ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2022-23

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 2022-23

Contents

EXECUTIVE SUMMARY

Overview

California Gambling Education and Treatment Services (CalGETS) is a highly successful statewide program for clients with problem gambling and affected individuals (AIs) (family members and friends affected by someone with problem gambling). Over 1,100 individuals received treatment through CalGETS in fiscal year (FY) 2022-23. Services are accessible to all California residents, aged 18 and older, at no cost to the client. Oversight of CalGETS is conducted by the California Department of Public Health (CDPH) Office of Problem Gambling (OPG) and the University of California, Los Angeles (UCLA) Gambling Studies Program (UGSP). Since the beginning of CalGETS in 2009, over 19,500 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 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 mental health 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 gamblers 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 gamblers who require a 24-hour residential treatment setting.
- **Problem Gambling Telephone Interventions (PGTI)** are provided to gamblers and AIs in English, Spanish, and various Asian languages.

CalGETS Providers: A Diverse and Skilled Workforce

CalGETS trains, authorizes, provides clinical guidance, and oversees 149 licensed mental health providers (with an average of 9 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 2022-23)

Gamblers:

- 889 gamblers received treatment across the treatment network. Nearly two-thirds (65%) received outpatient services, 26% were served in PGTI, 7% were served in IOP,

and 2% were served in RTP. Of gamblers enrolled in outpatient services, 31 were served in group treatment.

- By the end of CalGETS treatment, client levels of depression, on average, improved to the mild or subclinical levels (depending on level of treatment service).
- Anxiety also improved to subclinical levels by the end of treatment.
- During treatment, the degree to which clients perceived that gambling interfered with their normal activities decreased by an average of 5 to 28 points on a 100-point scale (depending on level of treatment service).
- The intensity of gambling urges reported by CalGETS clients from Intake to last treatment contact decreased by an average of 16 to 28 points (depending on level of treatment service) on a self-reported 100-point scale, except RTP with a 1-point increase.
- Life satisfaction as measured by a self-reported 100-point scale increased from Intake to last treatment contact by an average of 8 to 13 points (depending on level of treatment service), except RTP with a 15-point decrease.

CalGETS GAMBLER CHARACTERISTICS AT INTAKE: HEALTH AND WELLNESS

Smoking	Among CalGETS outpatient clients, 20% currently smoke. This percentage is nearly twice the state average of 11%. In IOP, the prevalence rate of smoking is 24%, among PGTI clients 20%, and among RTP clients 6%.
Alcohol Use	55% of CalGETS outpatient clients reported at Intake that they drank alcoholic beverages. 24% reported at least one binge drinking episode (for men, more than five drinks, and for women, more than four drinks in a single occasion) in the past month, compared to 22% of adult Californians reporting binge drinking in the past month (National Survey on Drug Use and Health [NSDUH]).
Cannabis	According to the National Survey on Drug Use and Health (NSDUH), 15% of the adult population of California reported using cannabis within the past month. Among CalGETS outpatient clients, 21% used cannabis.
State of Health	According to the Centers for Disease Control (CDC), 16% of adults in California reported their health as “fair or poor” in 2021. In comparison, about 35% of gamblers across the treatment network reported their health as “fair or poor.”
Health Insurance	About 89% of all CalGETS outpatient clients reported having health insurance, but less is known about their costs to maintain insurance, including premiums and deductibles.
Access to Health Care	Approximately 77% of CalGETS outpatient clients reported they currently have a physician they can access for primary care needs.
Depression	41% of CalGETS outpatient clients scored in the moderate to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 8% of adult Californians reporting a major depressive episode in the past year (NSDUH).
Anxiety	47% of outpatient clients appear to have Generalized Anxiety Disorder based on their scores on the GAD-2 anxiety screening instrument.
ADHD	Based on the ASRS screening instrument for attention-deficit hyperactivity disorders (ADHD), it appears that 4% of outpatient clients may have ADHD.

Affected Individuals:

- 234 AIs received treatment across the treatment network. Most (94%) were served as outpatients (n=219). The remaining 15 clients received treatment from PGTI.
- AIs are spouses/significant others (44%), parents (20%), children (12%), siblings (11%), or other relation (13%) of gamblers; 79% of AIs are female.
- 33% of AI clients reported moderate to severe depression at Intake.
- During treatment, the degree to which AIs report that the problem gambler's behaviors interfered with normal activities, the degree to which they felt responsible for the gambler's treatment and recovery, and the amount of time they spent dealing with the consequences of problem gambling improved (decreased). Depression and anxiety also decreased and life satisfaction increased.

Co-occurring health diagnoses reported by AIs were similar in prevalence to gamblers; however, a smaller percentage (27%) of AIs participating in the outpatient program reported that their health was fair or poor. Nineteen percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking was 4% in FY 2022-23, lower than the percentage of smokers among Californians (11%). Also, 80% reported that they had health insurance.

Client Follow-up

Treatment follow-up interviews take place at 30 days, 90 days, and one year after treatment entry and are designed for program evaluation and to assess the impact of treatment. UGSP completed 137 treatment follow-up telephone interviews. Plans were made to increase follow-up outreach in FY 2023-24 via on-line and text-message survey links.

Cultural and Linguistic Clinical Integrations

Housed within UGSP, these projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY 2022-23, UGSP and OPG worked with two community agencies to address disparities among those reached for CalGETS education and treatment.

UGSP and *Visión y Compromiso* (VyC) are conducting a project in Los Angeles and San Diego Counties to provide culturally relevant enhancements to CalGETS' outreach, education, screening, and referral system. This enhancement involves the use of *promotoras* (lay health workers) to increase CalGETS utilization in the Latino community. The pilot project in Los Angeles and San Diego Counties is designed to increase CalGETS utilization among Latino communities. UGSP developed an extensive gambling-specific training which was delivered by VyC to *promotoras* in Los Angeles and San Diego. During Fiscal Years 2021-23, *Visión y Compromiso* (VyC) was provided approximately $325,000 for this cultural and linguistic clinical integration. Additionally, UGSP provided project development, training, project monitoring, and evaluation services.

UGSP and the Riverside San Bernardino Indian Health Centers (RSBIHC) are conducting a pilot project to provide education, screening, and treatment referrals for those with gambling problems in the tribal community. This clinical integration project includes plans for data

sharing as well as an evaluation of the program implementation. Dr. Timothy Fong of UGSP provided training sessions to RSBIHC staff members including training to RSBIHC peer specialists on techniques to implement screening for problem gambling and trainings to RSBIHC physicians and therapists on how to identify problem gambling and assist patients to obtain CalGETS treatment services.

1. CalGETS PROGRAM STRUCTURE

Introduction

In 2003, the Office of Problem Gambling (OPG) was established under Section 4369 of the California Welfare and Institutions Code. OPG's mandate is to develop and provide quality statewide prevention and treatment programs for Californians with gambling disorder and for family members experiencing a negative impact to their lives due to problem gambling behavior. In 2006, OPG conducted a gambling prevalence study in California with 7,121 respondents, at the time it was the largest gambling prevalence study in the United States. The State was at the higher end of the range of prevalence rates identified in the United States; overall lifetime prevalence for problem and pathological gambling combined was 3.7% (estimated at just over one million individuals today). An additional 6-7% (2.2 to 2.7million individuals) were estimated, in the report, to be classified as lifetime at-risk gamblers – those who scored low on the problem gambling screen, but may transition to problem gambling or gambling disorder at some point in their lives. Gambling problems exist on a continuum and vary in severity and duration. Gambling disorder (formerly known as pathological gambling) lies at the most severe end of the continuum of gambling problems.

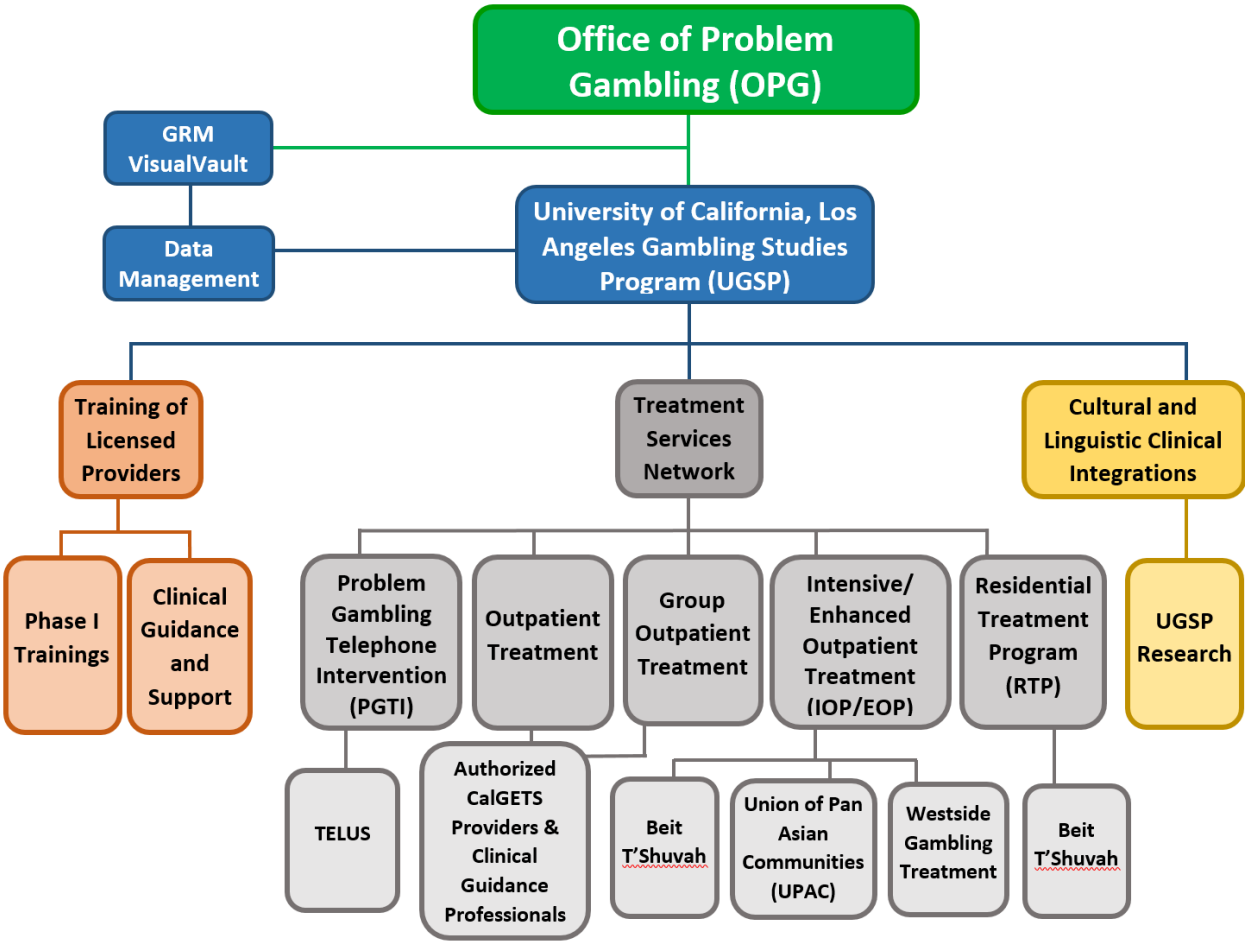
The California Gambling Education and Treatment Services (CalGETS) program is a highly successful statewide program for clients with problem gambling and affected individuals (AIs) (family members and friends affected by someone with problem gambling). It is the result of a collaboration between the California Department of Public Health's Office of Problem Gambling (OPG) and the University of California, Los Angeles (UCLA) Gambling Studies Program (UGSP). This collaboration, which has been ongoing since 2009, has the following goals:

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

Since the beginning of CalGETS in 2009, over 19,500 individuals have received treatment through the program to address the harmful impacts of problem gambling.

CalGETS consists of three main components: treatment provider training, a treatment services network, and a cultural and linguistic clinical integrations program. The treatment services network consists of the following: PGTI for gamblers and AIs, Outpatient (Individual and Group) treatment for gamblers and AIs, Intensive Outpatient (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

To become an authorized CalGETS provider, licensed mental health providers attend training comprised of an 18-hour online course and three additional virtual live 4-hour training days (12 hours). 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. Additionally, UGSP staff members conduct in-person and virtual 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. Treatment is available in 30 languages/dialects. During the COVID pandemic, CalGETS/OPG provided for telehealth treatment. The most recent version of the CalGETS Policies and Procedures Manual now includes telehealth options for IOP and Outpatient services, making the addition of telehealth a permanent change in the CalGETS program.

Within the Treatment Services Network, the following treatment services are offered:

Outpatient (Individual and Group): Gamblers and AIs may receive 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 2022-23, there were 149 active, authorized CalGETS providers. Gamblers and AIs may also receive 24 in-treatment group sessions. This does not include the mandatory individual screening prior to attending group in-treatment sessions or the individual end-of-group session. Group treatment sessions may be comprised of a mixture of gamblers and AIs and must include 3-10 participants.

Intensive Outpatient (IOP) (also known as Enhanced Outpatient): Gamblers requiring more intensive services may receive up to two 30-day treatment blocks (up to 60 days) of IOP care. Union of Pan Asian Communities (UPAC) in San Diego and Beit T'Shuvah Right Action Gambling Program in Los Angeles offer IOP care for problem gamblers. Both programs provide services that include individual, group, and family counseling. Westside Gambling Treatment in Los Angeles provides IOP care which specializes in services for problem gamblers with crypto/trading, sports betting, or gaming addiction. This program was added during FY 2022-23. All IOP providers deliver services three times per week, three hours each day.

Residential Treatment Programs (RTP): Individuals with gambling disorder, including those with significant comorbidity, may receive up to two 30-day treatment blocks (up to 60 days) of residential care. RTP services are offered through Beit T'Shuvah Right Action Gambling Program, a residential facility in Los Angeles. Individuals in RTP receive a minimum of 15 hours of gambling-specific treatment per week. Participants attend groups on a daily basis, receive individual therapy once per week, and are encouraged to attend 12-step groups. Treatment addressing comorbid conditions such as mood disorders and substance abuse is provided as needed.

Problem Gambling Telephone Intervention (PGTI): Gamblers and AIs may receive up to three treatment blocks of eight sessions in the PGTI program. Telephone intervention allows access

to treatment services for clients who may be disabled, lack transportation, or live in rural areas of the state where outpatient services are not available. PGTI services are provided in English, Spanish, and Asian languages. Intake is provided by TELUS (formerly named LifeWorks and Morneau Shepell), the toll-free helpline administrator, that then coordinates referrals to PGTI providers. Services are delivered by licensed, trained mental health providers with the intention of immediate service delivery and the goal of transferring clients to outpatient services if needed.

Treatment Participant Follow-up

UGSP collects follow-up information via telephone interviews 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 entering treatment. Participants are queried on satisfaction with treatment, current gambling behaviors, depression, and quality of life. Referrals to additional treatment are provided when requested. For Fiscal Year 2023-24, on-line survey capability was added via the Qualtrics survey platform and follow-up results will include results from both telephone interviews and on-line surveys.

Cultural and Linguistic Clinical Integrations

This component of CalGETS consists of ongoing and innovative research designed to advance the field, improve access by underserved populations, and establish best practices and evidence-based treatments for gamblers and AIs throughout California. UGSP partnered with *Visión y Compromiso* (VyC) to provide an extensive gambling-specific training to *promotoras* (lay health workers) to increase CalGETS utilization among Hispanic communities. During Fiscal Years 2021-23, *Visión y Compromiso* (VyC) was provided approximately $325,000 for this cultural and linguistic clinical integration. Additionally, UGSP provided project development, training, project monitoring, and evaluation services. Another cultural and linguistic clinical integration involved training Riverside San Bernardino Indian Health Clinic physicians and therapists on how to identify problem gambling and assist patients to obtain CalGETS treatment services.

2. FY 2022-23 TREATMENT REPORT DATA SOURCES AND METHODS

Data Sources

Data are obtained from the CalGETS client forms completed during Fiscal Year 2022-23. 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/VisualVault, OPG, and UGSP to run reporting functions on the data in the system. Due to technical issues, GRM/VisualVault provided additional data cuts for gambling behavior, health behavior, and mental health data.

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 nine 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 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.

Generalized Anxiety Disorder (GAD) 2: The GAD-2 is a two-item anxiety screening scale. Treatment participants are asked to rate how much they have been bothered over the past two

[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.

weeks by feeling nervous, anxious, or on edge, and by not being able to stop or control worrying. They select from a four-point Likert scale (not at all = 0, several days = 1, more than half the days = 2, nearly every day = 3). A cutoff score of 3 on the GAD-2 has a sensitivity of 86% and specificity of 83% for a diagnosis of generalized anxiety disorder (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

Adult Attention Deficit Hyperactivity Disorder (ADHD) Self-Report Scale (ASRS-v.1.1): The ASRS screener consists of the six items based on DSM criteria most predictive of ADHD symptoms (Adler et al., 2006). Treatment participants rate the items based on how they have felt and conducted themselves over the past six months using a five-point Likert scale (never to very often). The instrument has been shown to have adequate sensitivity (68.7%), excellent specificity (99.5%), excellent total classification accuracy (97.9%) and good test-retest reliability (interclass correlation of 0.86) (Adler et al., 2006; Kessler, et al., 2005; Kessler, et al., 2007; Matza, Van Brunt, Cates, & Murray, 2011). The instrument has a scoring algorithm – four or more ratings of "sometimes," "often," or "very often" (depending on the item) indicate that the treatment participant has symptoms highly consistent with ADHD in adults and further investigation is warranted.

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 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.

GAD-2: See Above.

ASRS-v.1.1: See Above.

Life Satisfaction: See Above.

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

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

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

Analyses

In the current report, unduplicated new 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 actually 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. The analyses for gambling behavior, health behavior, and mental health data were delayed due to technical issues with the data provided. The datasets used for those analyses are separate from the datasets used for the rest of the report.

Outpatient treatment is offered in blocks of eight sessions, and IOP and RTP are offered in 30-day treatment blocks. Clients may discontinue treatment at any time, not just at the end of a scheduled treatment block. This means the "dose" of treatment a client receives may vary not only by the type of treatment they participate in, but also in how long they chose to participate. To ensure we capture data about clients as they leave treatment (Last Treatment Contact), we utilize data from the End of Treatment (EOT) form, or, from the client's last In-Treatment form when an EOT form is not available. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Versions 28 and 29. Data distributions were examined and, if necessary, extreme outliers were trimmed to reduce the effect of possibly spurious values. The Appendix provides the numeric breakout of race/ethnicity, gender, and sexual orientation variables. In accordance with Assembly Bill 1726, data on specific Asian and Pacific Islander groups was collected; however, aggregate data categories are presented in instances that could permit identification of individuals. Numbers for those reporting in a category in which there are 10 or less individuals are indicated by <11.

3. GAMBLER TREATMENT SERVICE OUTCOMES

The sections below summarize demographics and outcomes for gamblers receiving treatment from the CalGETS treatment services network. Results are grouped according to treatment services offered during FY 2022-23.

Treatment Service Provision

In FY 2022-23, a total of 889 gamblers entered treatment across the treatment services network (**Table 1**). Most clients (65%) enrolled in Outpatient, followed by PGTI (26%), IOP (7%), and RTP (2%), In addition, 52 Outpatient clients received group treatment. During FY 2021-22, a total of 795 gamblers entered treatment across the treatment services network. Most clients (61%) enrolled in Outpatient, followed by PGTI (29%), IOP (9%), and RTP (2%). Of these clients, 31 also participated in Outpatient Group services.

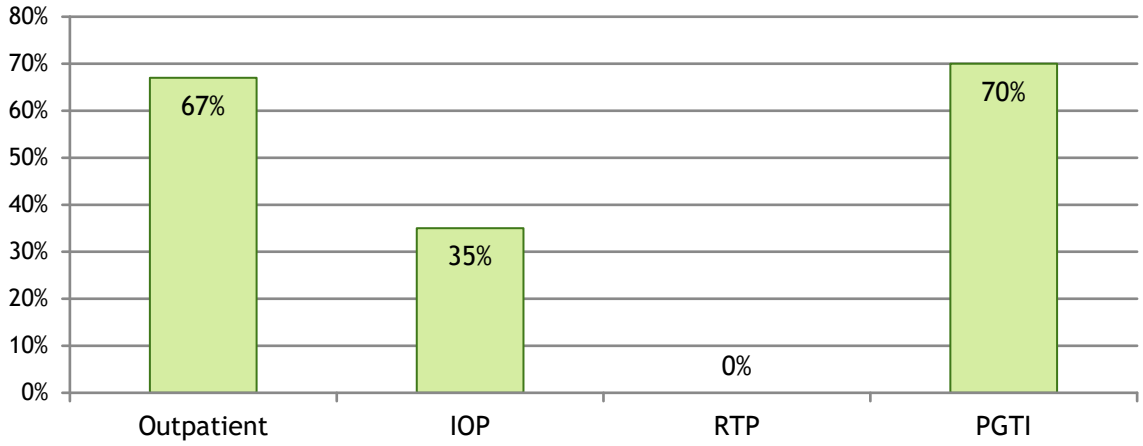
TABLE 1. TREATMENT SERVICES: NUMBER OF NEW CLIENT INTAKES FOR GAMBLERS

Service Level	FY 2022-23 N	Percent	FY 2021-22 N	Percent
Outpatient	580	65%	482	61%
Outpatient Group	*(52)*	*(9%)*	*(31)*	*(6%)*
Intensive Outpatient Program (IOP)	59	7%	68	9%
Residential Treatment Programs (RTP)	16	2%	16	2%
Problem Gambling Telephone Intervention (PGTI)	234	26%	229	29%
Total[2]	889	100%	795	100%

The provider network generally offers rapid entry into treatment from the time of first contact with a provider (**Figure 2**). The majority of clients in Outpatient and PGTI entered treatment within one week. In IOP, 35% entered treatment within a week. Entry into RTP was delayed, but 31% entered within one month.

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

FIGURE 2. TREATMENT SERVICES: PERCENTAGE OF CLIENTS ENTERING TREATMENT WITHIN 7 DAYS OF FIRST CONTACT FY 2022-23



As shown in **Table 2**, race/ethnicity varies by level of service. Compared to the California population, Hispanic/Latinos are under-represented in the treatment population and most other race/ethnicity categories are over-represented. (More detailed analyses of race/ethnicity, gender, and sexual orientation, are available in the appendix.)

TABLE 2. TREATMENT SERVICES: RACE/ETHNICITY OF GAMBLERS BY LEVEL OF TREATMENT SERVICE AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 579	IOP N = 59	RTP N = 16	PGTI N = 232	Total N = 886	CA Population[3] N = 39,029,342
White, Non-Hispanic only[4]	40%	51%	75%	29%	38%	35%
Asian/Pacific Islander only	18%	20%	0%	24%	19%	17%
Hispanic or Latino only	18%	7%	6%	24%	19%	39%
Black or African American only	9%	12%	13%	12%	10%	7%
American Indian/Alaskan Native only	1%	2%	0%	3%	1%	2%
Other race/ethnicity only	6%	3%	6%	5%	6%	0%
Multiracial or Multi-ethnic[5]	9%	5%	0%	3%	7%	4%

Note: Outpatient had 1 case with missing data. PGTI had 2 cases with missing data

[3] Quick Facts: California, US Census Bureau, accessed 12/01/2023, at https://www.census.gov/quickfacts/fact/table/CA/PST045222.

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

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

Table 3 illustrates the high number of problem gamblers entering treatment with a comorbid condition. Depression was most prevalent among Outpatient gamblers, with 417 reporting symptoms of depression, followed by generalized anxiety (254), binge drinking (129), cannabis use (114), smoking (107), and ADHD (21).

TABLE 3. TREATMENT SERVICES: NUMBER OF PROBLEM GAMBLERS SERVED WITH PRIORITIZED COMORBIDTIES

Prioritized Comorbidity	Outpatient	IOP	Residential	PGTI	TOTAL
Depression	417	44	9	130	600
Anxiety	254	31	8	37	330
ADHD	21	6	0	2	29
Smoking	107	14	1	46	168
Cannabis Use	114	5	2	28	149
Binge Drinking	129	5	1	40	175

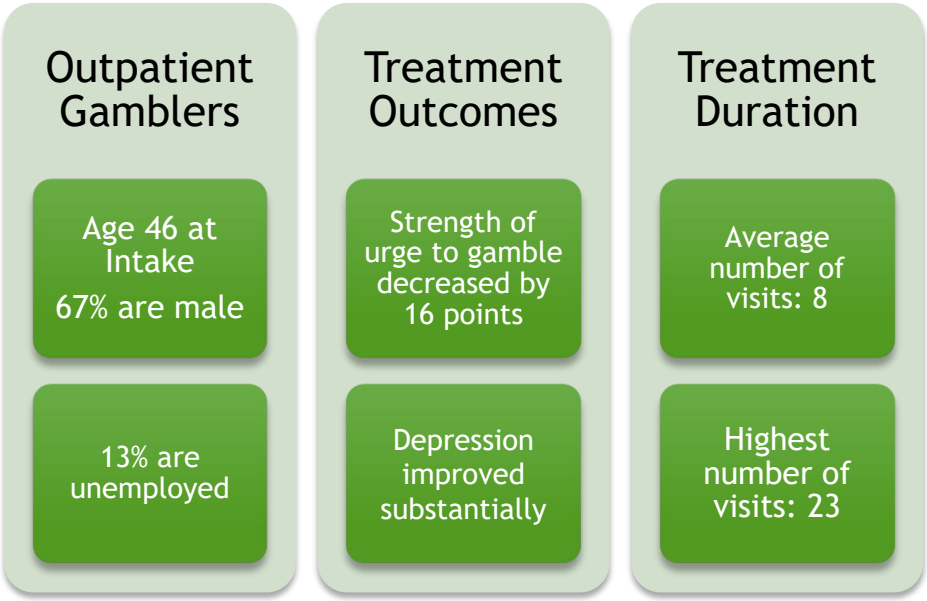
Note: Numbers for Outpatient and other service levels add up to more than the number of clients for that service level because each client may have more than one comorbidity.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown earlier in Table 1,[6] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 580 clients who enrolled in outpatient services. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2022-23, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (32%), former clients (11%), family/friends (13%), UCLA Gambling Studies Program (11%), health care professionals (7%), Gamblers Anonymous/Gam-Anon (10%), the California Council on Problem Gambling (6%), and the OPG website (2%). In addition, 8% cited other sources including media (television, radio, newspaper, billboard), casino signage, community presentations, Internet searches that yielded the CalGETS website, treatment providers' websites, or the Psychology Today referral website. The number of sessions completed by outpatient gambler clients (n=580) varied:

- 9% of clients had only an Intake session
- 58% received 1-8 treatment sessions
- 25% received 9-16 treatment sessions
- 7% received 17-23 treatment sessions

Demographics

Outpatient clients had an average age of 46 years and two-thirds (67%) were male. Clients identified their race as White, Non-Hispanic (40%), followed by 18% reporting Asian/Pacific

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

Islander, 18% Hispanic/Latino, 9% African American, 1% American Indian/Alaska Native, 6% another race/ethnicity, and 9% multiracial/multi-ethnic. (More detailed analyses of race/ethnicity, gender, and sexual orientation, are available in the appendix.) Clients are, for the most part, well-educated; 80% reported completing some college or above. The reported household income varied widely from less than $15,000 per year to over $200,000, but 19% reported incomes of less than $35,000 (**Table 4**).

TABLE 4. OUTPATIENT GAMBLER: DEMOGRAPHICS

Age	n=580
Mean Age	46 years old
Gender	n=580
Male	67%
Female	32%
Transgender/Other Gender Category	1%
Race/Ethnicity (for those reporting a single category only)	n=579
White, Non-Hispanic	40%
Asian/Pacific Islander	18%
Hispanic or Latino	18%
Black or African American	9%
American Indian/Alaskan Native	1%
Other race/ethnicity	6%
Multiracial or Multi-ethnic	9%
Education	n=580
Less than High School	4%
High School	16%
Some College	37%
Bachelor's Degree	31%
Graduate/Professional Degree	12%
Household Income	n=580
Less than $15,000	7%
$15,000-$24,999	4%
$25,000-$34,999	8%
$35,000-$49,999	13%
$50,000-$74,999	16%
$75,000-$99,999	11%
$100,000-$149,999	13%
$150,000-$199,999	8%
$200,000 or more	10%
Decline to state	10%

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 5**), including 93% with moderate to severe gambling disorder, while 2% reported one to three problem gambling behaviors.

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

Severity	NODS Score	N	%
Problem gambling behavior	1 to 3	11	2%
Mild gambling disorder	4 to 5	28	5%
Moderate gambling disorder	6 to 7	140	26%
Severe gambling disorder	8 to 9	365	67%

Note: N=545, 35 cases had missing data

Gambling Behaviors

At Intake, outpatient clients (n=552, 28 missing data) 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 (72%), followed by the Internet, (37%), lottery stores (12%), family/friend's house (8%), private club (5%), horse-racing track (2%), and other locations (5%).[7]

Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines (51%), blackjack (36%), and poker (26%) were the most commonly selected gambling activities.[8]

- At **tribal casinos,** clients most frequently stated that they played slot machines (43%), blackjack (23%), and poker (12%).[9]
- At **other casinos,** clients most frequently reported playing slot machines (18%), blackjack (16%), poker (11%), roulette (5%), and baccarat (5%).
- In the **community**, 19% of clients reported gambling on the Lottery.
- At **cardrooms,** clients most often reported playing poker (13%), and blackjack (13%).
- On the **Internet**, clients most often indicated playing slots (9%), poker (7%), other internet gambling (8%), and blackjack (9%).

[7] In FY 2019-20, mostly prior to the pandemic, gambling locations were – casinos (81%), followed by the Internet, (22%), lottery stores (15%), family/friend's house (11%). The FY 2022-23 increase in internet gambling and the decreases at the other locations are most likely due to long-term changes in behavior after COVID-19 restrictions imposed by the state and counties.

[8] In FY 2019-20, the major activities were - slot machines (61%), blackjack (38%), and poker (38%). The FY 2022-23 decreases are most likely due to long-term changes in behavior after COVID-19 restrictions.

[9] Gambling activities reported by 5% or more of clients are listed here.

- Finally, clients reported gambling on sporting events (26%), financial/stock markets (8%), and other gambling on sporting events (6%).

Intake to Last Treatment Contact (LTC) Outcomes

In order to measure the impact of treatment, we analyzed depression, anxiety, perceived interference of gambling with normal activities, urge to gamble, and life satisfaction at Intake and LTC (**Table 6**).

Treatment participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact (LTC). Outpatient clients showed, on average, mild depression at Intake and improved mild depression at their last treatment session in both FY 2022-23 and 2021-22. The GAD-2 is a two-item anxiety screening scale. A cutoff score of 3 is used for a diagnosis of generalized anxiety disorder. At Intake during both years, on average, gamblers were positive for generalized anxiety but were below the cutoff at last treatment contact.

TABLE 6. OUTPATIENT GAMBLER: TREATMENT OUTCOMES FOR FY 2022-23 AND 2021-22

Outcome Indicator	2022-23 Intake Mean	2022-23 LTC Mean	2021-22 Intake Mean	2021-22 LTC Mean
Depression (PHQ-9) score	9	6	9	6
Anxiety (GAD-2) score	3	2	3	2
Gambling interference with normal activities	52	30	50	29
Urge to gamble	54	38	56	37
Life satisfaction	54	62	54	62

Note: FY 2022-23 Intake N=545, Last Treatment Contact (LTC) N=529, FY 2021-22 Intake N=439, LTC N=457.

The question, "How much has gambling interfered with your normal activities?" assesses gambling-related interference in daily life. Respondents rate life interference on a scale ranging from 0 (no interference) to 100 (extreme interference). Higher scores indicate greater life interference due to gambling. Outpatient clients reported less interference of gambling with their normal activities at last treatment contact compared to Intake. Average scores decreased 22 points in FY 2022-23 and by 21 points from Intake to last treatment contact in FY 2021-22. Urge to gamble is assessed with the question, "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. The average intensity of the urge to gamble from Intake to last treatment contact decreased by16 points in FY 2022-23 and by 19 points on the 100-point scale in FY 2021-22. Lower scores at last treatment contact indicated a less intense urge to gamble after receiving outpatient services. 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. Over the course of treatment, outpatient clients reported an improvement of 8 points on average in overall life satisfaction during both years.

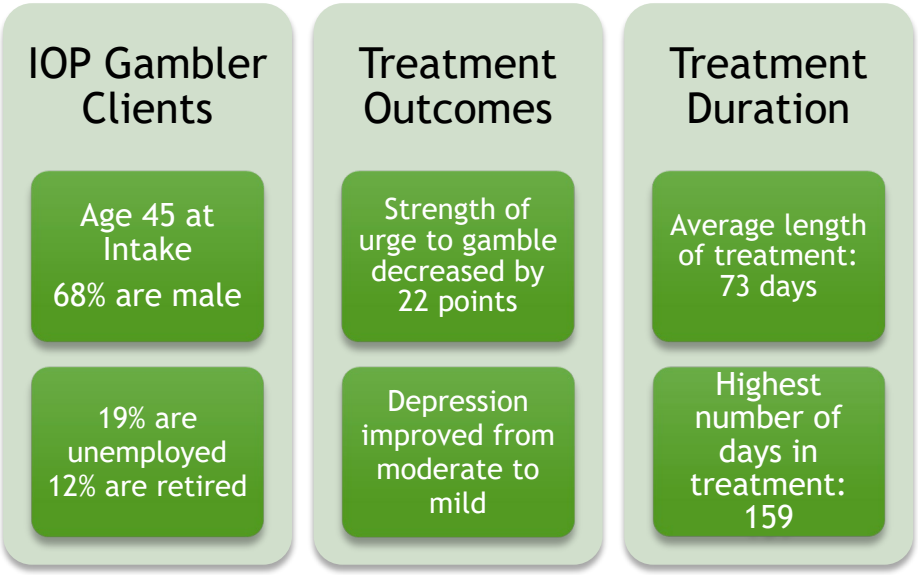
Group Outpatient

A total of 85 clients participated in group treatment in FY 2022-23. Of these participants, 52 were gamblers and 33 were AIs. The average age of gambler clients was 54 years old and 60% were male. Many gamblers (44%) were referred to group treatment by a CalGETS provider. Other referral sources included former CalGETS clients (33%), Gamblers Anonymous (10%), and family or friends (6%), and other sources (7%). The average age of AI clients was 40years old and 82% were female. Most of the AIs (76%) were referred to group treatment by a former CalGETS client, followed by a CalGETS provider (21%), and Gamblers Anonymous (3%). Group Outpatient treatment is usually a step-down treatment from Outpatient treatment and gambler participants are only asked about the gambling they have done in the past 30 days. As a result, a limited number of clients report any kind of gambling (15 reporting slot machine gambling 2 reported poker and 1 reported black jack at tribal casinos; 1 reported video poker at a Las Vegas-style casino; 1 reported Pai Gow and 1 poker at a card room; 1 reported internet poker; and 2 reported gambling on the lottery, and 1 reported gambling on a sporting event). Fifteen percent of gambler participants reported moderately severe to severe depression at screening. Twelve percent of AIs reported moderately severe to severe depression.

Intensive Outpatient (IOP)

Data were available from 59 clients enrolled at Intake in IOP during FY 2022-23 (**Figure 4**). Clients received treatment from Union of Pan Asian Communities (UPAC; N=37), Beit T'Shuvah (N=18), or Westside Gambling Treatment (N=4). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

FIGURE 4. IOP SNAPSHOT



Demographics

A total of 59 clients entered IOP during FY 2022-23. IOP clients' average age was 45. About half (51%) identified as White, Non-Hispanic only, followed by 20% Asian/Pacific Islander only, 12% African American only, 7% Hispanic/Latino only, 5% as Multiracial or Multi-ethnic, 2% Native American, and 3% as another race/ethnicity only. (More detailed analyses of race/ethnicity, gender, and sexual orientation, are available in the appendix.) Like Outpatient clients, IOP clients have fairly high levels of education with 85% reporting some college education or higher. Although clients' household income varied from less than $15,000 per year to $200,000 or higher, 23% of IOP clients reported an income less than $35,000 and 2% declined to state their household income.

Gambling Severity

All IOP clients met criteria established in the DSM-5 for gambling disorder (100%). Specifically, 3% were classified with mild gambling disorder (endorsing 4-5 criteria), 10% with moderate gambling disorder (endorsing 6-7 criteria), and 86% 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 (75%), followed by the Internet (50%), food/convenience stores (9%), and other venues (7%).[10]

Across all venues the most commonly selected gambling activities were slot machines (52%), blackjack (48%), poker (30%), and sports betting (16%).

- At **tribal casinos,** IOP clients most frequently stated that they played slot machines (36%), blackjack (30%), poker (16%), and roulette (5%).
- In the **community**, 9% of clients reported gambling on the Lottery.
- At **other casinos,** clients most frequently reported playing blackjack (27%), slot machines (16%), poker (13%), baccarat (7%), roulette (7%), and craps (5%).
- At **cardrooms,** clients most often reported playing poker (18%) and blackjack (14%).
- On the **Internet**, clients most often indicated playing slots (18%), poker (11%), blackjack (10%), sports (5%), and other internet gambling (7%).
- Finally, clients reported gambling on sporting events (16%) and stocks/financial markets (11%).

Intake to Last Treatment Contact Outcomes

Treatment outcomes are measured by examining depression, anxiety, gambling interference with normal activities, intensity of gambling urge, and life satisfaction (**Table 7**). At Intake, none of the 59 IOP clients had missing data. At last treatment contact, two clients had missing data. IOP participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. During both years, they showed, on average, moderate depression at Intake and mild depression at their last treatment contact. At Intake during both years, on average, gamblers were positive for generalized anxiety (GAD-2), but were below the cutoff at last treatment contact.

TABLE 7. IOP GAMBLER: TREATMENT OUTCOMES FOR FY 2022-23 AND 2021-22

Outcome Indicator	2022-23 Intake Mean	2022-23 LTC Mean	2021-22 Intake Mean	2021-22 LTC Mean
Depression (PHQ-9) score	11	6	11	7
Anxiety (GAD-2) score	3	2	3	2
Gambling interference with normal activities	48	28	58	26
Urge to gamble	52	30	53	28
Life satisfaction	49	62	44	57

Note: FY 2022-23 Intake N=59, Last Treatment Contact (LTC) N=57, FY 2021-22 Intake N=68, LTC N=65.

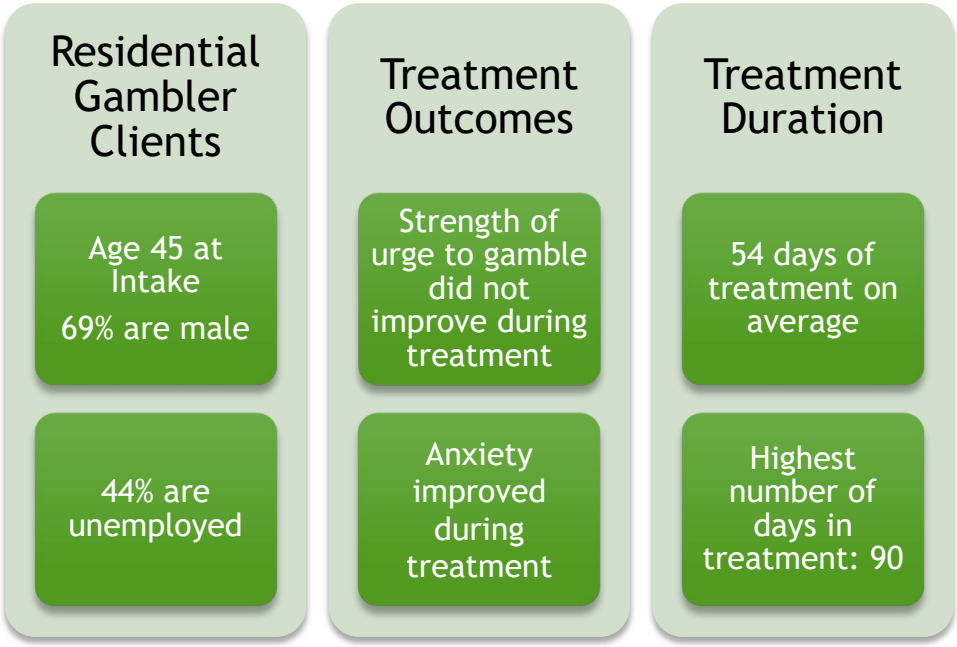
[10] Gambling behavior FY 2022-23 N=56, 3 missing.

Clients' reports of interference by gambling with their normal activities showed an average decrease of 20 points in FY 2022-23 and 32 points from Intake to last treatment contact in FY 2021-22. Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. The intensity of the urge to gamble also decreased from Intake to last treatment contact during both years. In FY 2022-23 it decreased by an average of 22 points and in FY 2021-22 by an average of 25 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble. IOP clients entered treatment reporting lower life satisfaction scores compared to Outpatient clients. Over the course of treatment, IOP clients reported an improvement of 13 points on average in overall life satisfaction during both years. As above, life satisfaction was measured on a 100-point scale.

Residential Treatment Programs (RTP)

Data were available from 16 clients enrolled at Intake in RTP during FY 2022-23 (**Figure 5**). Because COVID-19 directives were still in place, fewer clients could be housed simultaneously and therefore the average wait time to enter treatment was 46 days. The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 5. RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT



Demographics

Three-quarters (75%) of RTP clients identified as White, Non-Hispanic only, followed by 13% African American, 6% Hispanic/Latino only, and 6% other race/ethnicity. (More detailed analyses of race/ethnicity are available in the appendix.) Seventy percent of RTP clients report some college education or higher. RTP clients reported higher household income than in past years, with only 6% reporting that their income was less than $35,000.

Gambling Severity

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

Gambling Behaviors

RTP clients (n=16) 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 (56%) and the Internet (63%) were the most frequently selected gambling venues from the options provided.

Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, sporting events (50%), slot machines (31%), blackjack (19%), and poker (19%) were the most commonly selected gambling activities. Below are the gambling locations and activities reported by 2 or more of the 16 RTP clients.

- At **tribal casinos,** clients most frequently stated that they played slot machines (25%) and poker (13%).
- At **other casinos,** clients most frequently reported playing slot machines (25%), poker (19%), and blackjack (13%).

Intake to Last Treatment Contact Outcomes

Intake to last treatment contact data is available on the 16 clients who entered residential treatment in FY 2022-23 and on the on the 16 clients who entered residential treatment in FY 2021-22 (**Table 8**). During both years, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and LTC. During FY 2022-23, at both Intake and LTC, participants showed mild depression. During FY 2021-22 they showed, on average, an improvement in depression from mild depression at Intake to below the threshold for depression at last treatment contact. About 25% entered treatment with moderate depression during both years. In FY 2022-23, gamblers came into residential treatment with GAD-2 scores indicating generalized anxiety at a diagnosable level which improved during treatment, while in FY 2021-22, GAD-2 scores were below the cut off at Intake and Last Treatment Contact.

TABLE 8. RTP GAMBLER: TREATMENT OUTCOMES FOR FY 2022-23 AND 2021-22

Outcome Indicator	2022-23 Intake Mean	2022-23 LTC Mean	2021-22 Intake Mean	2021-22 LTC Mean
Depression (PHQ-9) score	7	6	7	3
Anxiety (GAD-2) score	3	1	1	1
Gambling interference with normal activities	50	45	56	48
Urge to gamble	40	41	40	31
Life satisfaction	48	33	38	34

Note: FY 2022-23 Intake N=16, Last Treatment Contact (LTC) N=15, FY 2021-22 Intake N=16, LTC N=15.

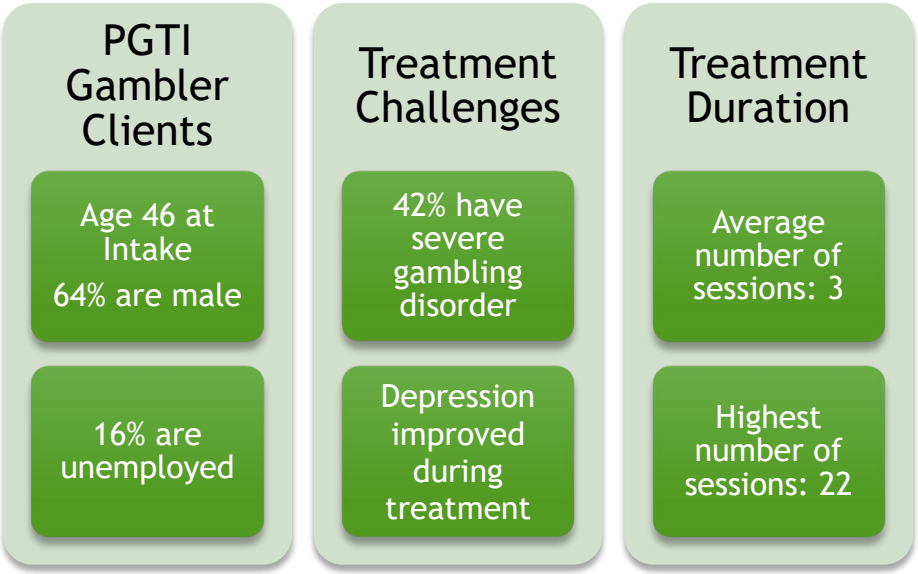
By the end of treatment, the average rating of interference by gambling with normal activities decreased among RTP clients by 5 points in FY 2022-23 and 8 points in FY 2021-22. Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. The intensity of the urge to gamble, on average, did not decrease during FY 2022-23. During FY 2021-22, the urge to gamble decreased from Intake to last

treatment contact by 9 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble. In both years, RTP clients entered treatment with lower ratings of life satisfaction compared to Outpatient or IOP clients. Unlike these other levels of treatment services, over the course of treatment, RTP clients reported a *decrease* on average in overall life satisfaction. As above, life satisfaction was measured on a 100-point scale.

Problem Gambling Telephone Intervention (PGTI)

As described above, PGTI services are provided over the telephone to gamblers and AIs throughout California. Services are provided in English, Spanish, Mandarin, Cantonese, Vietnamese, Korean, Tagalog, Hindi, and additional languages.

FIGURE 6. PGTI PROGRAM SNAPSHOT



The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for PGTI gamblers served.

Within PGTI, data were available for 234 gambler clients enrolled at Intake during FY 2022-23. Of the 229 total clients assessed at Intake, 138 received further treatment services.

Clients participating in PGTI (n=234) most often reported being referred by the Helpline (1-800-GAMBLER) (87%). Referrals also came via former CalGETS clients (4%); family or friends (3%); UCLA Gambling Studies Program (3%); and other sources (3%).

PGTI clients (n=234) participated in three treatment sessions on average, with a maximum of 22 sessions in total.

Demographics

Gamblers in PGTI treatment were, on average, 46 years old and predominately male. Household income varied widely, but 20% had yearly household incomes of less than $35,000. Among PGTI clients, 29% were White, Non-Hispanic only, followed by 24% Asian/Pacific Islander only, 24% Hispanic/Latino only, 12% African American only, 3% another race/ethnicity only, and 5% Multiracial/Multi-ethnic. (See the appendix for more detailed gender, sexual orientation, and race/ethnicity information.) In addition, nearly 70% had completed some college or more (**Table 9**).

TABLE 9. PGTI GAMBLER: DEMOGRAPHICS

Age	(n=234)
Mean Age	46 years old
Gender	(n=234)
Male	64%
Female	36%
Transgender	0%
Race/Ethnicity (for those reporting a single category only)	(n=232)
White, Non-Hispanic only	29%
Asian/Pacific Islander only	24%
Hispanic or Latino only	24%
Black or African American only	12%
American Indian/Alaskan Native only	3%
Other race/ethnicity only	5%
Multiracial or Multi-ethnic	3%
Education	(n=234)
Less than High School	5%
High School	26%
Some College	36%
Bachelor's Degree	27%
Graduate/Professional Degree	6%
Household Income	(n=234)
Less than $15,000	7%
$15,000-$24,999	6%
$25,000-$34,999	7%
$35,000-$49,999	12%
$50,000-$74,999	23%
$75,000-$99,999	15%
$100,000-$149,999	16%
$150,000-$199,999	3%
$200,000 or more	5%
Decline to state	6%

Gambling Severity

Of those enrolled in PGTI services, 93% could be classified as having mild to severe gambling disorder (**Table 10**).

TABLE 10. PGTI GAMBLER: GAMBLING DISORDER (NODS DSM-5) CLASSIFICATION

Severity	NODS Score	N	%
Problem gambling behavior	1 to 3	17	7%
Mild gambling disorder	4 to 5	23	10%
Moderate gambling disorder	6 to 7	96	41%
Severe gambling disorder	8 to 9	98	42%

Note: N=234

Gambling Behaviors

PGTI clients were asked at Intake to describe their gambling behaviors and the types of gambling activities they had engaged in over the last 12 months. Typical gambling locations included casinos, mentioned by 69% of clients, Internet (23%), and food/convenience stores for Lottery tickets (13%). Across all venues, the most common gambling activities were slot machines (44%), blackjack (21%), poker (19%), and sporting event betting (11%).

Clients were able to select multiple activities at each of the major gambling venues. PGTI clients reported gambling activities at tribal casinos most often and the most frequent activities were slot machines (40%), blackjack (14%), and poker (15%). The other major gambling activities were the Lottery (11%) and other gambling activities (10%).

Intake to Last Treatment Contact Outcomes

PGTI participants' levels of depression were measured using the PHQ-9 both at Intake and at the last treatment contact during both years summarized in **Table 11**. Clients showed, on average, mild depression at Intake and subclinical levels of depression at the last treatment contact. Anxiety, as measured by the GAD-2, was below the cut off on average in both years at Intake and Last Treatment Contact. At Intake, PGTI clients' average rating of interference by gambling with normal activities was higher compared to those who responded at the last treatment contact. Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. Among PGTI clients, the intensity of the urge to gamble, on average, was higher at Intake compared to those who responded at the last treatment contact on the 100-point scale. Lower scores at clients' last treatment contact indicated a less intense urge to gamble. PGTI clients reported higher levels on average in overall life satisfaction at last treatment contact compared to Intake during both years. As above, life satisfaction was measured on a 100-point scale.

TABLE 11. PGTI GAMBLER: TREATMENT OUTCOMES FOR FY 2022-23 AND 2021-22

Outcome Indicator	2022-23 Intake Mean	2022-23 LTC Mean	2021-22 Intake Mean	2021-22 LTC Mean
Depression (PHQ-9) score	6	4	5	4
Anxiety (GAD-2) score	2	1	1	1
Gambling interference with normal activities	62	34	51	36
Urge to gamble	73	45	71	51
Life satisfaction	54	65	61	67

Note: FY 2022-23 Intake N=234, Last Treatment Contact (LTC) N=135; FY 2021-22 Intake N=225, LTC N=150.

Health Information on Gamblers

Co-Occurring Health Conditions

A notable percentage of gamblers reported co-occurring health conditions and problematic health behaviors at Intake. Below are health conditions reported by 5% or more of respondents **(Table 12).**

TABLE 12. GAMBLERS: CO-OCCURRING HEALTH RELATED CONDITIONS

Service Level	Self-Reported Hypertension	Self-Reported Diabetes	Self-Reported Obesity	Obesity Calculated from BMI
Outpatient (N = 552)	17%	8%	10%	32%
IOP (N = 56)	11%	7%	7%	31%
RTP (N = 16)	0%	6%	13%	13%
PGTI (N = 234)	11%	14%	5%	29%

- While 10% of CalGETS Outpatient clients reported obesity, using body mass index (BMI) standards, approximately 32% of them meet BMI obesity criteria, slightly higher than the percentage for California adults (28%).[11]
- 17% of CalGETS Outpatient clients reported hypertension and 8% reported diabetes.
- Compared to California adults, smoking percentages were high across the treatment services network – 20% of Outpatient clients reported smoking, nearly twice the state average of 11%.[12] Among RTP clients, 6% reported smoking in FY 2022-23. Of IOP clients, 24% reported smoking. Among PGTI clients, 20% reported smoking.
- About 35% of gamblers across the treatment services network reported their health as fair or poor (38% in Outpatient, 29% in IOP, 13% in RTP, and 31% in PGTI). This compares to 16% of adults in California reporting their health as “fair or poor” in 2021, according to the CDC.[13]
- High percentages of clients in all treatment modalities reported having health insurance (Outpatient 89%, IOP 95%, RTP 100%, and PGTI 91%). A somewhat smaller percentage report that they currently have a physician that they can access for primary care needs (Outpatient 77%, IOP 81%, RTP 94%, and PGTI 81%).

[11] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online], 2021. [accessed Feb 9, 2023]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

[12] California Health Interview Survey. CHIS 2020 and CHIS 2021 Adult Files. Los Angeles, CA: UCLA Center for Health Policy Research; October 2022.

[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], 2021. [accessed Feb 8, 2023]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

Co-Occurring Psychiatric Disorders

CalGETS clients reported that the co-occurring mental health conditions they were treated for most often were mood disorders (up from 19% last year) and anxiety (**Table 13**).

TABLE 13. GAMBLERS: CO-OCCURRING PSYCHIATRIC DISORDERS TREATED FOR IN THE PAST YEAR

Service Level	Mood Disorders	Psychotic Disorders	Anxiety Disorders	Substance Use Disorders	Personality Disorder	ADD/ ADHD
Outpatient (N = 552)	26%	4%	17%	4%	1%	7%
IOP (N = 56)	50%	4%	21%	5%	4%	7%
RTP (N = 16)	81%	0%	6%	0%	0%	6%
PGTI (N = 234)	17%	2%	8%	3%	<1%	2%

Anxiety, Depression, and ADHD Symptom Screening

In addition to self-report of treatment for co-occurring mental health conditions, CalGETS also screened for anxiety, depression, and ADHD.

- At treatment entry, 47% of CalGETS Outpatient clients were above the cutoff on the GAD-2 anxiety screener, indicating that they have a possible diagnosis of Generalized Anxiety Disorder. Additionally, 53% of IOP, 50% of RTP, and 16% of PGTI clients scored above the cutoff on the GAD-2 anxiety screener.
- 41% of CalGETS Outpatient clients, 48% of IOP, 25% of RTP, and 20% of PGTI clients scored in the moderate to severe depression range at Intake as measured by the PHQ-9. This is compared to 8% of adult Californians reporting a major depressive episode in the past year.[14]
- 4% of CalGETS Outpatient clients scored above the cutoff for adult attention-deficit hyperactivity disorders (ADHD) on the ASRS screening instrument, indicating that they have a possible diagnosis of ADHD. Additionally, 10% of IOP, 0% of RTP, and 1% of PGTI clients scored above the cutoff.

Substance Use Behaviors

- Among Outpatient clients, 55% reported at Intake that they drank alcoholic beverages. In other treatment modalities, a smaller percentage of clients reported current drinking: 32% among IOP clients, 13% among RTP clients, and 36% among PGTI clients.
- Of Outpatient clients, 24% reported at least one binge drinking episode (more than five drinks in a single occasion for men, more than four drinks in a single occasion for women) in the month before treatment entry. Among IOP clients, 9% reported binge

[14] SAMHSA, Center for Behavioral Health Statistics and Quality, *2021 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 32) [accessed Dec 3, 2023]. URL https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf.

drinking in the past month; 6% RTP clients, and 17% of PGTI clients reported binge drinking in the past month. This is compared to the 22% of California adults reporting any binge drinking in the past month.[15]

After alcohol, cannabis was the most frequently reported substance used in the past month across the treatment services network, with 21% of CalGETS clients in Outpatient reporting use of cannabis. This is higher than the 15% reported by NSDUH for past month use in California in 2021.[16] Approximately 9% of IOP, 13% of RTP, and 12% of PGTI clients reported cannabis use in the past month. However, clients also reported use of other substances (**Table 14**).

TABLE 14. GAMBLERS: SUBSTANCE USE IN THE PAST 30 DAYS

Service Level	Cocaine	Cannabis	Methamphetamine	Opiates
Outpatient (N = 545)	3%	21%	2%	1%
IOP (N = 59)	2%	9%	3%	2%
RTP (N = 16)	0%	13%	13%	0%
PGTI (N = 234)	1%	12%	1%	0%

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 the RTP program has experience providing substance use disorder treatment, it is better able to meet the complex needs of the CalGETS clients in residential treatment who have co-occurring substance use 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.

[15] SAMHSA, Center for Behavioral Health Statistics and Quality, *2021 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 15) [accessed Dec 2, 2023]. URL https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf.

[16] SAMHSA, Center for Behavioral Health Statistics and Quality, *2021 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 3) [accessed Dec 2, 2023]. URL https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf.

5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2022-23 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

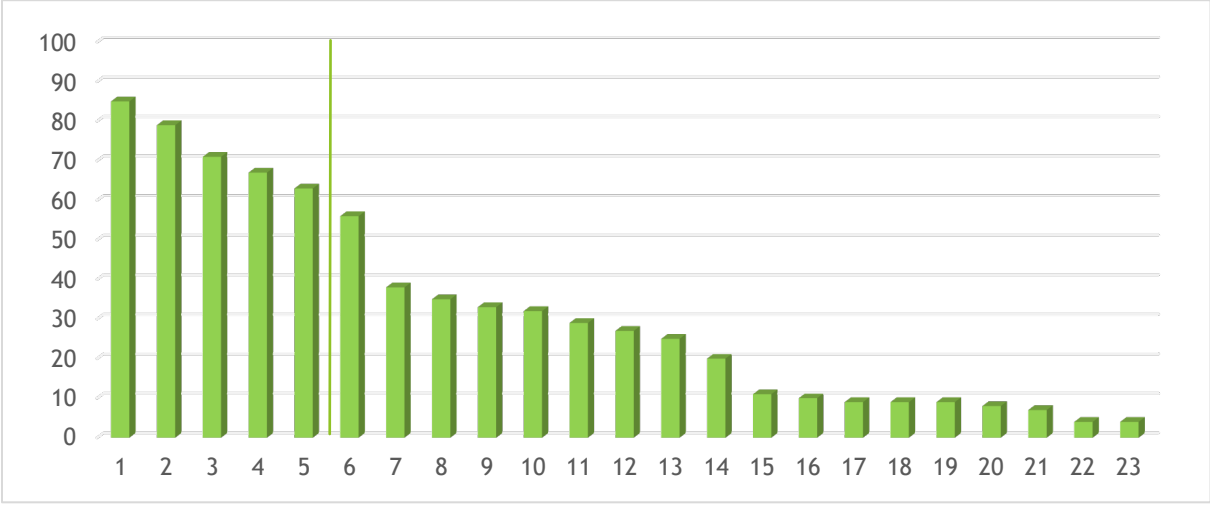
In FY 2022-23, a total of 234 AIs entered treatment across the treatment services network (**Table 15**). Most (94%) were served as Outpatients (n=219). The remaining 15 clients received treatment from PGTI.

TABLE 15. TREATMENT SERVICES: NUMBER OF NEW CLIENT INTAKES FOR GAMBLERS

Service Level	FY 2021-22 N	Percent	FY 2022-23 N	Percent
Outpatient	220	94%	219	94%
Problem Gambling Telephone Intervention (PGTI)	13	6%	15	6%
Total	233	100%	234	100%

The number of Outpatient treatment sessions AIs attended ranged from 0 to 23, excluding the Intake and End of Treatment sessions. AI attendance in Outpatient was greater than 60% during the primary treatment sessions (sessions 1-5) (**Figure 7**).

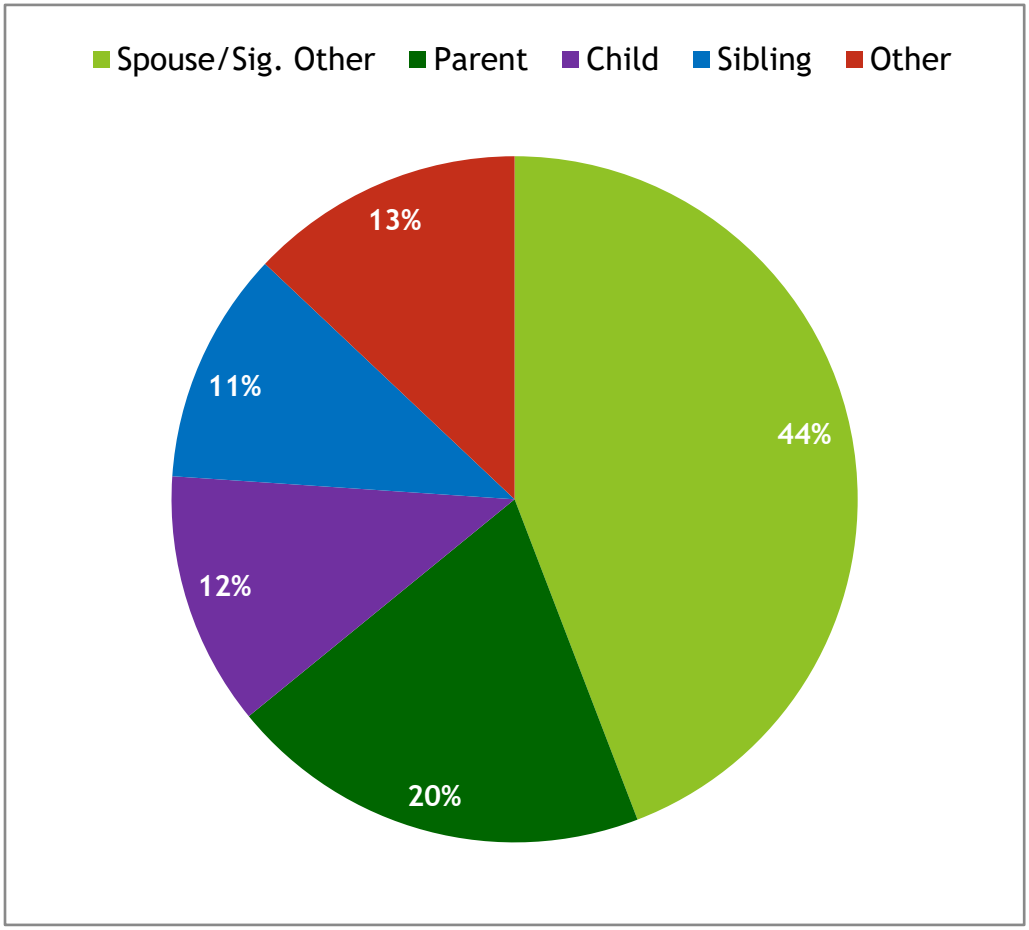
FIGURE 7. OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Note: N=219

Of the 219 Outpatient AI clients, 44% identified as a spouse or significant other of a gambler, 20% as a parent of a gambler, 12% as an adult child of a gambler, 11% as a sibling of a gambler, and 13% were another relation to a gambler (**Figure 8**).

FIGURE 8. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

AIs in Outpatient treatment were 43 years old, on average, and predominately female (79%), whereas about two-thirds of gambler clients are male. About 36% were White, Non-Hispanic, followed by 33% Hispanic/Latino, 14% Asian/Pacific Islander, 6% African American, 0% American Indian/Alaska Native, 9% another race/ethnicity, and 3% Multiracial/Multi-ethnic. (See the appendix for more detailed gender, sexual orientation, and race/ethnicity information.) Similar to Outpatient gamblers, Outpatient AIs have widely varying household incomes and high education levels, but 51% report a household income of less than $35,000 per year. A high percentage (77%) report having some college education or higher (**Table 16**).

TABLE 16. OUTPATIENT AI: DEMOGRAPHICS

Age	n=219
Mean Age	44 years old
Gender	n=219
Male	21%
Female	79%
Transgender	0%
Choose not to disclose	0%
Race/Ethnicity (for those reporting a single category only)	n=219
White, Non-Hispanic only	36%
Asian/Pacific Islander only	14%
Hispanic or Latino only	33%
Black or African American only	6%
American Indian/Alaska Native only	0%
Other race/ethnicity only	3%
Multiracial or Multi-ethnic	8%
Education	n=219
Less than High School	6%
High School	16%
Some College	32%
Bachelor's Degree	30%
Graduate/Professional Degree	16%
Household Income	n=219
Less than $15,000	35%
$15,000-$24,999	7%
$25,000-$34,999	9%
$35,000-$49,999	13%
$50,000-$74,999	18%
$75,000-$99,999	8%
$100,000-$149,999	5%
$150,000-$199,999	3%
$200,000 or more	2%
Decline to State	0%

Treatment Service Findings

Intake to Last Treatment Contact Outcomes

As seen in **Table 17**, AIs have mild depression scores at Intake and at their last treatment contact scores were at the subclinical level, on average in FY 2022-23. For FY 2021-22, AIs entered treatment with mild depression on average and at LTC had a lower mild depression score (PHQ-9 range is 0 – 27). For generalized anxiety, AIs entered treatment with average scores above the threshold for generalized anxiety. (Anxiety scores were not available for FY 2021-22.) In both years, average life satisfaction scores (measured on a scale from 0 to 100) are moderate at Intake and at LTC are slightly higher. In addition, 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 improved (decreased), on average, from treatment Intake to the last treatment contact (both measured on a scale from 0 to 100). In addition, AIs reported a decrease in the amount of time they spent dealing with the consequences of problem gambling (measured on a scale from 0 to 100).

TABLE 17. OUTPATIENT AI: TREATMENT OUTCOMES FOR FY 2022-23 AND 2021-22

Outcome Indicator	FY 2022-23 Intake Mean	FY 2022-23 Last Treatment Contact Mean	FY 2021-22 Intake Mean	FY 2021-22 Last Treatment Contact Mean
Depression (PHQ-9) score	8	4	8	5
Anxiety (GAD-2) score	3	1	2	3
Life satisfaction	61	66	62	66
Degree to which problem gambler's behaviors have interfered with normal activities	45	39	47	34
Feel responsible for gambler's treatment and recovery	39	33	39	28
Percentage of time spent dealing with the consequences of problem gambling	47	40	45	35

Note: FY 2022-23 Intake N=214, LTC N=175; FY 2021-22 Intake N=196, LTC N=183.

Health Information on Affected Individuals

Co-occurring health diagnoses reported by AIs were similar in prevalence to gamblers; however, a smaller percentage (27%) of AIs participating in the outpatient program reported that their health was fair or poor. Nineteen percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking was 4% in FY 2022-23,

lower than the percentage of smokers among Californians (11%).[17] Also, 80% reported that they had health insurance.

Also of note was the percentage of Outpatient AIs who reported current drinking (35%) relative to Outpatient gamblers (55%). Cannabis use in the past 30 days was reported by 11% of Outpatient AIs, while 2% reported opioid use, 1% reported cocaine use, and 1% reported methamphetamine use in the past 30 days.

In regard to co-occurring psychiatric disorders reported at Intake, using the PHQ-9 criteria, 33% of AI clients reported moderate to severe depression, and 39% are above the threshold for generalized anxiety disorder.

[17] California Health Interview Survey. CHIS 2020 and CHIS 2021 Adult Files. Los Angeles, CA: UCLA Center for Health Policy Research; October 2022.

6. FOLLOW-UP OF TREATMENT PARTICIPANTS

UGSP staff members collect follow-up data from clients served within Outpatient, IOP, RTP, and PGTI modalities using GRM/Visual Vault's web-based DMS. Follow-up interviews with treatment participants take place at 30 days, 90 days, and one year after treatment entry via telephone survey. For those clients who agree to participate in follow-up interviews, the DMS automatically generates follow-up forms for each client. 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 2022-23, therefore, five attempts were made to reach each client.

During FY 2022-23, 889 clients completed the CalGETS intake form. Of these clients, 793 consented to participate in follow-up for an opt-in rate of 89%. Compared to during the pandemic (FY 2021-22), the number of completed surveys went down dramatically during FY 2022-23, primarily because the number of people answering the phone calls from the follow-up staff substantially decreased (**Table 18**).

TABLE 18. COMPLETED SURVEYS BY FISCAL YEAR

Outcome	FY 2022-23	FY 2021-22
Number of completed surveys	137	261

Table 19, 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 2022-23. The numbers differ slightly from DMS data because they are based on call logs. UGSP made more than 3,000 attempts to reach clients for follow-up interviews; completing 137 interviews, and ultimately closing 327 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 19. FOLLOW-UP: ATTEMPTS, COMPLETED INTERVIEWS, AND CLOSED CASES

Status	30-day G	30-day AI	30-day Total	90-day G	90-day AI	90-day Total	1-Yr G	1-Yr AI	1-Yr Total	Total G	Total AI	Grand Total
Attempts	1,040	201	1,241	923	225	1,148	586	94	680	2,549	520	3,069
Completed	54	6	60	49	14	63	10	4	14	113	24	137
Closed	112	20	132	88	21	109	69	17	86	269	58	327

Note: G = Gamblers, AI = Affected individuals

Because the number of CalGETS participants reached by phone for follow-up interviews has been low, UGSP and OPG developed a new data collection strategy for implementation in FY 2023-24. The follow-up surveys were programmed into the Qualtrics survey platform to be sent by email and text message to those opting in. Phone calls will continue as an additional means of reaching participants. Next year's report will include the results of these efforts.

7. CLINICAL INTEGRATIONS

Housed within UGSP, clinical integration projects create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY 2022-23, UGSP and OPG worked with two community agencies to address disparities in problem gambling education and treatment.

Facilitating Latino/a Community Utilization of CalGETS Services *Visión y Compromiso*

The project in Los Angeles and San Diego Counties is designed to increase CalGETS utilization among Latino communities. There are three elements to this project: training, community outreach, and evaluation. To inform the training, focus groups were conducted with *Visión y Compromiso* (VyC) *promotoras* (lay health workers) and jointly analyzed by UGSP and VyC. UGSP developed an extensive gambling-specific training informed by the focus group results and provided a focus group report to OPG. VyC delivered the training to *promotoras* in Los Angeles and San Diego. UGSP conducted an evaluation of these trainings and prepared a training evaluation report for OPG. In FY 2022-23, VyC implemented the outreach protocol for the two target counties. UGSP is assessing the community outreach activities using qualitative and quantitative methods that include outcomes from three data sets: (1) a data set tracking *promotoras* activities in the two counties; (2) helpline call data from TELUS; and, (3) CalGETS utilization data from the Data Management System. During FY 2022-23, plans were made to expand the *promotoras* outreach to other high-need counties.

Gambling Disorder Screening at the Riverside San Bernardino Indian Health Clinic

A California Gambling Education and Treatment Services (CalGETS) Pilot Project

This clinical integration project involves providing education, screening, and treatment referrals for those with gambling problems in the tribal community. This project is being implemented by Riverside San Bernardino Indian Health Clinics (RSBIHC) with support from UGSP and OPG and includes plans for data sharing as well as an evaluation of the program implementation. Dr. Timothy Fong of UGSP provided training sessions to RSBIHC peer specialists on techniques to implement screening for problem gambling. He also provided trainings to RSBIHC physicians and therapists on how to identify problem gambling and assist patients to obtain CalGETS treatment services.

References

Adler, L. A., Spencer, T., Faraone, S. V., Kessler, R. C., Howes, M. J., Biederman, J., & Secnik, K. (2006). Validity of pilot Adult ADHD Self-Report Scale (ASRS) to rate adult ADHD symptoms. *Annals of Clinical Psychiatry, 18*(3), 145-148.

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

Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E. V. A., ... & Walters, E. E. (2005). The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. *Psychological medicine, 35*(2), 245-256.

Kessler, R. C., Adler, L. A., Gruber, M. J., Sarawate, C. A., Spencer, T., & Van Brunt, D. L. (2007). Validity of the World Health Organization Adult ADHD Self-Report Scale (ASRS) Screener in a representative sample of health plan members. *International journal of methods in psychiatric research, 16*(2), 52-65.

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

Kroenke, K., Spitzer, R. L., Williams, J. B., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of internal medicine, 146*(5), 317-325.

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

Matza, L. S., Van Brunt, D. L., Cates, C., & Murray, L. T. (2011). Test–retest reliability of two patient-report measures for use in adults with ADHD. *Journal of Attention Disorders, 15*(7), 557-563.

APPENDIX: DETAILED RACE/ETHNICITY AND GENDER CATEGORIES

TABLE 20. GAMBLERS: NUMBER OF INDIVIDUALS REPORTING RACE/ETHNICITY BY LEVEL OF TREATMENT SERVICE

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 579	IOP N = 59	RTP N = 16	PGTI N = 232
White, Non-Hispanic	232	30	12	70
Black or African American	52	12	0	56
American Indian/Alaskan Native	<11	<11	0	<11
Hispanic/Latino categories				
Mexican, Mexican American, Chicano	112	<11	<11	52
Puerto Rican	<11	0	0	0
Cuban	<11	0	0	0
Other Hispanic	24	<11	0	<11
Asian/Pacific Islander categories				
East Asian	41	11	0	21
South Asian	<11	<11	0	<11
Southeast Asian	54	<11	0	29
Pacific Islanders	<11	0	0	<11
Other race/ethnicity	35	<11	<11	12
Multiracial or Multi-ethnic[18]	52	<11	<11	<11

Note: In accordance with Assembly Bill 1726, data on specific Asian and Pacific Islander groups was collected; however, aggregate data categories are presented in instances that could permit identification of individuals. Race/ethnicity numbers for those reporting in a category in which there are 10 or less individuals are indicated by <11.

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

TABLE 21. GAMBLERS: GENDER DETAILS BY LEVEL OF TREATMENT SERVICE, ACTUAL NUMBERS

Gender – assigned at birth	Outpatient N = 580	IOP N = 59	PGTI N = 234
Male	393	40	150
Female	187	19	84
Unknown	0	0	0
Gender – current self-described gender	**Outpatient N = 580**	**IOP N = 59**	**PGTI N = 234**
Male	390	41	152
Female	185	18	82
Transgender woman	<11	0	<11
Transgender man	<11	0	<11
Other gender category	<11	0	<11

TABLE 22. GAMBLERS: SEXUAL ORIENTATION DETAILS BY LEVEL OF TREATMENT SERVICE, ACTUAL NUMBERS

Sexual Orientation	Outpatient N = 580	IOP N = 59	PGTI N = 234
Lesbian, gay, or homosexual	49	<11	<11
Straight or heterosexual	508	51	225
Bisexual	<11	<11	<11
Don't know	<11	<11	<11
Choose not to disclose	12	0	<11
Something else	<11	0	<11

Note: Gender and sexual orientation numbers for those reporting in a category in which there are 10 or less individuals are indicated by <11. RTP numbers are not reported for Affected Individuals to prevent identification of individuals.

TABLE 23. AI: NUMBER OF INDIVIDUALS REPORTING RACE/ETHNICITY BY LEVEL OF TREATMENT SERVICE

Race/Ethnicity	Outpatient N = 219
White, Non-Hispanic	79
Black or African American	14
American Indian/Alaskan Native	0
Hispanic/Latino categories	
Mexican, Mexican American, Chicano	75
Puerto Rican	0
Cuban	<11
Other Hispanic	<11
Asian categories	
East Asian	15
South Asian	<11
Southeast Asian	15
Pacific Islanders	<11
Multiracial or Multi-ethnic[19]	17
Other race/ethnicity	<11

Note: In accordance with Assembly Bill 1726, data on specific Asian and Pacific Islander groups was collected; however, aggregate data categories are presented in instances that could permit identification of individuals. Race/ethnicity numbers for those reporting in a category in which there are 10 or less individuals are indicated by <11. PGTI numbers are not reported for Affected Individuals because all Ns are <11.

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

TABLE 24. AI: GENDER DETAILS BY LEVEL OF TREATMENT SERVICE

Gender – assigned at birth	Outpatient N = 219
Male	46
Female	173
Unknown	-
Gender – current self-described gender	**Outpatient N = 219**
Male	46
Female	173
Transgender woman	0
Transgender man	0
Choose not to disclose	0

TABLE 25. AI: SEXUAL ORIENTATION DETAILS BY LEVEL OF TREATMENT SERVICE

Sexual Orientation	Outpatient N = 219
Lesbian, gay, or homosexual	<11
Straight or heterosexual	206
Bisexual	<11
Don't know	<11
Choose not to disclose	<11
Something else	<11

Note: Gender and sexual orientation numbers for those reporting in a category in which there are 10 or less individuals are indicated by <11. PGTI numbers are not reported for Affected Individuals because all Ns are <11.

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