California Department of Public Health

CalGETS ANNUAL TREATMENT SERVICES REPORT

FISCAL YEAR 2024-25

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 2024-25

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 (family members and friends affected by someone with problem gambling). Nearly 1,000 individuals received treatment through CalGETS in fiscal year (FY) 2024-25. 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 21,500 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 affected individuals. Treatment is provided via a range of treatment modalities in the Treatment Services Network and is available in a variety of languages. At follow-up, CalGETS clients report 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 affected individuals, including:

- **Outpatient** treatment is offered by a network of OPG-authorized, licensed mental health providers. Gamblers and affected individuals participate in

individual and group treatment that is based on the provider's treatment approach and philosophy. Treatment incorporates CalGETS training and clinical guidance, which gives providers access to leading-edge knowledge and developments in the field of gambling treatment.

- **Intensive Outpatient (IOP)** allows 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 affected individuals in English, Spanish, and various Asian languages. Telephone intervention allows access to treatment services for clients who may be disabled or lack internet access.

CalGETS Providers: A Diverse and Skilled Workforce

CalGETS trains, authorizes, provides clinical guidance, and oversees 143 licensed mental health providers, as well as oversees six treatment programs, all engaged in delivering evidence-based treatment to gamblers and affected individuals. Treatment services are available in 25 languages/dialects.

CalGETS Treatment Outcomes (FY 2024-25)

Gamblers:

- A total of 799 gamblers received treatment across the treatment network. More than three quarters (78%) received outpatient services, 10% were served in PGTI, 10% were served in IOP, and 2% were served in RTP. Of gamblers enrolled in outpatient services, 96 were served in group treatment.
- By the end of CalGETS treatment, client levels of depression, on average, improved to 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 from Intake to Last Treatment Contact.
- The intensity of gambling urges reported by CalGETS clients from Intake to Last Treatment Contact decreased.
- Life satisfaction increased from Intake to Last Treatment Contact.

CALGETS GAMBLER CHARACTERISTICS AT INTAKE: HEALTH AND WELLNESS

General Health	According to the California Health Interview Survey (CHIS), 17% of adults in California reported their health as "fair or poor" in 2024. In comparison, 36% of outpatient gamblers reported "fair or poor" health.
Smoking	Among CalGETS outpatient clients, 14% currently smoke. This percentage is nearly three times the state average of 5.4% (CHIS). In IOP, the prevalence of smoking is 18%, among PGTI clients 8%, and among RTP clients 12%.
Alcohol Use	At Intake, 47% of CalGETS outpatient clients reported they drank alcoholic beverages. 20% 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 16% of adult Californians reporting binge drinking in the past month (CHIS).
Cannabis	According to CHIS, 15% of the adult population of California reported using cannabis within the past month. Among CalGETS outpatient clients, 16% used cannabis.
Health Insurance	About 87% of CalGETS outpatient clients reported having health insurance but less is known about their costs to maintain insurance, including premiums and deductibles.
Access to Care	Approximately 80% of CalGETS outpatient clients reported they currently have a physician they can access for primary care needs.
Obesity	27% of CalGETS outpatient clients meet Body Mass Index obesity criteria.
Depression	39% of CalGETS outpatient clients scored in the moderate to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 7% of adult Californians reporting a major depressive episode in the past year (National Survey on Drug Use and Health) and 14% reporting serious psychological distress in the past year (CHIS).
Anxiety	42% 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 9% of outpatient clients may have ADHD.

Affected Individuals:

- 176 affected individuals received treatment across the treatment network. Nearly all were served as Outpatients, while less than 11 clients received treatment from PGTI.
- Affected individuals are spouses/significant others (36%), parents/step-parents (23%), adult children (26%), or a close relative (sibling, aunt/uncle, grandparent) or another relation to a gambler (15%); 73% of affected individuals are female.
- At Intake, 43% of affected individuals reported moderate to severe depression.
- During treatment, the degree to which affected individuals 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 affected individuals differed from gamblers; a larger percentage (45%) of affected individuals reported that their health was fair or poor. Twenty-four percent of Outpatient affected individuals had a body mass index indicating obesity. The percentage of affected individuals reporting smoking was 4% in FY 2024-25, lower than the percentage of smokers among Californians (5.4%). Also, 79% 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. Beginning in July 2023, UGSP introduced online surveys and transitioned the follow-up process from the DMS to the Qualtrics online survey platform. As a result, UGSP completed 305 treatment follow-up surveys.

Cultural and Linguistic Clinical Integrations

UGSP oversees clinical integration projects that create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY 2024-25, UGSP and OPG worked with three community agencies, *Visión y Compromiso,* Riverside San Bernadino County Indian Health, Inc., and Los Angeles County Substance Abuse Prevention and Control (SAPC) to address disparities among those reached for CalGETS screening, education, and treatment.

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 in Los Angeles, San Diego, Kern, and Tulare counties. Additionally, UGSP provided project development, training, project monitoring, and evaluation services.

UGSP partnered with Riverside San Bernadino County Indian Health, Inc. (RSBCIHI) to conduct a pilot project to provide education, screening, and treatment referrals for those with gambling problems in the tribal community. This project is being implemented by RSBCIHI with support from UGSP and OPG. UGSP provided training sessions to RSBCIHI peer specialists, physicians and therapists on techniques to implement screening for problem gambling and on CalGETS intake.

UGSP initiated a pilot study with Substance Abuse Prevention and Control (SAPC), Los Angeles County Department of Public Health: UGSP and SAPC Screening and Gambling Treatment for Patients in Substance Use Disorder (SUD) Treatment Programs. This study involves training treatment providers, screening SUD treatment clients, and monitoring outcomes.

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.[1,2] 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 over one million individuals today). An additional 6-7% (2.3 to 2.7 million individuals today) were estimated to be classified as lifetime at-risk gamblers – those who scored low on the problem gambling screen, but who 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 (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.
- 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.

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[1] Volberg, R. A., McNamara, L. M., & Carris, K. L. (2018). Risk factors for problem gambling in California: Demographics, comorbidities and gambling participation. *Journal of Gambling Studies*, *34*(2), 361-377.

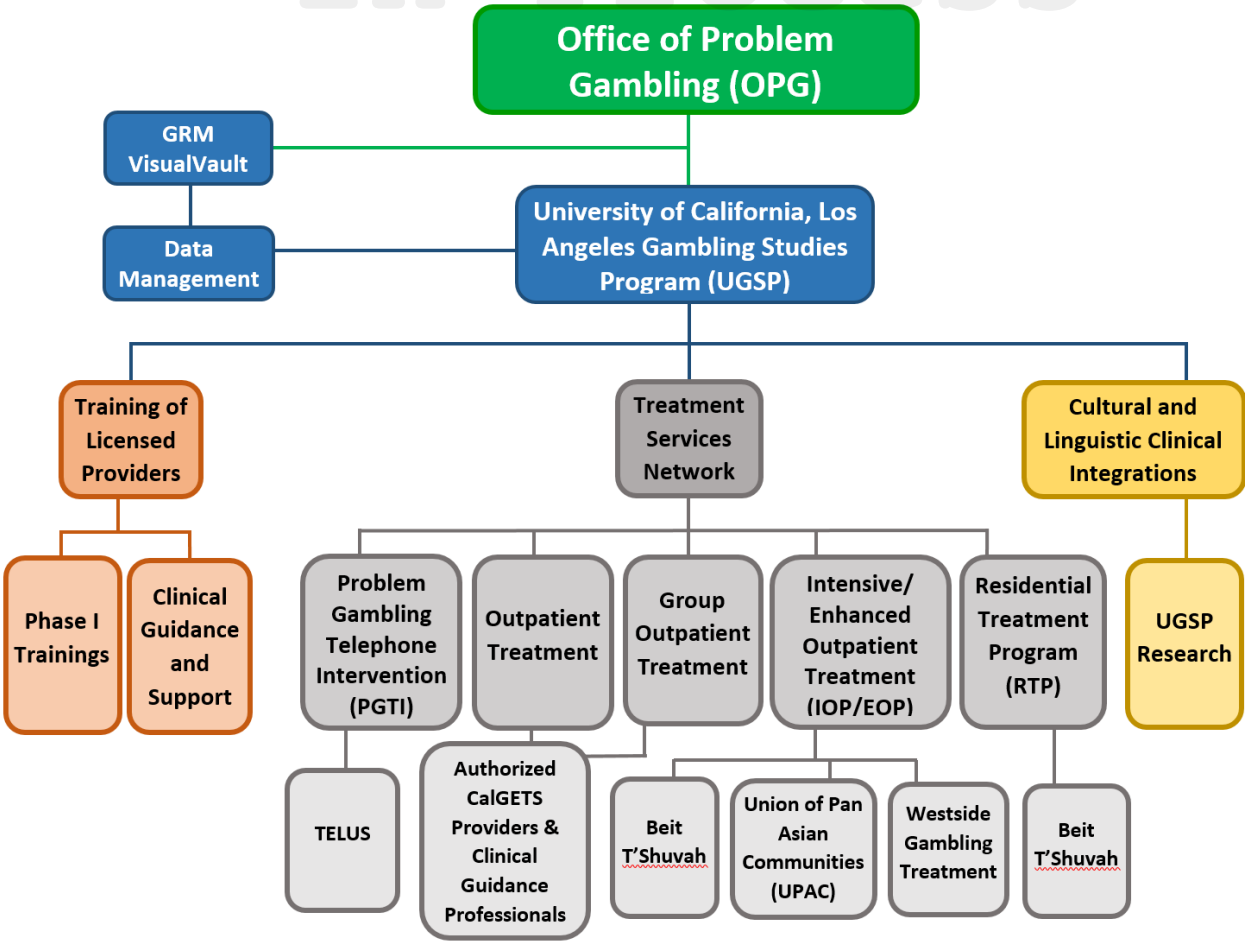
[2] Williams, R. J., Volberg, R. A., & Stevens, R. M. G. (2012). The population prevalence of problem gambling: Methodological influences, standardized rates, jurisdictional differences, and worldwide trends. Guelph: Ontario Problem Gambling Research Centre.

- 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 21,500 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: Problem Gambling Telephone Intervention (PGTI) for gamblers and affected individuals, Outpatient (Individual and Group) treatment for gamblers and affected individuals, Intensive/Enhanced 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 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 evidence-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 25 languages/dialects. To improve services during the COVID pandemic, CalGETS/OPG implemented a telehealth treatment option starting in December 2020. 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 affected individuals 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 2024-25, there were 143 active, authorized CalGETS providers. Gamblers and affected individuals may also receive 24 in-treatment group sessions. This does not include the mandatory individual screening prior to attending group in-treatment sessions or the individual end-of-group session. Group treatment sessions may be comprised of a mixture of gamblers and affected individuals and must include 3-10 participants.

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. They deliver IOP services three times per week, three hours each day.

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 2023-24 and provides six hours of weekly group therapy and a single hour of individual counseling with a trained gambling addiction specialist.

Residential Treatment Programs (RTP): Individuals with gambling disorder, including those with significant co-occurring disorders, 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 Gamblers Anonymous and other self-help groups. Treatment addressing co-occurring conditions such as mood disorders and substance abuse is provided as needed.

Problem Gambling Telephone Intervention (PGTI): Gamblers and affected individuals may receive up to three treatment blocks of eight sessions in the PGTI program. Telephone intervention allows access to treatment services for clients who prefer telephone-based treatment or who may not be able to attend in-person programs or internet-based telehealth appointments. 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 and online surveys 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. Starting in Fiscal Year 2023-24, online survey capability was added via the Qualtrics survey platform and follow-up results include results from both telephone interviews and online surveys. (See Section 5 for more details.)

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 affected individuals throughout California. (See Section 6 for more details.)

2. FY 2024-25 TREATMENT REPORT DATA SOURCES AND METHODS

Data Sources

Data were obtained from the CalGETS client forms completed during Fiscal Year 2024-25. Data are entered by CalGETS providers into the CalGETS Data Management System (DMS), an online, real-time data entry, storage, and reporting system. 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.

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.[3] 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

[3] 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.

over the past two 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. 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 an updated scoring algorithm – that assigns 0-4 points for Likert responses to each question of "never," "rarely," "sometimes," "often," and "very often." The summed range is 0-24, with a cutoff point of 14 or more to screen positive for ADHD. Total scores of 0-9 = low negative, 10-13 = high negative, 14-17 = low positive range, and 18-24 = high positive (Department of Health Care Policy Harvard Medical School, 2024).

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

PHQ-9: See Above.

GAD-2: See Above.

ASRS-v.1.1: See Above.

Life Satisfaction: See Above.

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

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

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

Analyses

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 ASRS scoring update described above was applied to the current analyses, so the results may not be comparable to reporting from past years.

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 that the "dose" of treatment a client receives may vary not only by the type of treatment they participate in, but also in how long they chose to participate. To ensure we capture data about clients as they leave treatment (Last Treatment Contact), we utilize data from the End of Treatment (EOT) form, or, from the client's last In-Treatment form when an EOT form is not available. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Version 30. Data distributions were examined and, if necessary, extreme outliers were trimmed to reduce the effect of possibly spurious values. To protect participants' privacy, percentage reporting in demographic categories in which there are 10 or fewer individuals is represented by a less-than sign (<) or if all cells are 10 or less, that row or column is not included or combined with another category. 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 2024-25.

Treatment Service Provision

In FY 2024-25, a total of 799 gamblers entered treatment across the treatment services network (**Table 1**). Most clients (78%) enrolled in Outpatient, followed by PGTI (10%), IOP (10%), and RTP (2%). In addition, 96 Outpatient clients received group treatment. During FY 2023-24, a total of 878 gamblers entered treatment across the treatment services network. Most clients (66%) enrolled in Outpatient, followed by PGTI (23%), IOP (8%), and RTP (3%). Of these clients, 76 also participated in Outpatient Group services.

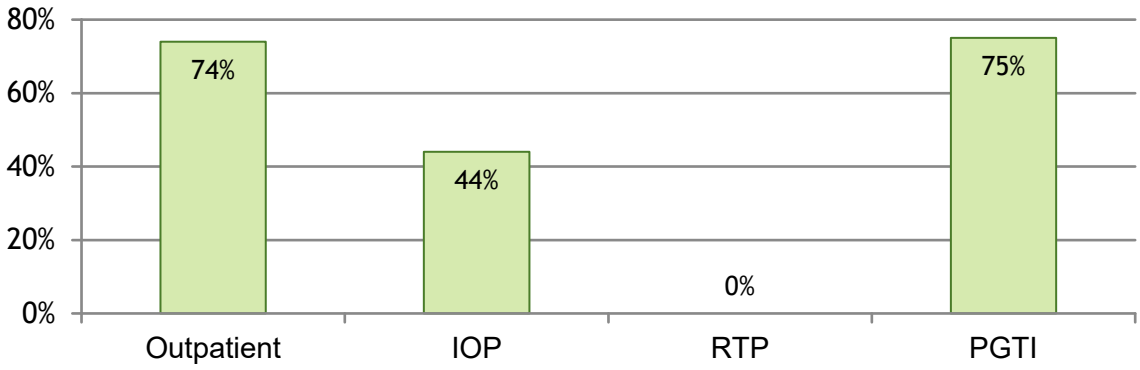
TABLE 1. TREATMENT SERVICES: NUMBER OF NEW CLIENT INTAKES FOR GAMBLERS

Service Level	FY 2023-24 N	Percent	FY 2024-25 N	Percent
Outpatient	582	66%	627	78%
Outpatient Group	*(76)*	-	*(96)*	-
Intensive Outpatient Program (IOP)	72	8%	76	10%
Residential Treatment Programs (RTP)	22	3%	17	2%
Problem Gambling Telephone Intervention (PGTI)	202	23%	79[4]	10%
Total[5]	878	100%	799	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, 44% entered treatment within a week. Entry into RTP was delayed, but 77% entered within one month.

[4] PGTI numbers declined in FY 2024-25 due to a break in service.
[5] 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 2024-25



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 = 598	IOP N = 74	RTP N = 17	PGTI N = 77	Total N = 766	CA Population[6] N = 38,965,193
White, Non-Hispanic only[7]	40%	42%	71%	31%	40%	34%
Hispanic or Latino only	23%	<	<	31%	22%	40%
Asian/Pacific Islander only	19%	<	<	16%	18%	17%
Black or African American only	6%	<	0	<	6%	7%
Other race/ethnicity only	4%	<	<	<	4%	2%
Multiracial or Multi-ethnic[8]	8%	32%	<	<	10%	4%

Note: Outpatient had 29 cases with missing data. IOP had 2 cases with missing data. RTP had 0 cases with missing data. PGTI had 2 cases with missing data. Percentages for those reporting in a category in which there are 10 or less individuals are indicated by <.

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[6] Quick Facts: California, US Census Bureau, July 1, 2023 population estimate accessed 04/13/2025, at https://www.census.gov/quickfacts/fact/table/CA#. For Census percentages, "Hispanics may be of any race, so also are included in applicable race categories," as a result, the column total adds up to more than 100%.

[7] "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.

[8] "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 co-occurring behavioral health condition. Generalized anxiety was most prevalent among gamblers, with more than 266 reporting symptoms of anxiety, followed by depression (more than 254), binge drinking (more than 122), smoking (more than 90), cannabis use (more than 99), and ADHD (more than 46).

TABLE 3. TREATMENT SERVICES: NUMBER OF PROBLEM GAMBLERS SERVED WITH PRIORITIZED CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS

Behavioral Health Condition	Outpatient	IOP	Residential	PGTI
Depression	205	31	<11	18
Anxiety	220	32	<11	14
ADHD	46	<11	<11	<11
Smoking	76	14	<11	<11
Cannabis Use	87	12	0	<11
Binge Drinking	105	17	<11	<11

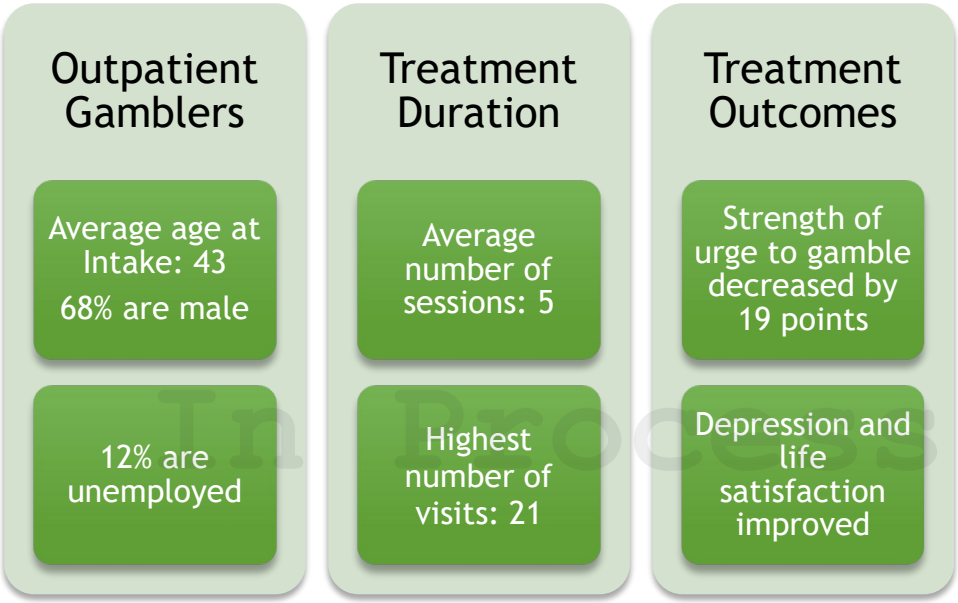
Note: Numbers for Outpatient and other service levels add up to more than the number of clients for that service level because each client may have more than one co-occurring behavioral health condition.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown earlier in Table 1,[9] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 627 problem gambler clients who enrolled in outpatient services. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2024-25, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (35%), family/friends (10%), former clients (9%), treatment providers' websites (7%), health care professionals (9%), Gamblers Anonymous/Gam-Anon (6%), another CalGETS provider (12%), and the California Council on Problem Gambling (5%). In addition, 7% cited other sources including the UPAC IOP program, employee assistance programs, OPG website, media (television, radio, newspaper, and billboard), UCLA Gambling Studies Program, casino signage, community presentations, community health workers, Internet searches, or the Psychology Today referral website.

The number of sessions completed by outpatient gambler clients (n= 627) varied:

- 29% of clients had only an Intake session
- 47% received 2-8 treatment sessions
- 23% received 9-16 treatment sessions
- 1% received 17-22 treatment sessions

[9] 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 43 years and ranged in age from 18 to 85 years. More than two-thirds (68%) were male. Clients identified their race as White, Non-Hispanic (40%), followed by 23% Hispanic/Latino, 19% reporting Asian/Pacific Islander, 6% African American, 4% another race/ethnicity, and 8% multiracial/multi-ethnic. (Fewer than 11 clients reported American Indian/Alaska Native race/ethnicity. More detailed analyses of race/ethnicity, gender, and sexual orientation, are available in the appendix.) Clients are, for the most part, well educated; nearly 75% reported completing some college or above. At Intake, 76% of clients were employed full- or part-time and 12% described themselves as unemployed. The reported household income varied widely from less than $15,000 per year to over $200,000, but 22% reported incomes of less than $35,000 (**Table 4**).

TABLE 4. OUTPATIENT GAMBLER: DEMOGRAPHICS

Age	N= 627
Mean Age	43 years old
Gender	N= 627
Male	68%
Female	31%
Transgender or Other	<
Race/Ethnicity (for those reporting a single category only)	N= 598
White, Non-Hispanic	40%
Hispanic or Latino	23%
Asian/Pacific Islander	19%
Black or African American	6%
American Indian/Alaska Native	1%
Other race/ethnicity	3%
Multiracial or Multi-ethnic	8%
Education	N= 627
Less than High School	5%
High School	21%
Some College	26%
Bachelor's Degree	8%
Graduate/Professional Degree	41%
Household Income	N= 627
Less than $15,000	12%
$15,000-$24,999	5%
$25,000-$34,999	5%
$35,000-$49,999	9%
$50,000-$74,999	15%
$75,000-$99,999	11%
$100,000-$149,999	13%
$150,000-$199,999	8%
$200,000 or more	14%
Decline to state	9%

Note: Outpatient race/ethnicity had 29 cases with missing data. Percentages for those reporting in a category in which there are 10 or less individuals are indicated by a less-than sign (<). Percentages may add up to greater than 100% due to rounding. Additional details on race/ethnicity, gender, and sexual orientation can be found in the Appendix.

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.

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

Severity	NODS Score	%
Problem gambling behavior	1 to 3	<
Mild gambling disorder	4 to 5	5%
Moderate gambling disorder	6 to 7	21%
Severe gambling disorder	8 to 9	72%

Note: N= 551 Percentages for those reporting in a category in which there are 10 or less individuals are indicated by <.

Gambling Behaviors

At Intake, outpatient clients (n= 627) were asked to indicate both their typical gambling locations and the types of gambling activities that they have engaged at those locations over the last 12 months.

Across all venues the most commonly selected gambling activities were slot machines (41%), blackjack (30%), sports betting (27%), poker (17%), and lottery/scratchers (16%).

Clients were able to select multiple activities at each of the major gambling venues.

- At **tribal casinos,** clients most frequently stated that they played slot machines (33%), blackjack (18%), poker (9%), roulette (6%), and baccarat (5%).[10]
- At **other casinos,** clients most frequently reported playing slot machines (17%), blackjack (15%), poker (9%), and roulette (5%).
- On the **Internet**, clients most often indicated sports betting (26%), playing slots (12%), blackjack (13%), poker (6%), fantasy sports betting (6%), and other internet gambling (12%, financial trading, including day trading, stocks, options and crypto trading were mentioned most often).
- In the **community**, 13% of clients reported gambling on lottery tickets and 13% on scratchers.
- At **cardrooms,** clients most often reported playing poker (7%), and blackjack (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**).

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

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 2023-24 and 2024-25. 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 2023-24 AND 2024-25

Outcome Indicator	2023-24 Intake Mean	2023-24 LTC Mean	2024-25 Intake Mean	2024-25 LTC Mean
Depression (PHQ-9) score	9	6	9	5
Anxiety (GAD-2) score	3	2	3	2
Gambling interference with normal activities	52	30	54	32
Urge to gamble	54	34	55	36
Life satisfaction	53	64	54	61

Note: FY 2023-24 Intake N= 582, Last Treatment Contact (LTC) N= 522, FY 2024-25 Intake N= 529, LTC N= 439.

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 2023-24 and by 22 points from Intake to Last Treatment Contact in FY 2024-25.

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 by 20 points in FY 2023-24 and by 19 points on the 100-point scale in FY 2024-25. 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 9 points on average in overall life satisfaction in FY 2023-24 and 7 points in FY 2024-25.

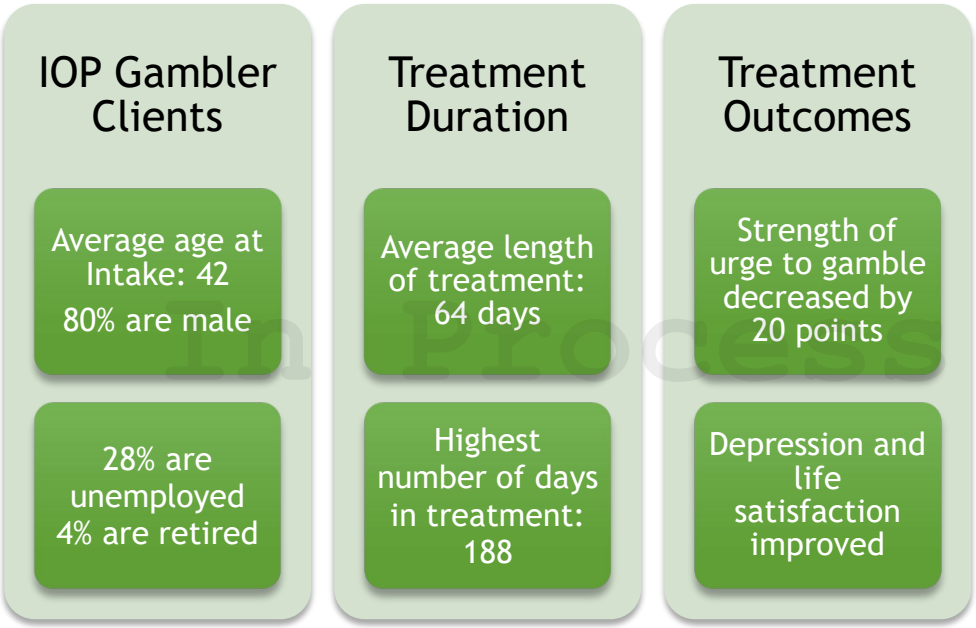
Group Outpatient

A total of 96 clients participated in group treatment in FY 2024-25. Of these participants, 77 were gamblers and 19 were affected individuals. The average age of gambler clients was 48 years old and 66% were male.

Intensive Outpatient (IOP)

Data were available from 76 clients enrolled at Intake in IOP during FY 2024-25 (**Figure 4**). Clients received treatment from Union of Pan Asian Communities (UPAC; N= 34), Beit T'Shuvah (N= 13), or Westside Gambling Treatment (N= 29). 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 76 clients entered IOP during FY 2024-25. IOP clients' average age was 42. Forty-two percent identified as White, Non-Hispanic only, followed by Multiracial or Multiethnic (32%), Asian/Pacific Islander, African American, Hispanic/Latino, and another race/ethnicity. (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 71% reporting some college education or higher. Although clients' household income varied from less than $9,999 per year to $200,000 or higher, 7 % of IOP clients reported an income of less than $35,000, and 45% of IOP clients reported an income greater than $100,000.

Gambling Severity

All IOP clients met criteria established in the DSM-5 for gambling disorder (100%). Specifically, 4% were classified with mild gambling disorder (endorsing 4-5 criteria), 12% 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), the internet was the most frequently selected gambling venue from the options provided (78%), followed by casinos (50%), and food/convenience stores (17%).

Across all venues the most commonly selected gambling activities were sports betting (47%), slot machines (46%), blackjack (38%), poker (24%), and lottery/scratchers (17%).

- At **tribal casinos,** clients most frequently stated that they played slot machines (32%), blackjack (20%), and poker (11%).
- At **other casinos,** clients most frequently reported playing poker (11%), blackjack (13%), and slot machines (24%).
- On the **Internet**, clients indicated sports betting (43%), blackjack (25%), slots (22%), poker (16%), and other internet gambling (14%, including stocks, options and crypto trading) were their most frequent gambling activities.
- At **cardrooms,** clients most often reported playing blackjack (8%).

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, 5 of the 76 IOP clients had missing data, and at LTC, 3 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, mild depression at Intake and improved mild depression at their Last Treatment Contact. During both years, on average, gamblers were positive for generalized anxiety (GAD-2) at Intake, but were below the cutoff at Last Treatment Contact.

TABLE 7. IOP GAMBLER: TREATMENT OUTCOMES FOR FY 2023-24 AND 2024-25

Outcome Indicator	2023-24 Intake Mean	2023-24 LTC Mean	2024-25 Intake Mean	2024-25 LTC Mean
Depression (PHQ-9) score	9	6	9	5
Anxiety (GAD-2) score	3	2	3	2
Gambling interference with normal activities	45	29	52	36
Urge to gamble	52	35	54	34
Life satisfaction	44	56	56	69

Note: FY 2023-24 Intake N= 72, Last Treatment Contact (LTC) N= 72, FY 2024-25 Intake N= 71, LTC N= 73.

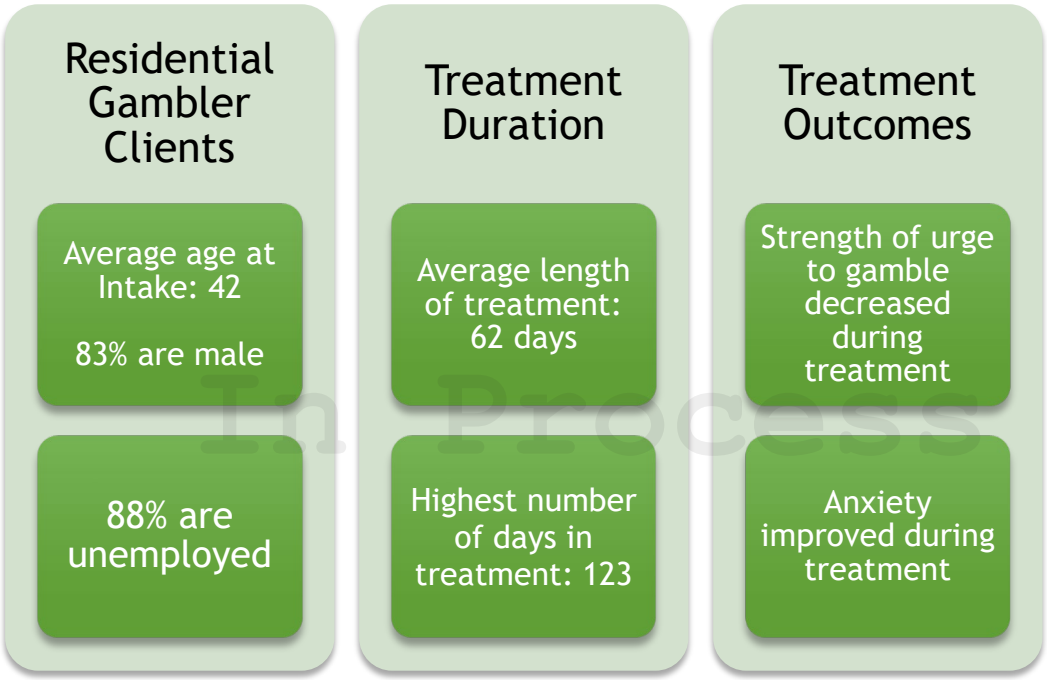
Clients' reports of interference by gambling with their normal activities showed an average decrease of 16 points in FY 2023-24 and 16 points from Intake to Last Treatment Contact in FY 2024-25. Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. The

intensity of the urge to gamble also decreased from Intake to Last Treatment Contact during both years. In FY 2023-24 it decreased by an average of 17 points and in FY 2024-25 by an average of 20 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 FY 2023-24 and an improvement of 13 points in FY 2024-25. As above, life satisfaction was measured on a 100-point scale.

Residential Treatment Program (RTP)

Data were available from 17 clients enrolled at Intake in RTP during FY 2024-25 (**Figure 5**). The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 5. RESIDENTIAL TREATMENT PROGRAM SNAPSHOT



Demographics

More than two-thirds (71%) of RTP clients identified as White, Non-Hispanic only, and the other 29% were other races/ethnicities or multiracial. (More detailed analyses of race/ethnicity are available in the appendix.) Twenty-nine percent of RTP clients report some college education or higher. Although clients' household income varied, just over 75% reported incomes between $50,000 and $100,000.

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=17) 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), the Internet (94%) and casinos (47%) 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, sports betting (82%), blackjack (65%), poker (68%), and slot machines (24%), were the most commonly selected gambling activities. Below are the gambling locations and activities reported by 2 or more of the 17 RTP clients.

- At **tribal casinos,** clients most frequently stated that they played poker (12%) blackjack (12%), and slots (12%).
- At **other casinos,** clients most frequently reported playing blackjack (41%), poker (41%), and slots (18%).
- On the **Internet**, clients indicated sports betting (82%), blackjack (53%), poker (53%), and slots (18%) were their most frequent gambling activities.

Intake to Last Treatment Contact Outcomes

Intake to Last Treatment Contact data is available on the 22 clients who entered residential treatment in FY 2023-24 and on the 17 clients who entered residential treatment in FY 2024-25 (**Table 8**). During both years, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and LTC. During FY 2023-24 and FY 2024-25 they showed, on average, an improvement in depression from mild depression at Intake to below the threshold for depression at Last Treatment Contact. In FY 2023-24 gamblers came into residential treatment with GAD-2 scores indicating generalized anxiety at a diagnosable level and at Last Treatment Contact GAD-2 scores were below the cut off. In FY 2024-25, RTP clients were below the GAD-2 cutoff at both Intake and LTC.

TABLE 8. RTP GAMBLER: TREATMENT OUTCOMES FOR FY 2023-24 AND 2024-25

Outcome Indicator	2023-24 Intake Mean	2023-24 LTC Mean	2024-25 Intake Mean	2024-25 LTC Mean
Depression (PHQ-9) score	7	3	5	3
Anxiety (GAD-2) score	3	2	2	1
Gambling interference with normal activities	55	63	74	66
Urge to gamble	48	33	50	39
Life satisfaction	49	56	60	66

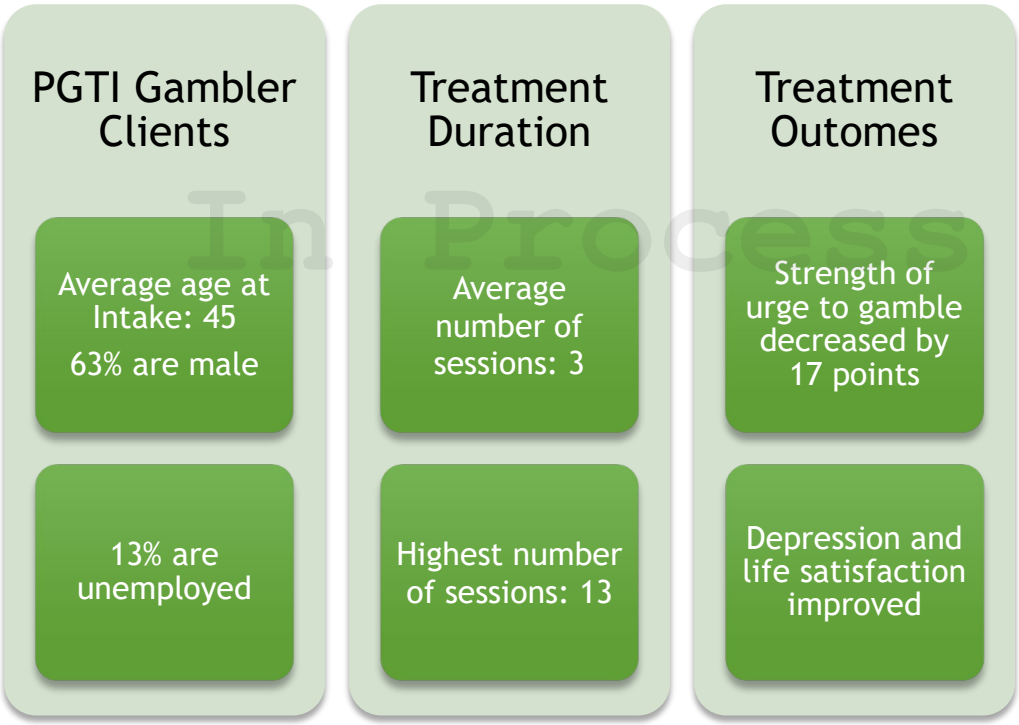
Note: FY 2023-24 Intake N= 22, Last Treatment Contact (LTC) N= 22, FY 2024-25 Intake N= 17, LTC N= 17.

Surprisingly, in FY 2023-24, RTP clients judged interference by gambling with normal activities to be 8 points higher at LTC than at Intake. However, in FY 2024-25, RTP clients reported an average decrease of 8 points. Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities. During FY 2023-24 the urge to gamble decreased from Intake to Last Treatment Contact by 15 points on the 100-point scale and during FY 2024-25 the urge decreased by 11 points. Lower scores at LTC indicated a less intense urge to gamble. RTP clients reported an increase in overall life satisfaction by 7 points over the course of treatment in FY 2023-24, and they reported higher levels of life satisfaction over the course of treatment by 6 points in FY 2024-25. 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 affected individuals throughout California. Services are provided in English, Spanish, Mandarin, Cantonese, Vietnamese, Korean, Tagalog, Hindi, and additional languages. The PGTI program has two goals – to provide immediate service delivery and to transfer clients to outpatient services if needed. As a result, treatment duration is shorter and treated clients have lower levels of gambling disorder severity. The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for PGTI gamblers served.

FIGURE 6. PGTI PROGRAM SNAPSHOT



Within PGTI, data were available for 79 gambler clients enrolled at Intake during FY 2024-25. Of the 79 total clients assessed at Intake, 42 received further treatment services. Clients participating in PGTI most often reported being referred by the Helpline (1-800-GAMBLER) (92%) and 8% came from other referral sources. PGTI clients participated in 3 treatment sessions on average, with a maximum of 13 sessions in total.

Demographics

Gamblers in PGTI treatment were, on average, 45 years old and predominately male. Household income varied widely, but 20% had yearly household incomes of less than $35,000. Among PGTI clients, 31% were White, Non-Hispanic only, 31% Hispanic/Latino only, followed by 16% Asian/Pacific Islander only, and 22% another race/ethnicity or multiracial/multi-ethnic. (See the appendix for more detailed gender, sexual orientation, and race/ethnicity information.) In addition, 66% had completed some college or more (**Table 9**).

TABLE 9. PGTI GAMBLER: DEMOGRAPHICS

Age	(N= 79)
Mean Age	45 years old
Gender	(N= 79)
Male	63%
Female	37%
Transgender or Other	0%
Race/Ethnicity (for those reporting a single category only)	(N= 77)
White, Non-Hispanic only	31%
Hispanic or Latino only	31%
Asian/Pacific Islander only	16%
Other Race/Ethnicity or Multiracial or Multi-ethnic	22%
Education	(N= 79)
Less than High School or High School	34%
Some College or Bachelor's Degree	33%
Graduate/Professional Degree	33%
Household Income	(N= 79)
Less than $34,999	20%
$35,000-$74,999	30%
$75,000-$100,000 or more	28%
Decline to state	22%

Note: Two clients were missing race/ethnicity data. Percentages for those reporting in a category in which there are 10 or less individuals have been combined with other categories. Additional details on race/ethnicity, gender, and sexual orientation can be found in the Appendix. Percentages may add up to greater than 100% due to rounding.

Gambling Severity

Of those enrolled in PGTI services, 92% 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	%
Problem gambling behavior	1 to 3	<
Mild gambling disorder	4 to 5	22%
Moderate gambling disorder	6 to 7	33%
Severe gambling disorder	8 to 9	37%

Note: N= 76 Percentages for those reporting in a category in which there are 10 or less individuals are indicated by <.

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 tribal or Las Vegas-style casinos, mentioned by 70% of clients, and Internet (23%). Across all venues, the most common gambling activities were slot machines (54%), blackjack (18%), poker (14%), and sports betting (14%).

Clients were able to select multiple activities at each of the major gambling venues. PGTI clients reported gambling activities at tribal casinos most often (65%) and the most frequent activities at tribal casinos were slot machines (44%), and blackjack (15%).

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 as 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.

PGTI clients' reports of interference by gambling with their normal activities showed an average decrease of 24 points in FY 2023-24 and 26 points from Intake to Last Treatment Contact in FY 2024-25. Client reports are made on a scale from 0 to 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 2023-24 it decreased by an average of 25 points and in FY 2024-25 by an average of 17 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble. Over the course of treatment, PGTI clients reported an improvement of 12 points on average in overall life satisfaction in FY 2023-24 and 5 points in FY 2024-25. As above, life satisfaction was measured on a 100-point scale.

TABLE 11. PGTI GAMBLER: TREATMENT OUTCOMES FOR FY 2023-24 AND 2024-25

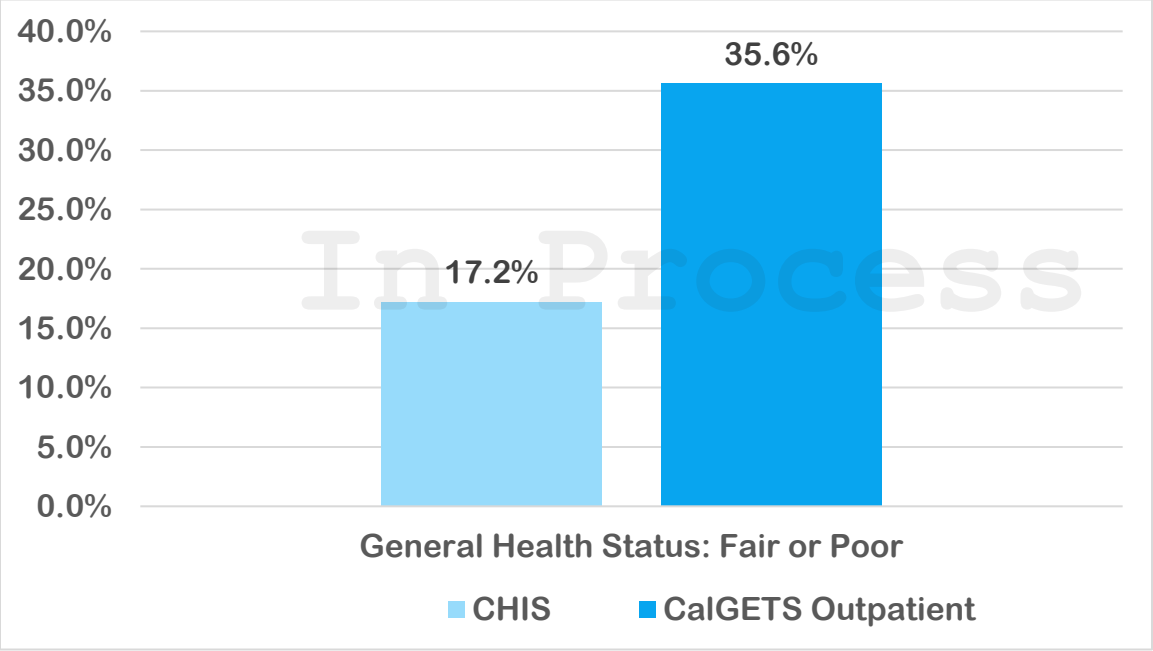
Outcome Indicator	2023-24 Intake Mean	2023-24 LTC Mean	2024-25 Intake Mean	2024-25 LTC Mean
Depression (PHQ-9) score	5	3	6	3
Anxiety (GAD-2) score	1	1	1	1
Gambling interference with normal activities	65	41	59	33
Urge to gamble	72	47	67	50
Life satisfaction	51	63	53	58

Note: FY 2023-24 Intake N= 202, Last Treatment Contact (LTC) N= 114; FY 2024-25 Intake N= 75, LTC N= 41.

Health Information on Gamblers

Gamblers enrolled in CalGETS tend to report greater health challenges than other adult Californians. About 29% of gamblers across the treatment services network reported their general health as fair or poor (36% in Outpatient, 34% in IOP, 12 % in RTP, and 32% in PGTI). This compares to 17% of adults in California reporting their health as "fair or poor" in 2024 (**Figure 7**), according to CHIS.[11]

FIGURE 7. ADULT GENERAL HEALTH STATUS: FAIR OR POOR



Note: CHIS 2024 California adult general health status - fair or poor. CalGETS Outpatient had 76 cases with missing data.

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).**

[11] California Health Interview Survey, 2024. [accessed December 6, 2025]. URL: https://healthpolicy.ucla.edu/our-work/askchis

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 = 627)	11%	9%	6%	27%
IOP (N = 76)	13%	5%	15%	41%
RTP (N = 17)	0%	6%	18%	18%
PGTI (N = 79)	15%	13%	11%	27%

- While 6% of CalGETS Outpatient clients reported obesity, using body mass index (BMI) standards, approximately 27% of them meet BMI obesity criteria, slightly lower than the percentage for California adults (28%).[12]
- 11% of CalGETS Outpatient clients reported hypertension and 9% reported diabetes.
- High percentages of clients in all treatment modalities reported having health insurance (Outpatient 87%, IOP 88%, 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 80%, IOP 80%, RTP 94%, and PGTI 83%).

Co-Occurring Psychiatric Disorders

CalGETS clients reported that the co-occurring mental health conditions they were treated for most often were mood disorders and anxiety. Below are psychiatric disorders that 5% or more of respondents reported they were treated for in the past year (**Table 13**).

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

Service Level	Mood Disorders	Anxiety Disorders	ADD/ADHD
Outpatient (N = 627)	23%	17%	6%
IOP (N = 76)	44%	17%	5%
RTP (N = 17)	88%	6%	6%
PGTI (N = 79)	17%	17%	<5%

[12] Centers for Disease Control and Prevention. Adult Obesity Prevalence Maps. U.S. Dept of Health and Human Services; 2023. [accessed November 11, 2025]. URL https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-maps.html.

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 (**Table 14**).

- 39% of CalGETS Outpatient clients, 41% of IOP, 24% of RTP, and 24% of PGTI clients scored in the moderate to severe depression range at Intake as measured by the PHQ-9. This is compared to 7% of adult Californians reporting a major depressive episode[13] and 13.5% reporting serious psychological distress in the past year. [14]
- At treatment entry, 42% 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, 42% of IOP, 29% of RTP, and 19% of PGTI clients scored above the cutoff on the GAD-2 anxiety screener.
- 9% 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, 5% of IOP, 0% of RTP, and 3% of PGTI clients scored above the cutoff.

TABLE 14. GAMBLERS: MENTAL HEALTH SCREENING

Service Level	PHQ-9 Depression	GAD-2 Anxiety	ASRS ADHD
Outpatient (N = 627)	39%	42%	9%
IOP (N = 76)	41%	42%	5%
RTP (N = 17)	24%	29%	0%
PGTI (N = 79)	24%	19%	3%

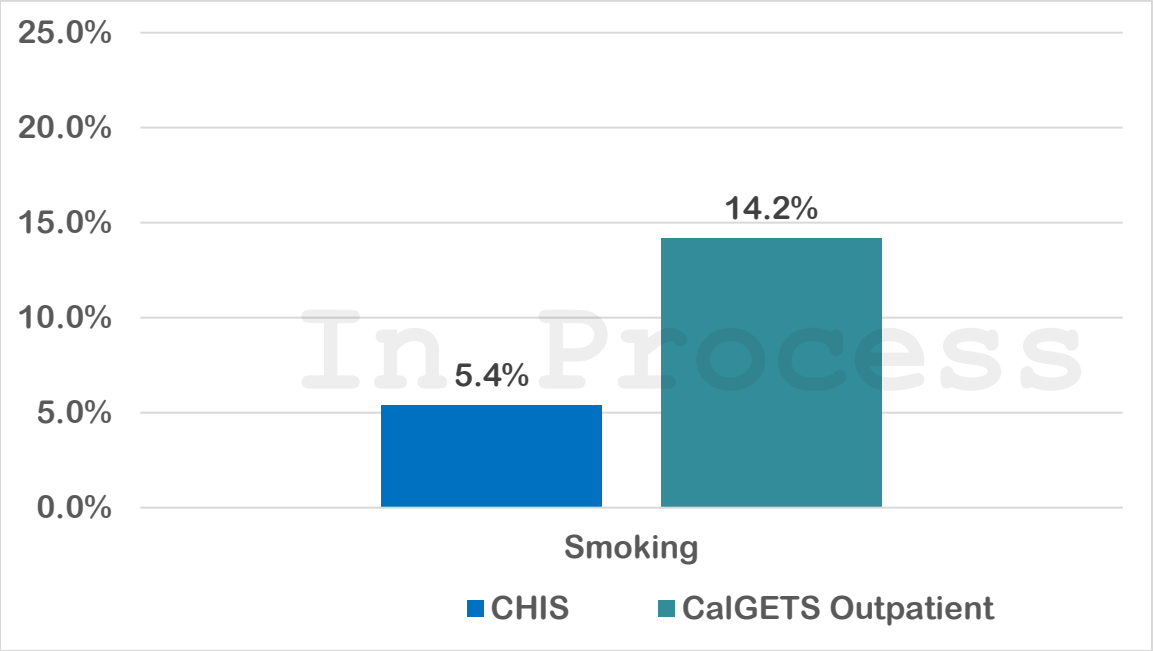
[13] SAMHSA, Center for Behavioral Health Statistics and Quality, *2022-2023 National Surveys on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)* (Table 38) [accessed April 15, 2025]. URL https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf.

[14] California Health Interview Survey, 2024. [accessed April 2, 2026]. URL: https://healthpolicy.ucla.edu/our-work/askchis

Substance Use Behaviors

Compared to California adults, smoking percentages were high across the treatment services network – 14% of Outpatient clients reported smoking, nearly three times the state average of 5.4% for current adult smoking (**Figure 8**).[15] Among RTP clients, 12% reported smoking in FY 2024-25. Of IOP clients, 18% reported smoking. Among PGTI clients, 8% reported smoking.

FIGURE 8. SMOKING

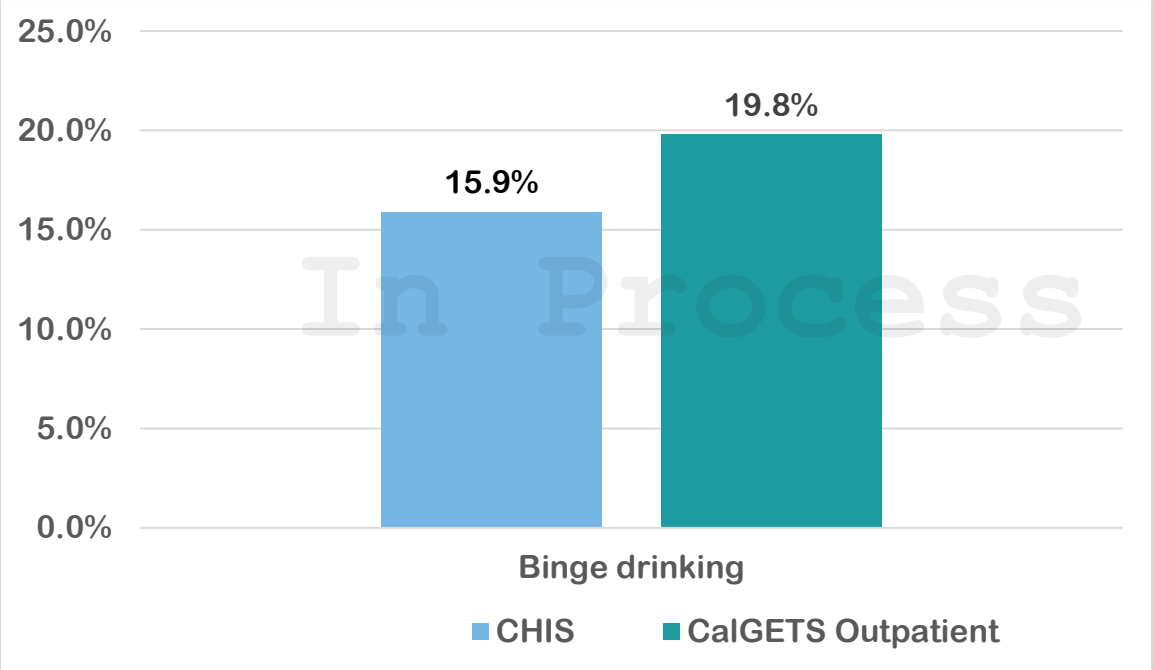


Note: CHIS 2024 California adult current smoking status. CalGETS Outpatient had 93 cases with missing data.

[15] California Health Interview Survey, 2024. [accessed December 6, 2025]. URL: https://healthpolicy.ucla.edu/our-work/askchis

Among Outpatient clients, 47% reported at Intake that they drank alcoholic beverages. In other treatment types, a smaller percentage of clients reported current drinking: 44% among IOP clients and 44% among PGTI clients.[16] Of Outpatient clients, 20% 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, 22% reported binge drinking in the past month, and 6% of PGTI clients reported binge drinking in the past month.[17] This is compared to the 16% of California adults reporting any binge drinking in the past month (**Figure 9**).[18]

FIGURE 9. BINGE DRINKING

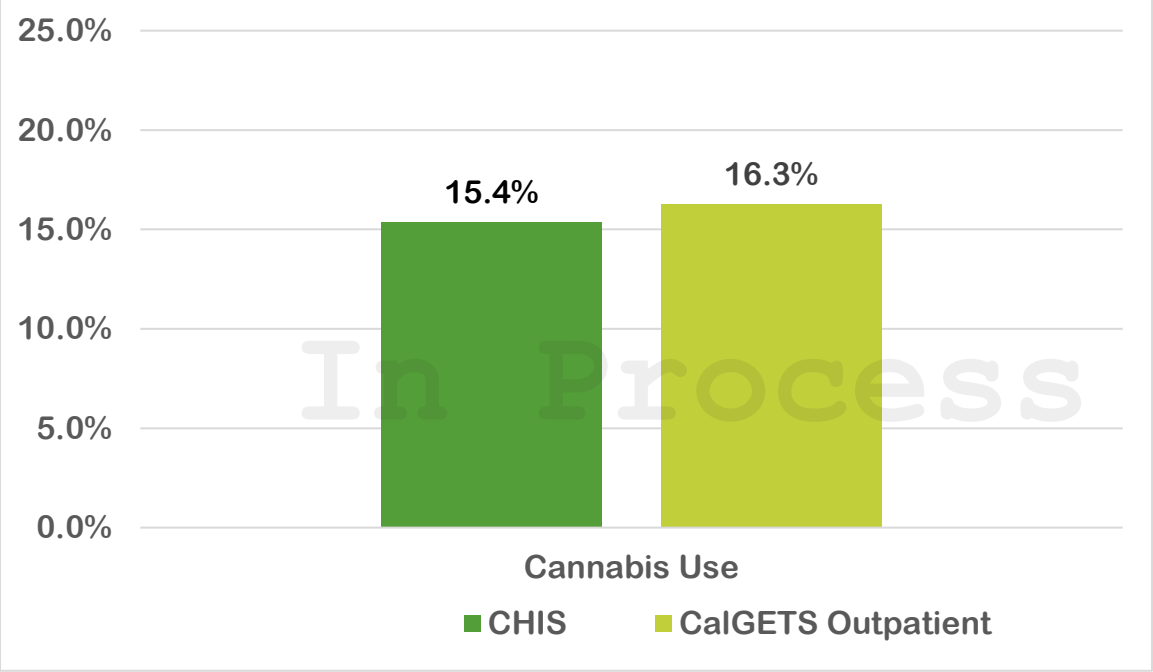


Note: CHIS 2024 California adult binge drinking past month. CalGETS Outpatient had 96 cases with missing data.

[16] RTP not included here because of small number.
[17] RTP not included here because of small number.
[18] California Health Interview Survey, 2024. [accessed December 6, 2025]. URL: https://healthpolicy.ucla.edu/our-work/askchis

After alcohol, cannabis was the most frequently reported substance used in the past month across the treatment services network, with 16% of CalGETS clients in Outpatient reporting use of cannabis (**Figure 10**). This is similar to the percentage (15%) reported by CHIS for past month use in California in 2024.[19] Approximately 16% of IOP clients, 0% of RTP clients reported cannabis use in the past month. However, clients also reported use of other substances (**Table 15**).

FIGURE 10. CANNABIS USE



Note: CHIS 2024 California adult, last time used marijuana – past month. Data corrected for whole population (using the total population that was asked the "ever used" question). CalGETS Outpatient had 94 cases with missing data.

TABLE 15. GAMBLERS: SUBSTANCE USE IN THE PAST 30 DAYS

Service Level	Cocaine	Cannabis	Methamphetamine	Opiates
Outpatient (N = 627)	4%	16%	<	<
IOP (N = 76)	<	16%	0%	0%
RTP (N = 17)	<	0%	<	0%
PGTI (N = 79)	0%	<	0%	0%

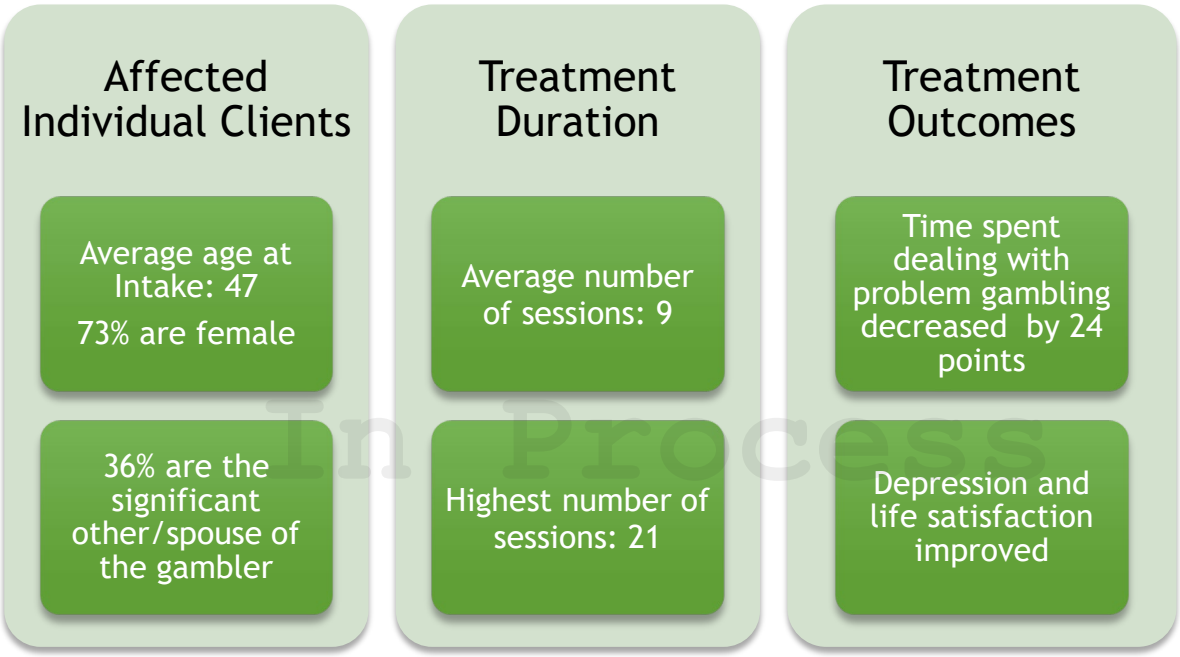
Note: Percentages for those reporting in a category in which there are 10 or less individuals are indicated by a less-than sign (<).

[19] California Health Interview Survey, 2024. [accessed December 6, 2025]. URL: https://healthpolicy.ucla.edu/our-work/askchis

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.

4. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

FIGURE 11. AFFECTED INDIVIDUAL PROGRAM SNAPSHOT



This section summarizes key findings from FY 2024-25 data that were available from the DMS on affected individuals' 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

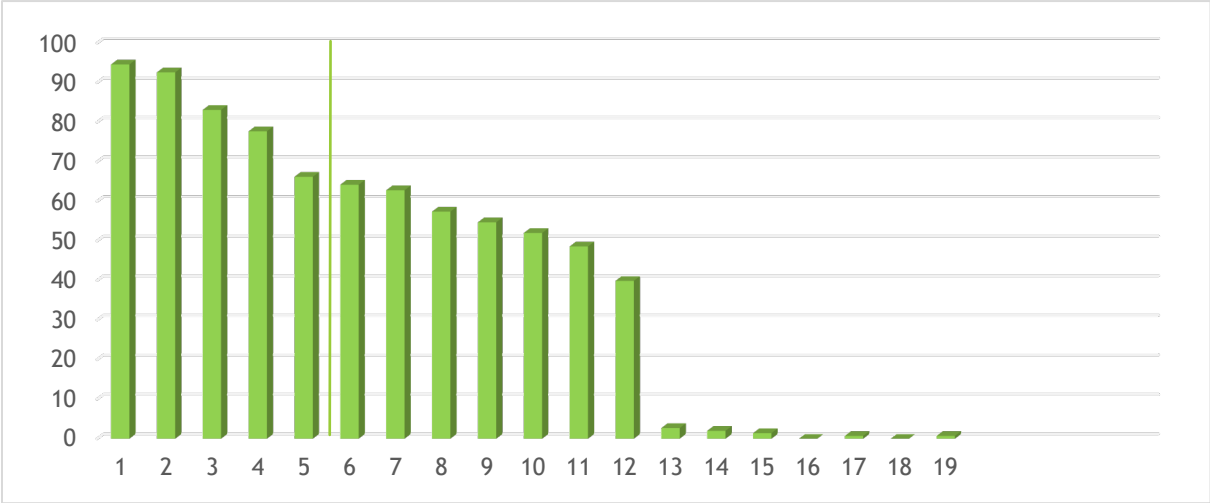
In FY 2024-25, a total of 176 affected individuals entered treatment across the treatment services network (**Table 16**). Nearly all were served as Outpatients, while less than 11 clients received treatment from PGTI.

TABLE 16. TREATMENT SERVICES: NUMBER OF NEW CLIENT INTAKES FOR AFFECTED INDIVIDUALS

Service Level	FY 2023-24 N	FY 2024-25 N
Outpatient/Problem Gambling Telephone Intervention (PGTI)	211	176

The number of Outpatient/PGTI treatment sessions affected individuals attended after Intake ranged from 1 to 19, with an average of 9 sessions. Affected individuals' treatment attendance was greater than 60% during the primary treatment sessions (sessions 1-5) (**Figure 12**).

FIGURE 12. OUTPATIENT/PGTI AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION

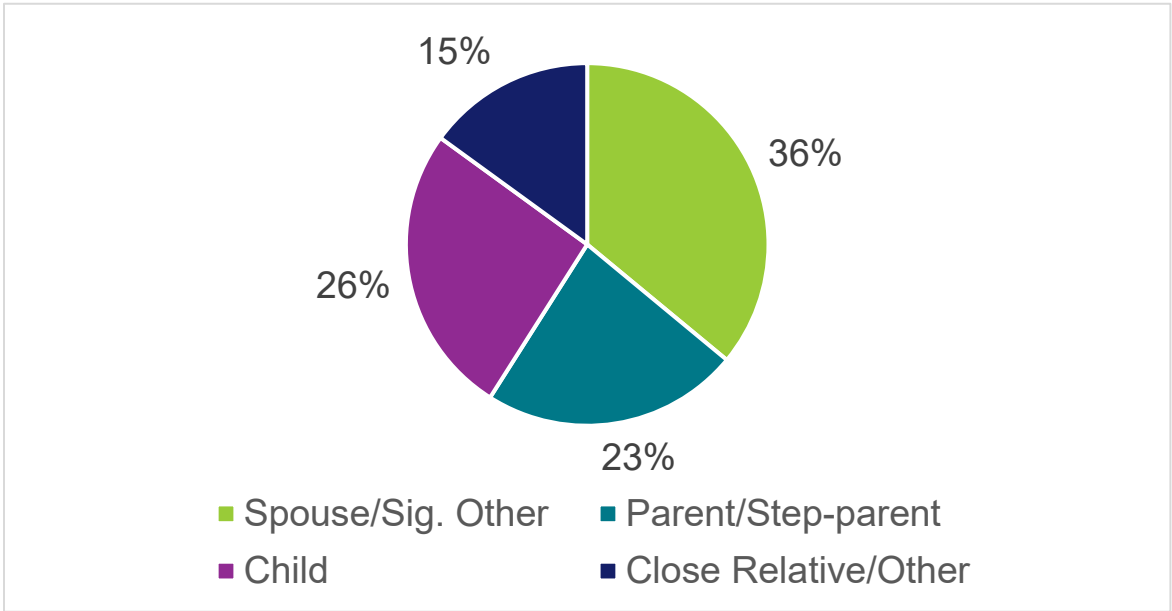


Note: N= 148

Demographics

Of the 176 affected individual clients, 36% identified as a spouse or significant other of a gambler, 23% as a parent/step-parent of a gambler, 26% as an adult child of a gambler, and 15% as a close relative (sibling, aunt/uncle, grandparent) or another relation to a gambler (**Figure 9**).

FIGURE 13. OUTPATIENT/PGTI AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



At Intake, affected individuals were 47 years old, on average, and predominately female (73%), whereas about two-thirds of gambler clients are male. About 46% were White, Non-Hispanic, followed by 23% Hispanic/Latino, 16% Asian/Pacific Islander, 8% another race/ethnicity, and 6% Multiracial/Multi-ethnic. (See the appendix for more detailed gender, sexual orientation, and race/ethnicity information.) Similar to gamblers, affected individuals have widely varying household incomes and high education levels, but 9% report a household income of less than $35,000 per year. A high percentage (80%) report having some college education or higher (**Table 17**).

TABLE 17. AFFECTED INDIVIDUALS: DEMOGRAPHICS

Age	N= 176
Mean Age	47 years old
Gender	N= 175
Male	27%
Female	73%
Transgender	0%
Race/Ethnicity (for those reporting a single category only)	N= 171
White, Non-Hispanic only	46%
Asian/Pacific Islander only	16%
Hispanic or Latino only	23%
Other Race/Ethnicity	8%
Multiracial or Multi-ethnic	6%
Education	N= 176
Less than High School or High School	21%
Some College	12%
Bachelor's Degree	11%
Graduate/Professional Degree	57%
Household Income	N= 176
Less than $34,999	9%
$35,000-$49,999	8%
$50,000-$74,999	16%
$75,000-$99,999	14%
$100,000-$149,999	14%
$150,000-$199,999	10%
$200,000 or more	14%
Decline to State	17%

Note: Five cases had missing demographic data. Percentages for those reporting in a category in which there are 10 or less individuals have been combined with other categories. Additional details on race/ethnicity, gender, and sexual orientation can be found in the Appendix. Percentages may add up to greater than 100% due to rounding.

Treatment Service Findings

Intake to Last Treatment Contact Outcomes

As seen in **Table 18**, affected individuals had moderate depression scores, on average, at Intake in both FY 2023-24 and FY 2024-25. At LTC, depression scores were, on average, at the subclinical level in FY 2023-24, and were mild in FY 2024-25 (PHQ-9 range is 0 – 27). For generalized anxiety, affected individuals entered treatment with scores above the threshold for generalized anxiety and were below the threshold at LTC during both years. Average life satisfaction scores (measured on a scale from 0 to 100) at LTC increased by 13 points in FY 2023-24 and 12 points in FY 2024-25. The degree to which affected individuals 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, affected individuals 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 18. AFFECTED INDIVIDUALS: TREATMENT OUTCOMES FOR FY 2023-24 AND 2024-25

Outcome Indicator	FY 2023-24 Intake Mean	FY 2023-24 Last Treatment Contact Mean	FY 2024-25 Intake Mean	FY 2024-25 Last Treatment Contact Mean
Depression (PHQ-9) score	10	4	10	5
Anxiety (GAD-2) score	3	2	3	2
Life satisfaction	54	67	53	65
Degree to which problem gambler's behaviors have interfered with normal activities	59	37	60	35
Feel responsible for gambler's treatment and recovery	52	30	56	24
Percentage of time spent dealing with the consequences of problem gambling	56	38	59	35

Note: FY 2023-24 Intake N= 204, LTC N= 196; FY 2024-25 Intake N= 166, LTC N= 147.

Health Information on Affected Individuals

General health and co-occurring health diagnoses reported by affected individuals differed from gamblers; a larger percentage (45%) of affected individuals reported that

their general health was fair or poor. Twenty-four percent of Outpatient affected individuals had a body mass index indicating obesity. The percentage of Outpatient affected individuals reporting smoking was 4% in FY 2024-25, lower than the percentage of smokers among Californians (5.4%).[20] Also, 79% reported that they had health insurance.

Of note was the percentage of Outpatient affected individuals who reported current drinking (34%) relative to Outpatient gamblers (47%). Cannabis use in the past 30 days was reported by 13% of Outpatient affected individuals, while less than 5% reported opioid, cocaine, or methamphetamine use in the past 30 days.

In regard to co-occurring psychiatric disorders reported at Intake, using the PHQ-9 criteria, 43% of affected individual clients reported moderate to severe depression, and 54% are above the threshold for generalized anxiety disorder.

[20] California Health Interview Survey, 2024. [accessed December 6, 2025]. URL: https://healthpolicy.ucla.edu/our-work/askchis

5. FOLLOW-UP OF TREATMENT PARTICIPANTS

UGSP staff members collect follow-up data from clients served within Outpatient, IOP, RTP, and PGTI modalities using Qualtrics. Follow-up surveys with treatment participants take place at 30 days, 90 days, and one year after treatment entry via telephone, text, and email surveys. For those clients who agree to participate in follow-up interviews, client information is exported to Qualtrics on a biweekly basis and added to contact lists. Beginning in July of 2023, UGSP introduced email surveys and transitioned the follow-up process from the DMS to Qualtrics. For FY 2024-25, five attempts were made to reach each client by email. Five phone call attempts were made for those clients without an email address in their file. During the third quarter of FY 2024-25, text surveys were introduced as another method of collecting follow-up data.

During FY 2024-25, 975 clients completed the CalGETS intake form. Of these clients, 665 consented to participate in follow-up for an opt-in rate of 68%. Compared to the previous fiscal year (FY 2023-24), the number of completed surveys increased during FY 2024-25 (**Table 19**).

TABLE 19. COMPLETED SURVEYS BY FISCAL YEAR

Outcome	FY 2023-24	FY 2024-25
Number of completed surveys	240	305

Table 20, below, is a breakdown of all follow-up attempts and completed interviews for the gamblers and affected individuals who agreed to follow-up during FY 2024-25. UGSP made more than 3,700 attempts to reach clients for follow-up interviews; completing 305 interviews. 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. Of the completed surveys collected this year, most (77%) were completed by email, followed by 12% of surveys completed by text, and then by 11% of surveys completed by phone.

TABLE 20. FOLLOW-UP: ATTEMPTS AND COMPLETED INTERVIEWS BY FISCAL YEAR

	FY 2023-24 Attempted	FY 2023-24 Completed	FY 2024-25 Attempted	FY 2024-25 Completed
30-Day	1228	82	1133	111
90-Day	769	77	1285	105
365-Day	1265	81	1059	89

6. CULTURAL AND LINGUISTIC CLINICAL INTEGRATIONS

UGSP oversees clinical integration projects that create and test new resources and clinical tools to identify best practices for the treatment of gambling disorders. During FY 2024-25, UGSP and OPG worked with three community agencies, *Visión y Compromiso,* Riverside San Bernardino Indian Health Centers, and Los Angeles County Substance Abuse Prevention and Control (SAPC) to address disparities among those reached for CalGETS screening, education, and treatment.

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

The project in Los Angeles, San Diego, and Tulare 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, San Diego, and Kern Counties. Tulare promotoras attended the Kern County training. In FY 2023-24, VyC implemented the outreach protocol for the three 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. UGSP provided an interim report to OPG on program activities conducted from the beginning of fiscal year 2023-24 to the midpoint of the fiscal year in February of 2025.

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. UGSP provided training sessions to RSBIHC peer specialists on techniques to implement screening for problem gambling and on CalGETS intake. They also provided trainings to RSBIHC physicians and therapists on how to identify problem gambling and assist patients to obtain CalGETS treatment services.

UGSP and SAPC Screening and Gambling Treatment for Patients in Substance Use Disorder (SUD) Treatment Programs

The UCLA Gambling Studies Program and Substance Abuse Prevention and Control (SAPC) in the Los Angeles County Department of Public Health are collaborating on a two-year pilot project to screen for and provide gambling disorder treatment in two SAPC clinics. The participating clinics are The Los Angeles Centers for Alcohol and Drug Abuse (L.A. CADA) and Behavioral Health Services (BHS). An online screening tool that uses the three screening questions from the Brief-Biosocial Gambling Screen (BBGS) is being administered at these two participating agencies. Persons admitted to substance abuse disorder (SUD) treatment are being screened for gambling disorder (GD) to establish prevalence rates of GD among this population and to identify who may benefit from GD-specific treatment. In the first year, nearly 420 patients were screened using the online tool with an approximately 9% positive rate for gambling problems. The UGSP has trained licensed clinicians and substance abuse counselors in these two agencies so they can become CalGETs providers and provide GD treatment. The goals of this project include: (1) establish prevalence estimates of gambling problem among SUD patients, (2) analyze SUD treatment outcomes among patients who screen positive for gambling problems using the BBGS screener, (3) train clinicians to become CalGETS providers, (4) track the number of SUD patients referred to CalGETS treatment, and (5) track gambling disorder treatment outcomes for SUD patients referred to CalGETS treatment.

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.

Department of Health Care Policy Harvard Medical School (2024). ADHD Self-Report Scale (ASRS) Scoring Update from: https://www.hcp.med.harvard.edu/ncs/ftpdir/adhd/ASRS_v1.1_screener(6Q)_scoring_update.pdf

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

Race/Ethnicity	Outpatient N = 598	IOP N = 74	RTP N = 17	PGTI N = 77
White, Non-Hispanic	237	31	12	26
Hispanic/Latino categories				
Mexican, Mexican American, Chicano	127	16	<11	20
Puerto Rican	<11	0	0	<11
Cuban	<11	0	0	<11
Other Hispanic	23	0	0	<11
Asian/Pacific Islander categories				
East Asian	42	<11	0	<11
South Asian	<11	0	0	<11
Southeast Asian	65	<11	<11	<11
Pacific Islanders	<11	<11	0	0
Black or African American	36	<11	0	<11
American Indian/Alaska Native	<11	0	0	0
Other race/ethnicity	25	<11	<11	<11
Multiracial or Multi-ethnic[21]	46	24	<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. Outpatient race/ethnicity had 29 cases with missing data, IOP had 2 cases with missing data, RTP had 0, and PGTI had 2.

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

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

Gender – assigned at birth	Outpatient N = 627	IOP/Residential N = 93	PGTI N = 79
Male	427	74	50
Female	198	19	29
Unknown	<11	0	0
Gender – current self-described gender	**Outpatient N = 559**	**IOP/Residential N = 92**	**PGTI N = 79**
Male	381	74	50
Female	171	18	29
Transgender woman	0	0	0
Transgender man	<11	0	0
Other gender category	<11	0	0
Choose not to disclose	<11	0	0

TABLE 23. GAMBLERS: SEXUAL ORIENTATION DETAILS BY LEVEL OF TREATMENT SERVICE, ACTUAL NUMBERS

Sexual Orientation	Outpatient N = 559	IOP/Residential N = 92	PGTI N = 79
Lesbian, gay, or homosexual	31	<11	
Straight or heterosexual	510	88	77
Other sexual orientation categories	18	<11	<11

Note: Gender and sexual orientation numbers for those reporting in a category in which there are 10 or less individuals are combined to prevent identification of individuals. Other sexual orientation categories include bisexual, don't know, choose not to disclose, and something else.

TABLE 24. AFFECTED INDIVIDUALS: NUMBER OF INDIVIDUALS REPORTING RACE/ETHNICITY

Race/Ethnicity	Outpatient/PGTI N= 171
White, Non-Hispanic	79
Black or African American	<11
American Indian/Alaskan Native	0
Hispanic/Latino categories	
Mexican, Mexican American, Chicano	22
Puerto Rican	<11
Cuban	0
Other Hispanic	<11
Asian categories	
East Asian	12
South Asian	<11
Southeast Asian	13
Pacific Islanders	0
Multiracial or Multi-ethnic[22]	11
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. Outpatient and PGTI numbers are combined for affected individuals to prevent identification of individuals.

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

TABLE 25. AFFECTED INDIVIDUALS: GENDER DETAILS

Gender – assigned at birth	Outpatient/PGTI N = 176
Male	47
Female	129
Unknown	0
Gender – current self-described gender	**Outpatient/PGTI N = 175**
Male	47
Female	128
Transgender woman	0
Transgender man	0
Choose not to disclose	0

TABLE 26. AFFECTED INDIVIDUALS: SEXUAL ORIENTATION DETAILS

Sexual Orientation	Outpatient/PGTI N = 175
Lesbian, gay, or homosexual	13
Straight or heterosexual	158
Bisexual	<11
Don't know	<11
Choose not to disclose	0
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. Outpatient and PGTI numbers are combined for affected individuals to prevent identification of individuals.

LIST OF TABLES

LIST OF FIGURES