GRM/VisualVault's web-based DMS. Follow-up interviews with treatment participants take place at 30 days, 90 days, and one year post-discharge. For those clients who agree to participate in follow-up interviews, the DMS automatically generates follow-up forms for each client who completes an EOT form or has discontinued treatment for more than 90 days. Beginning in January of 2017, UGSP put extra staff resources into client follow-up and began making five attempts to reach clients for follow-up interviews. For FY 2017-18, therefore, five attempts were made from July 2017 through June 2018.

**Table 13**, below, is a breakdown of all follow-up attempts, completed interviews, and closed cases (i.e., clients who were unable to be reached after five attempts) for the gamblers and AIs who agreed to follow-up during FY 2017-18. The numbers differ slightly from DMS data because they are based on call logs. UGSP made over 4,300 attempts to reach clients for follow-up interviews; completing 512 interviews, and ultimately closing 520 cases when clients were unable to be reached. It should be noted that cases are closed after 5 attempts at a particular follow-up point, but attempts to reach an individual begin anew at the next time point.

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

| | 30-day | | | 90-day | | | 1-Year | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | G | AI | Total | G | AI | Total | G | AI | Total | G | AI | Total |
| Attempts | 866 | 222 | **1088** | 1238 | 330 | **1568** | 1395 | 325 | **1720** | 3499 | 877 | **4376** |
| Completed | 125 | 29 | **154** | 141 | 52 | **193** | 126 | 39 | **165** | 392 | 120 | **512** |
| Closed | 87 | 19 | **106** | 120 | 23 | **143** | 228 | 43 | **271** | 435 | 85 | **520** |

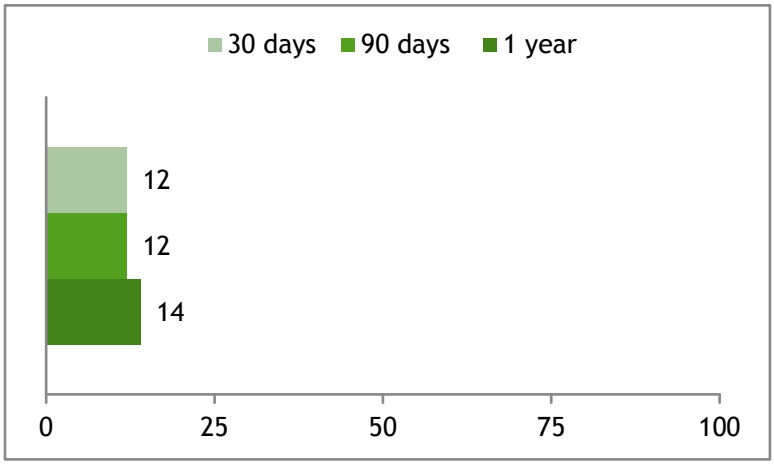
**Note:** G = Gamblers, AI = Affected individuals

Follow-up results are presented below for the two largest groups of gamblers receiving treatment: Outpatient gamblers and English/Spanish PGTI gamblers.

### *Gamblers: Outpatient Follow-up Results*

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

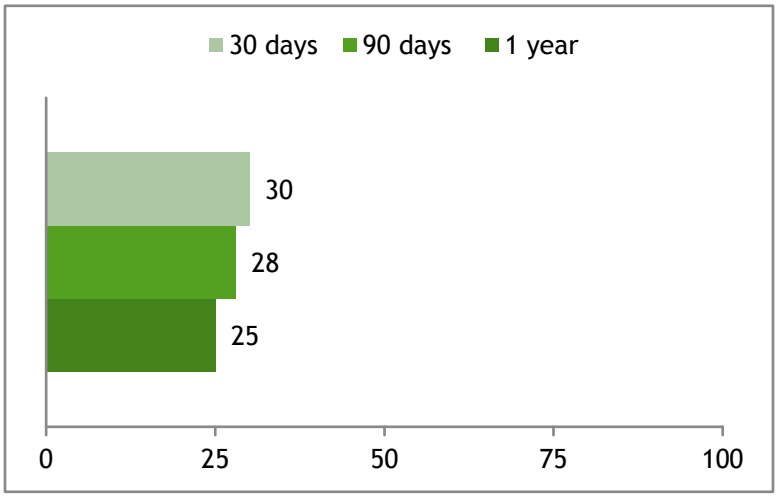
**FIGURE 25. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT FOLLOW-UP**




**Note:** 30 days N=99, 90 days N=113, 1 year N=94.

Likewise, the intensity of the urge to gamble, on average, was low during the post-treatment period, remaining at or below 30 points on the 100-point scale (**Figure 26**).

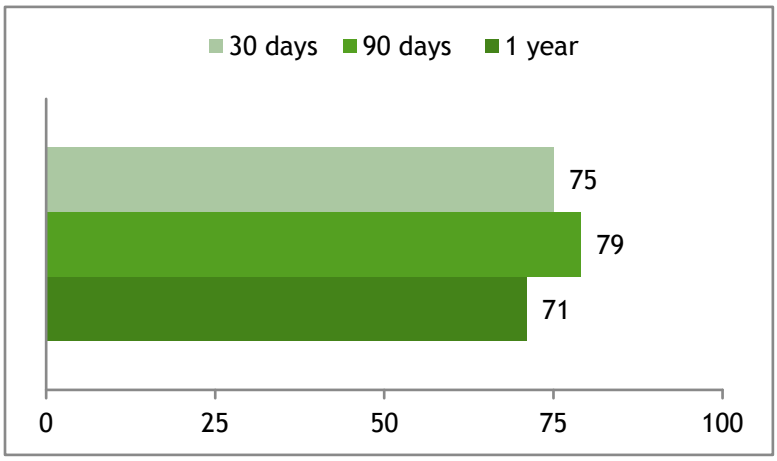
**FIGURE 26. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT FOLLOW-UP**




**Note:** 30 days N=99, 90 days N=113, 1 year N=94.

Clients' average overall life satisfaction remained relatively unchanged (**Figure 27**). As above, life satisfaction was measured on a 100-point scale.

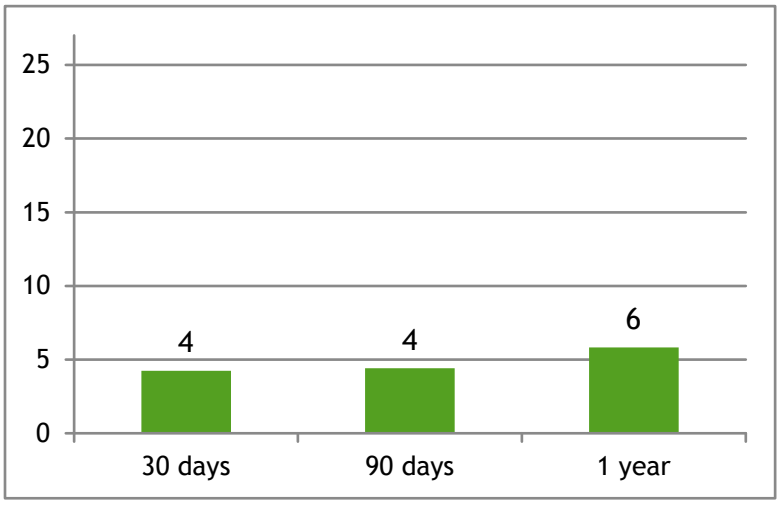
**FIGURE 27. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT FOLLOW-UP**




**Note:** 30 days N=99, 90 days N=113, 1 year N=94.

As shown in **Figure 28**, the average depression (PHQ-9) score was 4.23 at 30 days post-treatment, indicating sub-clinical levels of depression. At the 90-day and one-year follow-ups, the depression score remained between 4 and 6, still within the mild depression range.

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




**Note:** 30 days N=99, 90 days N=113, 1 year N=94.

### *Gamblers: English/Spanish PGTI Follow-up Results*

Morneau Shepell conducted 11 follow-up interviews with their English/Spanish language PGTI clients. As a result, the numbers are too small to provide an accurate description of the PGTI clients at follow-up.[18]

### *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 108 gambler clients offering comments on their treatment experiences, 82 (76%) had positive comments, 18 (17%) had negative comments, and 8 (7%) 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 AIs who provided feedback on their treatment experiences, 39 (78%) offered positive comments, 8 (16%) offered negative comments, and 3 (6%) offered neutral or mixed 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 were not fully met by the program. Participants who offered negative comments mentioned a lack of therapeutic alliance or commented that they did not find the treatment provider helpful.

[18] Starting in FY 2018-19 follow-up of PGTI clients was transferred to UGSP.

# 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 2017-18 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. The study will continue into FY 2018-19.

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LIST OF TABLES

LIST OF FIGURES