ANNUAL TREATMENT SERVICES REPORT FISCAL YEAR 2021-22

Prepared for the
California Department of Public Health,
Office of Problem Gambling

by the University of California Los Angeles
Gambling Studies Program

CalGETS Annual Treatment Services Report

Fiscal Year 2021-22

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EXECUTIVE SUMMARY

Overview

California Gambling Education and Treatment Services (CalGETS) is a statewide program for clients with problem gambling and affected individuals (AIs) (family members and friends affected by someone with problem gambling). Nearly 800 individuals received treatment through CalGETS in fiscal year (FY) 2021-22. 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, nearly 18,000 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 182 licensed mental health providers (with an average of 8 years of experience treating gambling), as well as oversees five treatment programs, all engaged in delivering evidenced-based treatment to gamblers and AIs.

Treatment services are available in 30 languages/dialects.

COVID Impact on CalGETS

To address COVID-related barriers to treatment, CalGETS/OPG approved secure web-cam telehealth services for providers of all treatment types in December 2020. Although access to in-person services has since been restored, many CalGETS clients and providers have

commented on the benefits of having virtual treatment options. As a result, CalGETS/OPG included telehealth options for IOP and Outpatient services in the most recent version of the Policies and Procedures Manual, making the addition of telehealth a permanent change in the CalGETS program. Outpatient treatment entry and treatment length may continue to be affected by COVID-19 policies and perceptions. During part of FY 2021-22, COVID-19 directives prevented new clients from being admitted to RTP, and OPG approved additional blocks of treatment (with clinical justification) for those currently in treatment. In addition, fewer clients could be housed simultaneously, increasing the average wait time to enter treatment.

CalGETS Treatment Outcomes (FY 2021-22)

Gamblers:

- 795 gamblers received treatment across the treatment network. Nearly two-thirds (61%) received outpatient services, 29% were served in PGTI, 9% were served in IOP, and 2% were served in RTP. Of gamblers enrolled in outpatient services, 4% were served in group treatment.
- During treatment, the degree to which clients perceived that gambling interfered with their normal activities decreased on a 100-point scale by an average of 8 to 32 points (depending on treatment modality).
- The intensity of gambling urges reported by CalGETS clients from Intake to last treatment contact decreased by an average of 9 to 25 points (depending on treatment modality) on a self-reported 100-point scale.
- Life satisfaction as measured by a self-reported 100-point scale increased from Intake to last treatment contact by an average of 6 to 13 points (depending on treatment modality), except RTP with a 4-point decrease.
- By the end of CalGETS treatment, client levels of depression, on average, improved to the mild or subclinical levels (depending on treatment modality).

CalGETS GAMBLER CHARACTERISTICS AT INTAKE: HEALTH AND WELLNESS

Medical Problems	The most common co-occurring health conditions of CalGETS clients are hypertension, obesity, and diabetes.
Smoking	Among CalGETS outpatient clients, 20% currently smoke. This percentage is nearly twice the state average of 12%. In IOP, the prevalence rate of smoking is 16%, among PGTI clients 19%, and among RTP clients 13%.
Alcohol Use	55% of CalGETS outpatient clients reported at Intake that they drank alcoholic beverages. 25% 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 24% 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, 18% 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 31% of gamblers across the treatment network reported their health as “fair or poor.”

Health Insurance	About 87% of all CalGETS clients reported having health insurance, but less is known about their costs to maintain insurance, including premiums and deductibles.
Access to Health Care	Approximately 79% of CalGETS clients reported they currently have a physician they can access for primary care needs.
Depression	42% 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 (NSDUH).
Anxiety	41% 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 3% of outpatient clients may have ADHD.

Affected Individuals:

- 233 AIs received treatment across the treatment network. Most (94%) were served as outpatients (n=220). The remaining 13 clients received treatment from PGTI.
- AIs are spouses/significant others (52%), children (14%), parents (14%), siblings (9%), or other relation (11%) of gamblers; 79% of AIs are female.
- 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 also decreased and life satisfaction increased.

AIs were similar to gamblers in terms of medical problems but were less likely to have health insurance (78%). Also of note was the percentage of Outpatient AIs who reported current drinking (42%) relative to Outpatient gamblers (55%). Fewer Outpatient AIs reported their state of health as fair or poor (26%) compared to Outpatient gamblers, but this was 11% greater than adult Californians. However, the percentage of Outpatient AIs reporting smoking was 4% in FY 2021-22, lower than the percentage of smokers among Californians (12%).

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 261 treatment follow-up telephone interviews. Results show that both gamblers and AIs are generally satisfied with treatment providers.

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 2021-22, 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 2-year project in Los Angeles and San Diego Counties to pilot and evaluate 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 informed by 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.

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. During FY 2021-22, Dr. Timothy Fong of UGSP provided three 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

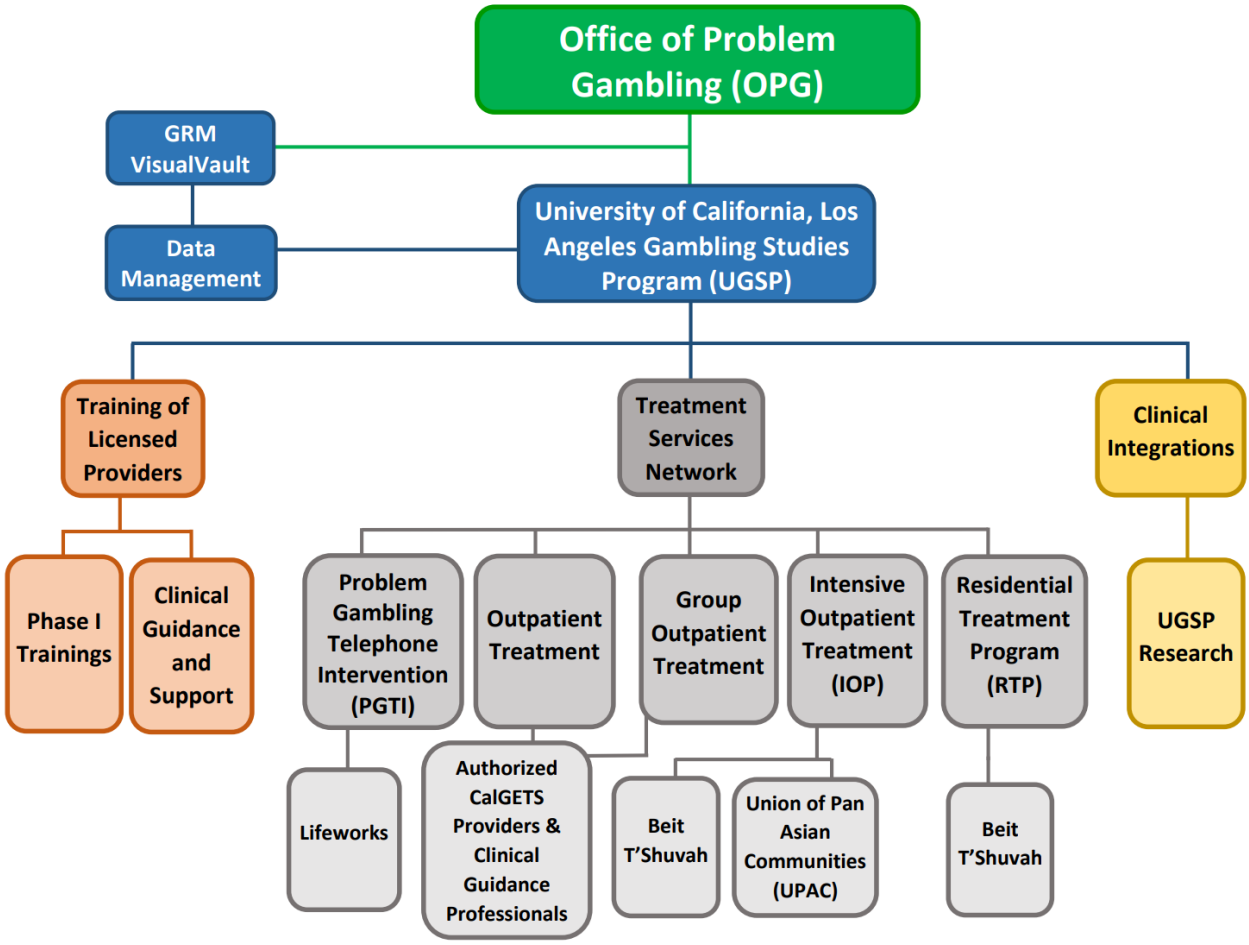
Introduction

The California Gambling Education and Treatment Services (CalGETS) program 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.

CalGETS consists of three main components: treatment provider training, a treatment services network, and a 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, 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, and during FY 2021-22 was provided in 20 languages/dialects. 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 2021-22, there were 182 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): Gamblers may receive up to two 30-day treatment blocks (up to 60 days) of IOP care. Beit T'Shuvah Right Action Gambling Program in Los Angeles and Union of Pan Asian Communities (UPAC) in San Diego currently provide IOP services three hours per day, three times per week to clients requiring more intensive services. Services include individual, group, and family counseling.

Residential Treatment Programs (RTP): Individuals with gambling disorder, including those with significant comorbidity, may receive up to 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. They 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 LifeWorks (formerly named 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.

In all cases, providers can request additional treatment blocks for their clients by providing clinical justification.

COVID Impact on CalGETS Program Structure

To address COVID-related barriers to treatment, CalGETS/OPG approved secure web-cam telehealth services for providers of all treatment types in December 2020. Although access to in-person services has since been restored, many CalGETS clients and providers have

commented on the benefits of having virtual treatment options. As a result, CalGETS/OPG included telehealth options for IOP and Outpatient services in the most recent version of the Policies and Procedures Manual, making the addition of telehealth a permanent change in the CalGETS program. Outpatient treatment entry and treatment length may continue to be affected by COVID-19 policies and perceptions. During part of FY 2021-22 COVID-19 directives prevented new clients from being admitted to RTP, and OPG approved additional blocks of treatment (with clinical justification) for those currently in treatment. In addition, fewer clients could be housed simultaneously, increasing the average wait time to enter treatment.

Treatment Participant Follow-up

UGSP collects follow-up information from CalGETS clients to determine whether they have benefitted from the services they received. CalGETS clients who consent to follow-up are contacted at 30, 90, and 365 days after 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.

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.

2. FY 2021-22 TREATMENT REPORT DATA SOURCES AND METHODS

Data Sources

Data are obtained from the CalGETS client forms. 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. During FY 2021-22, all providers entered their data into the DMS.

Instruments

Gamblers

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

National Opinion Research Center's DSM-IV Screen for Gambling Problems (NODS): A modified version of the NODS (Gerstein et al., 1999) is used to assess clients' past year gambling problems. This has been revised to reflect DSM-5 gambling disorder criteria. The Modified NODS combines questions to produce the 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 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

[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.

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

Outpatient treatment is offered in blocks of eight sessions, and IOP and RTP are offered in 30-day treatment blocks. Clients may discontinue treatment at any time, not just at the end of a scheduled treatment block. This means the "dose" of treatment a client receives may vary not only by the type of treatment they participate in, but also in how long they chose to participate. To ensure we capture data about clients as they leave treatment (Last Treatment Contact), we utilize data from the End of Treatment (EOT) form, or, from the client's last In-Treatment form when an EOT form is not available. Data analysis involved determining simple means, medians, and percentages and was performed using SPSS Version 27. Data distributions were examined and, if necessary, extreme outliers were trimmed to reduce the effect of possibly spurious values.

3. CalGETS PROVIDERS AND TRAINING

Trained CalGETS providers deliver treatment services through the Treatment Services Network. Clients are referred to the network from a number of sources including a problem gambling helpline (1-800-GAMBLER), family or friends, Gamblers Anonymous (GA), former clients, UGSP or OPG websites, health care professionals, outreach campaigns, information provided at gambling venues, and other sources. CalGETS providers are mental health professionals who are trained to ensure that high quality services are available for individuals seeking treatment. In addition to clinical training on the treatment of gambling disorder, CalGETS providers receive training on program quality assurance (i.e., specifying timelines for providers to make contact and meet with referrals, determining client eligibility according to CalGETS criteria, collecting and completing all required forms, referring clients to other programs and services if clinically indicated, and providing culturally and linguistically appropriate services). In FY 2021-22, UGSP and OPG conducted a Phase I training online on October 18-20, 2021. On March 1, 2022, OPG and UGSP conducted a one-day training Summit with three sessions. Then, every week in March, a pre-recorded session was released and made available for the entire month of March for CalGETS providers and others.

Shortly after the close of FY 2021-22, UGSP conducted a survey with all active CalGETS providers to obtain information on provider characteristics and experiences with CalGETS (2022

Provider Survey Report). All providers were required by OPG to complete the survey between August and September 2022, unless given an exemption. The Treatment Services Network had 182 licensed providers who were authorized to provide services to gamblers and AIs at some point during the 2021-22 fiscal year; the responses of 162 of these providers who remained active or decided to participate after suspension or termination are included in the 2022 Provider Survey. **Table 1** details the number of clinicians and providers who completed Phase I training during FY 2021-22. Additionally, CalGETS clinical supervisors delivered 32 hours of clinical guidance and support to CalGETS providers via the Treatment Services Network.

TABLE 1. CalGETS TRAINING

Training	FY 2021-22
Licensed mental health clinicians who completed Phase I	24
Licensed mental health clinicians who completed Phase I and became authorized providers	4

Providers' demographic information is presented below (**Table 2**). Providers were primarily female and reported their race/ethnicity as: 56% White, 14% Hispanic/Latino, 10% Asian, and 6% Black/African American.

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

Gender	n=162
Female	75%
Male	25%
Transgender	<1%
Race/Ethnicity	n=162
White	56%
Hispanic/Latino	14%
Asian	10%
Black/African American	6%
Multiracial	6%
Native Hawaiian/Pacific Islander	<1%
Choose not to designate or Other	8%

The data indicate that CalGETS providers are experienced mental health providers. On average, providers who completed the survey had been licensed for 16 years and had treated individuals with gambling disorder for an average of 8 years. In FY 2021-22, 64% of providers were Licensed Marriage and Family Therapists (LMFT), 14% were Licensed Clinical Social Workers

(LCSW), 8% were Psychologists (PhD), 7% Licensed Professional Clinical Counselors (LPCC), 4% were Clinical Psychologists (PsyD), 2% were Masters of Social Work (MSW), and 2% had other clinical degrees. CalGETS providers reach clients for whom English is not their primary language, as 38% reported that they are fluent in a language other than English. Thirty-seven providers (23%) reported providing treatment services in languages other than English. Of those, 49% indicated that they provided services in Spanish, 21% provided services in Mandarin/Cantonese, 8% Vietnamese, 5% Russian, and 18% provided services in other languages; including Arabic, Armenian, Japanese, Korean, Persian, Tagalog, and Taiwanese. Nearly half (47%) of CalGETS providers offered educational materials in languages other than English. Through the use of a translation service, treatment is available in a total of 30 languages.

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

- Phase I Training (95%)
- Annual Summit (77%)
- Problem Gambling Webinars (64%)
- Supplemental Recommended Reading Materials (67%)
- Clinical Guidance Sessions (60%)
- National Gambling Conferences (58%)
- Office of Problem Gambling Website (57%)

Providers also expressed high levels of satisfaction with OPG/UGSP services, and 85% planned to continue as authorized CalGETS providers into the next fiscal year.

4. GAMBLER TREATMENT SERVICE OUTCOMES

The sections below summarize demographics and outcomes for gamblers receiving treatment from the CalGETS treatment services network. Results are grouped according to treatment services offered during FY 2021-22.

Treatment Service Provision

In FY 2021-22, a total of 795 gamblers entered treatment across the treatment services network (**Table 3**). Most clients (61%) enrolled in Outpatient, followed by PGTI (29%), IOP (9%), and RTP (2%). Of these clients, 4% also participated in Outpatient Group services.

TABLE 3. TREATMENT SERVICES: NUMBER OF GAMBLERS ENROLLED

Service Level	N	Percentage
Outpatient	482	61%
Outpatient Group	*(31)*	-
Intensive Outpatient Program (IOP)	68	9%
Residential Treatment Programs (RTP)	16	2%
Problem Gambling Telephone Intervention (PGTI)	229	29%
Total[2]	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, IOP, and PGTI entered treatment within one week. Entry into RTP was delayed.

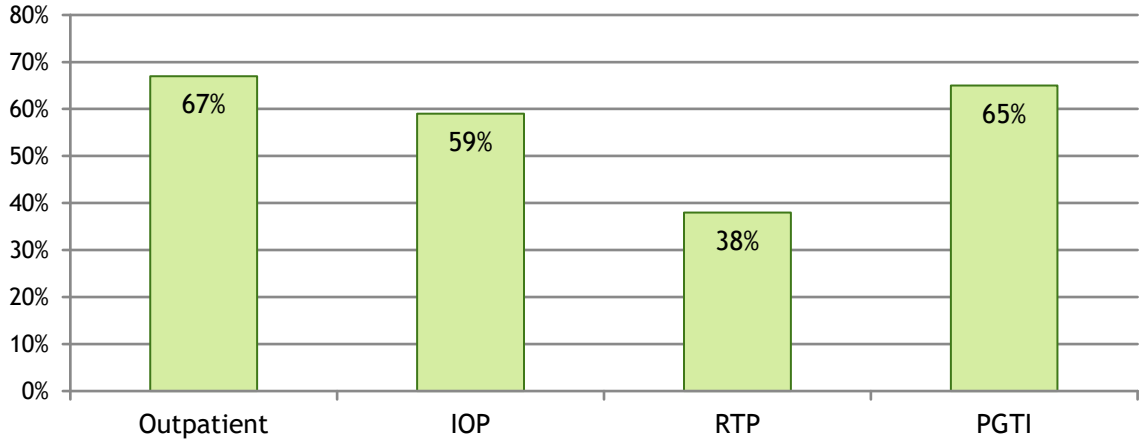


FIGURE 2. TREATMENT SERVICES: PERCENTAGE OF CLIENTS ENTERING TREATMENT WITHIN 7 DAYS OF FIRST CONTACT

[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.

As shown in **Table 4**, race/ethnicity varies by modality. Compared to the California population, White, Non-Hispanics are over-represented and Hispanic/Latinos are under-represented in the treatment population. (More detailed analyses of race/ethnicity are available in the appendix.)

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

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 480	IOP N = 68	RTP N = 16	PGTI N = 227	Total N = 791	CA Population[3] N = 39,237,826
White, Non-Hispanic only[4]	45%	49%	75%	32%	42%	37%
Asian/Pacific Islander only	17%	13%	6%	30%	20%	16%
Hispanic or Latino only	16%	15%	6%	20%	17%	39%
Black or African American only	9%	9%	0%	11%	9%	5%
American Indian/Alaskan Native only	<1%	2%	13%	0%	1%	2%
Other race/ethnicity only	3%	4%	0%	3%	3%	-
Multiracial or Multi-ethnic[5]	9%	9%	0%	4%	7%	4%

Note: Outpatient and PGTI each had 2 cases with missing data.

[3] Quick Facts: California, US Census Bureau, accessed 2/5/2022, at https://www.census.gov/quickfacts/fact/table/CA/PST045221.

[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.

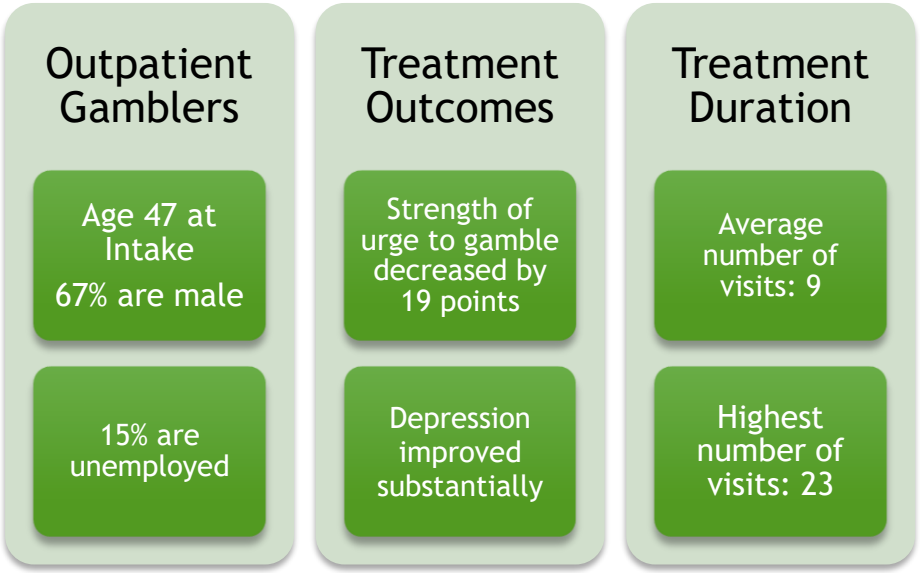
[5] "Multiracial or Multi-ethnic" category specifies the percentage of respondents who identify with multiple ethnic or racial designations.

Treatment Service Findings

Outpatient

Individual Outpatient

FIGURE 3. OUTPATIENT SNAPSHOT



As shown earlier in Table 3,[6] the largest number of CalGETS clients, by far, participate in outpatient treatment. Intake data are available from 482 clients who enrolled in outpatient services. Information summarized below reflects client demographics, gambling behaviors, and treatment outcomes for the gamblers served. During FY 2021-22, clients were most frequently referred via the problem gambling helpline (1-800-GAMBLER) (29%), former clients (17%), family/friends (11%), UCLA Gambling Studies Program (9%), health care professionals (7%), Gamblers Anonymous/Gam-Anon (7%), the California Council on Problem Gambling (4%), and the OPG website (3%). In addition, 14% 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=482) varied:

- 5% of clients had only an Intake session
- 54% received 1-8 treatment sessions
- 23% received 9-16 treatment sessions
- 15% received 17-23 treatment sessions[7]

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

[7] Due to additional needs during the COVID pandemic, some clients received additional blocks of treatment, which are not included here. In addition, some treatment participants may have continued treatment into FY 2022-23, but these additional sessions are not counted in the percentages above.

Although outpatient treatment entry has increased compared to FY 2020-21, treatment entry and treatment length may continue to be affected by COVID-19 policies and perceptions.

Demographics

Outpatient clients had an average age of 47 years and two-thirds (67%) were male. Less than half of clients identified their race as White, Non-Hispanic (45%), followed by 17% reporting Asian/Pacific Islander, 16% Hispanic/Latino, 9% African American, less than 1% American Indian/Alaska Native, 3% another race/ethnicity, and 9% multiracial/multi-ethnic. (More detailed analyses of gender and race ethnicity are available in the appendix.) Clients are, for the most part, well-educated; 82% reported completing some college or above. The reported household income varied widely from less than $15,000 per year to over $200,000, but 17% reported incomes of less than $35,000 (**Table 5**).

TABLE 5. OUTPATIENT GAMBLER: DEMOGRAPHICS

Ages	n=482
Mean Age	47 years old
Gender	n=482
Male	67%
Female	33%
Transgender/Other Gender Category	<1%
Race/Ethnicity (for those reporting a single category only)	n=480
White, Non-Hispanic	45%
Asian/Pacific Islander	17%
Hispanic or Latino	16%
Black or African American	9%
American Indian/Alaskan Native	<1%
Other race/ethnicity	3%
Multiracial or Multi-ethnic	9%
Education	n=482
Less than High School	4%
High School	15%
Some College	36%
Bachelor's Degree	34%
Graduate/Professional Degree	12%
Household Income	n=482
Less than $15,000	6%
$15,000-$24,999	5%
$25,000-$34,999	6%
$35,000-$49,999	13%
$50,000-$74,999	18%
$75,000-$99,999	12%
$100,000-$149,999	13%
$150,000-$199,999	8%
$200,000 or more	9%
Decline to state	10%

Gambling Severity

An overwhelming proportion of gamblers (97%) who sought outpatient treatment through CalGETS could be classified as having mild to severe gambling disorder (**Table 6**), including 91% with moderate to severe gambling disorder, while 3% reported one to three problem gambling behaviors.

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

Severity	NODS Score	N	%
Problem gambling behavior	1 to 3	13	3%
Mild gambling disorder	4 to 5	27	6%
Moderate gambling disorder	6 to 7	113	26%
Severe gambling disorder	8 to 9	286	65%

Note: N=439, 43 cases had missing data

Gambling Behaviors

At Intake, outpatient clients (n=439, 43 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 (75%), followed by the Internet, (34%), lottery stores (10%), family/friend's house (8%), private club (3%), horse-racing track (3%), and other locations.[8]

Clients were able to select multiple activities at each of the major gambling venues. Across all venues, slot machines (48%), blackjack (32%), and poker (22%) were the most commonly selected gambling activities.[9]

- At **tribal casinos,** clients most frequently stated that they played slot machines (47%), blackjack (24%), poker (14%), and video poker (6%).[10]
- At **other casinos,** clients most frequently reported playing slot machines (19%), blackjack (14%), and poker (8%).
- In the **community**, 15% of clients reported gambling on the Lottery.
- At **cardrooms,** clients most often reported playing poker (11%), and blackjack (13%).
- On the **Internet**, clients most often indicated playing slots (8%), poker (8%), other internet gambling (8%), and blackjack (7%).

[8] 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 2021-22 increase in internet gambling and the decreases at the other locations are most likely due to COVID-19 restrictions imposed by the state and counties, as well as the clients' efforts to avoid exposure.

[9] In FY 2019-20, the major activities were - slot machines (61%), blackjack (38%), and poker (38%). The FY 2021-22 decreases are most likely due to the closures of the casinos and card rooms as a result of COVID-19 restrictions or clients' desire to avoid exposure.

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

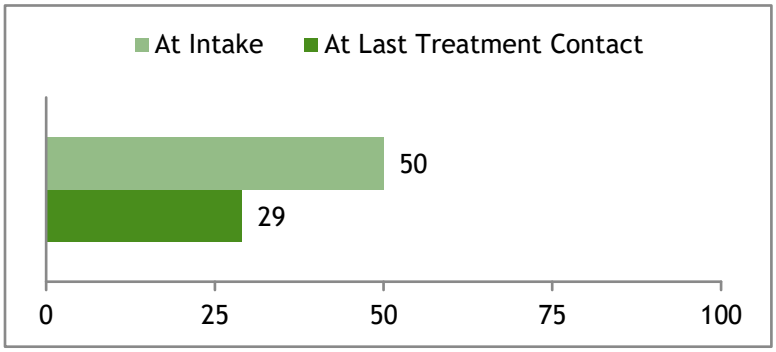
- Finally, clients reported gambling on sporting events (23%), financial/stock markets (8%), and horse racing (5%).

Intake to Last Treatment Contact (LTC) Outcomes

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

Outpatient clients reported less interference of gambling with their normal activities at last treatment contact compared to Intake. On a scale from 0-100, where higher scores indicate a greater impact of gambling on other activities, average scores decreased by 21 points from Intake to last treatment contact (**Figure 4**).

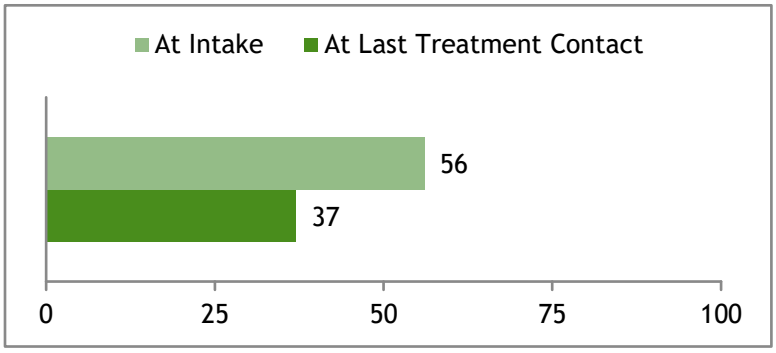
FIGURE 4. OUTPATIENT GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=439, LTC N=457.

Among outpatient clients, the average intensity of the urge to gamble from Intake to last treatment contact decreased by 19 points on the 100-point scale. Lower scores at last treatment contact indicated a less intense urge to gamble after receiving outpatient services (**Figure 5**).

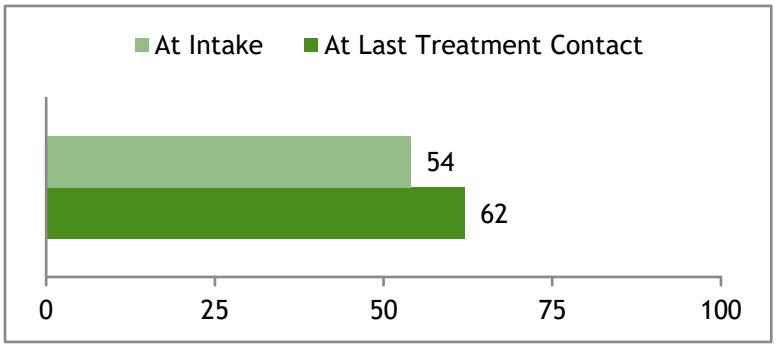
FIGURE 5. OUTPATIENT GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=439, LTC N=457.

Over the course of treatment, outpatient clients reported an improvement of 8 points on average in overall life satisfaction (**Figure 6**). As above, life satisfaction was measured on a 100-point scale.

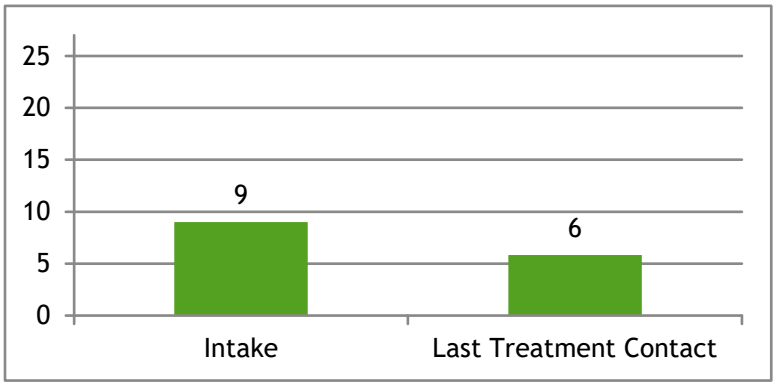
FIGURE 6. OUTPATIENT GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=439, LTC N=457.

During FY 2021-22, treatment participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. Outpatient clients showed, on average, mild depression at Intake and mild depression at their last treatment session (**Figure 7**). However, among these clients, 19% started treatment with moderately severe to severe depression.

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



Note: Intake N=439, LTC N=457.

Group Outpatient

A total of 31 clients participated in group treatment in FY 2021-22. Of these participants, 27 were gamblers and 4 were AIs. The average age of gambler clients was 53 years old and about 52% were male. Three-quarters of gamblers (74%) were referred to group treatment by a CalGETS provider. Other referral sources included Gamblers Anonymous (15%), former CalGETS clients (7%), and family or friends (4%). The average age of AI clients was 51 years old and 100% were female. All of the AIs were referred to group treatment by a CalGETS provider (100%). The primary types of gambling reported by gamblers at group screening were slot machines (15%),

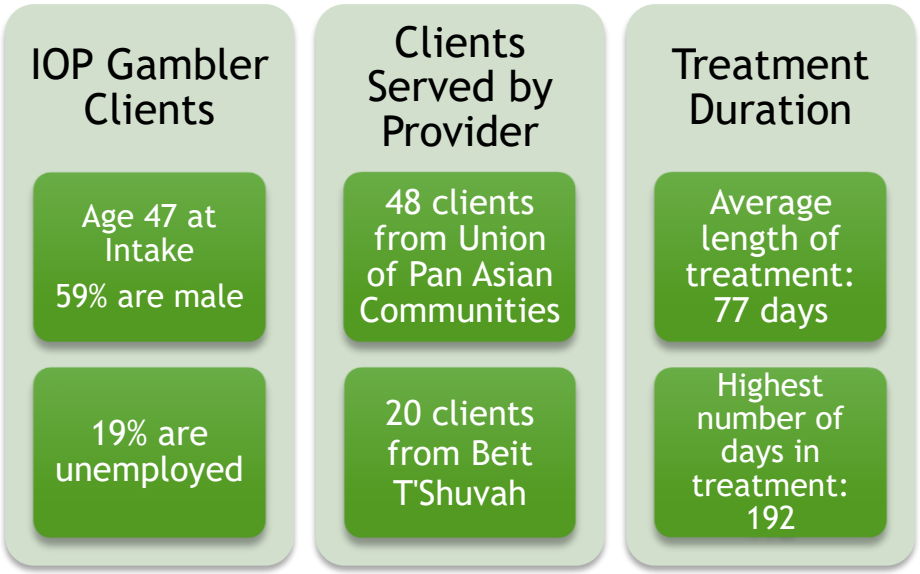
poker (11%), and blackjack (4%).[11] Tribal casinos were the most frequently reported gambling venue (19%), card rooms (11%), Internet (7%), Lottery (4%), and other casinos (0%). Nineteen percent of gambler participants reported moderately severe to severe depression at screening. No AIs reported moderately severe to severe depression.

[11] Percentages are low because group outpatient treatment usually occurs as a step-down treatment after a higher treatment intensity.

Intensive Outpatient Program (IOP)

Data were available from 68 clients enrolled at Intake in IOP during FY 2021-22 (**Figure 8**). Clients received treatment from either Union of Pan Asian Communities (UPAC; N=48) or Beit T'Shuvah (N=20). The following section summarizes frequency tables which include information on demographics, gambling behaviors, and treatment outcomes for IOP gamblers served.

FIGURE 8. INTENSIVE OUTPATIENT PROGRAM SNAPSHOT



Demographics

A total of 68 clients entered IOP during FY 2021-22. IOP clients' average age was 47. About half (49%) identified as White, Non-Hispanic only, followed by 15% Hispanic/Latino only, 13% Asian/Pacific Islander only, 9% African American only, 9% as Multiracial or Multi-ethnic, and 4% as another race/ethnicity only. Like Outpatient clients, IOP clients have fairly high levels of education with 90% reporting some college education or higher. Although clients' household income varied from less than $15,000 per year to $200,000 or higher, 15% of IOP clients reported an income less than $35,000 and 6% declined to state their household income.

Gambling Severity

All IOP clients met criteria established in the DSM-5 for gambling disorder (100%). Specifically, 6% were classified with mild gambling disorder (endorsing 4-5 criteria), 15% with moderate gambling disorder (endorsing 6-7 criteria), and 79% 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 (84%), followed by the Internet (43%), food/convenience stores (19%), and other venues (13%).

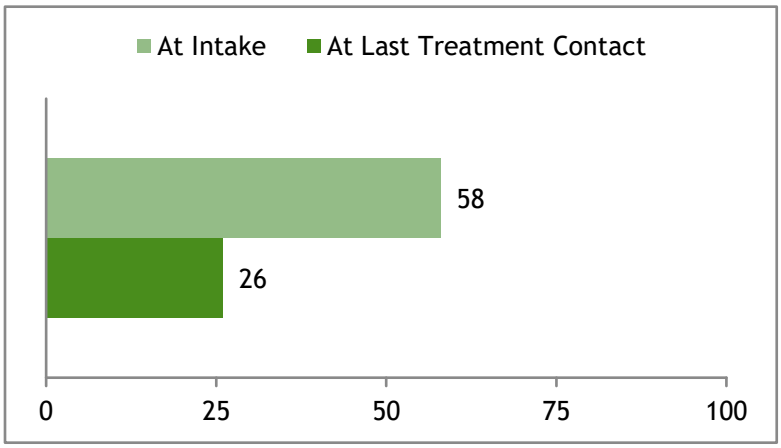
Across all venues the most commonly selected gambling activities were slot machines (49%), blackjack (34%), poker (24%), and sports betting (21%).

- At **tribal casinos,** IOP clients most frequently stated that they played slot machines (45%), blackjack (28%), and poker (15%).
- In the **community**, 19% of clients reported gambling on the Lottery.
- At **other casinos,** clients most frequently reported playing slot machines (20%), blackjack (16%), and poker (12%).
- At **cardrooms,** clients most often reported playing blackjack (16%) and poker (15%).
- On the **Internet**, clients most often indicated playing poker (10%), slots (10%), and other internet gambling (6%).
- Finally, clients reported gambling on sporting events (21%) and stocks/financial markets (9%).

Intake to Last Treatment Contact Outcomes

Treatment outcomes are measured by examining gambling interference with normal activities, intensity of gambling urge, life satisfaction, and depression. At Intake, none of the 68 IOP clients had missing data on the first three measures. At last treatment contact, three clients had missing data. IOP clients' reports of interference by gambling with their normal activities showed an average decrease of 32 points from Intake to last treatment contact (**Figure 9**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

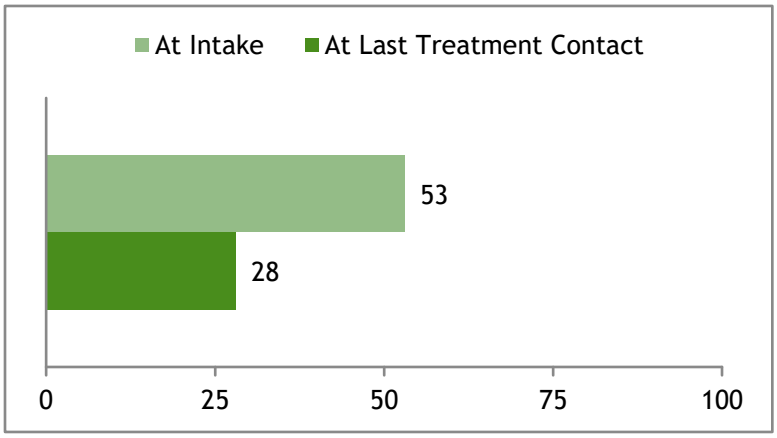
FIGURE 9. IOP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=68, LTC N=65.

Among IOP clients, the intensity of the urge to gamble decreased from Intake to last treatment contact by an average of 25 points on the 100-point scale. Lower scores at LTC indicated a less intense urge to gamble (**Figure 10**).

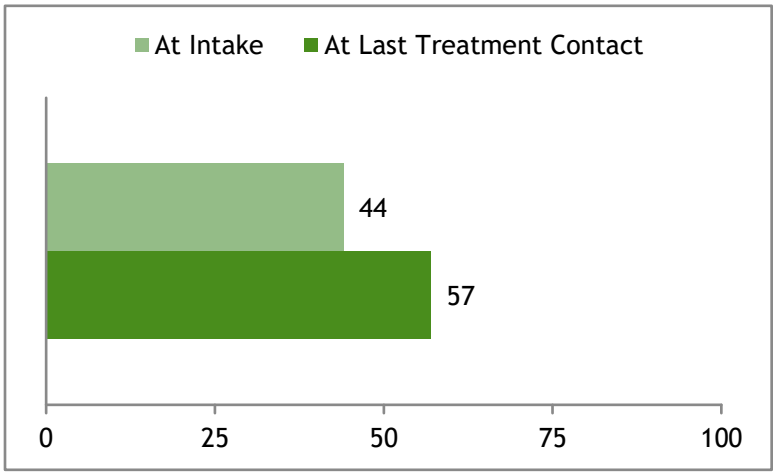
FIGURE 10. IOP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=68, LTC N=65.

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 (**Figure 11**). As above, life satisfaction was measured on a 100-point scale.

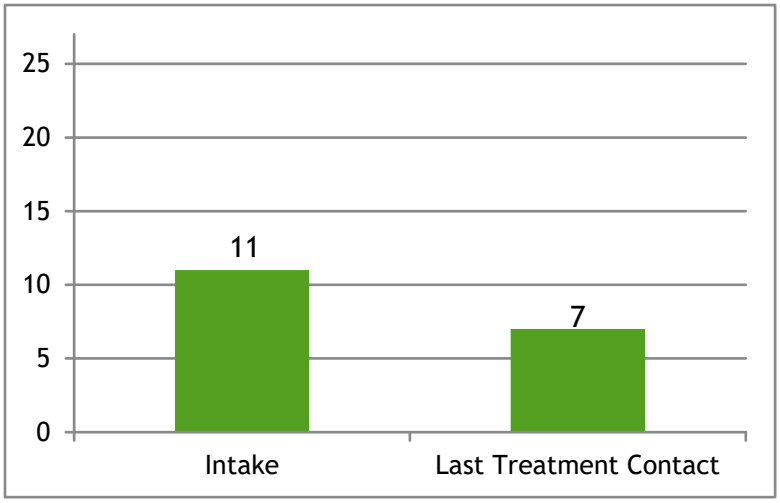
FIGURE 11. IOP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=68, LTC N=65.

During FY 2021-22, IOP participants' levels of depression were measured using the PHQ-9 both at Intake and at their last treatment contact. They showed, on average, moderate depression at Intake and mild depression at their last treatment contact (**Figure 12**). However, 35% entered treatment with moderately severe to severe depression.

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

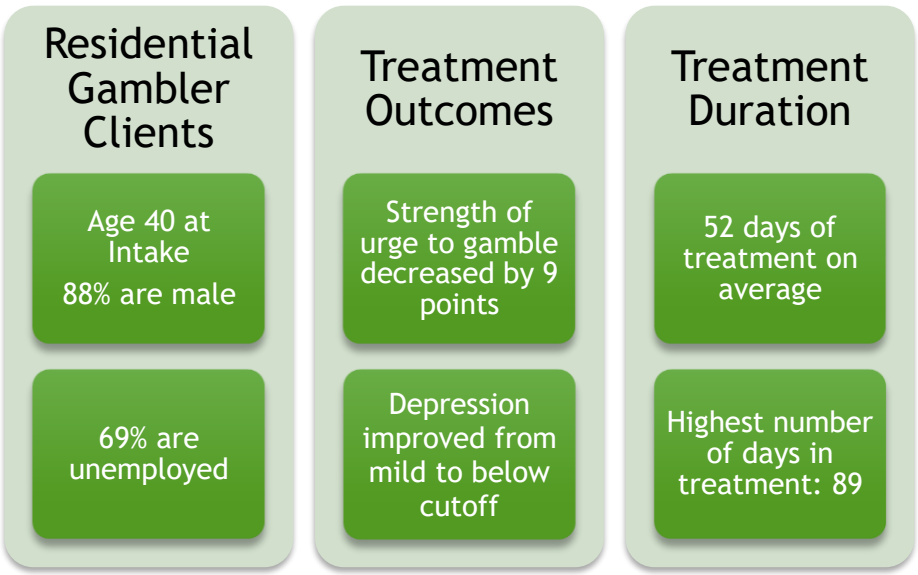


Note: Intake N=68, LTC N=65.

Residential Treatment Programs (RTP)

Data were available from 16 clients enrolled at Intake in RTP during FY 2021-22 (**Figure 13**). Clients received residential treatment from Beit T'Shuvah (N=16). Because COVID-19 shelter-in-place directives prevented new clients from being admitted to Beit T'Shuvah during part of FY 2021-22[12], OPG approved additional blocks of treatment (with clinical justification) for those currently in treatment. In addition, fewer clients could be housed simultaneously and therefore the average wait time to enter treatment was 48 days. The following section summarizes information on demographics, gambling behaviors, and treatment outcomes for gamblers participating in RTP.

FIGURE 13. RESIDENTIAL TREATMENT PROGRAMS SNAPSHOT



Demographics

Three-quarters (75%) of RTP clients identified as White, Non-Hispanic only, followed by 13% Native American/Alaska Native, 6% Asian/Pacific Islander only, and 6% Hispanic/Latino only. RTP clients have less education than Outpatient and IOP clients, with 25% reporting some college education or higher. This year, 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.

[12] During the 2021-2022 winter outbreak, admissions were closed from 12/13/2021 through 1/26/2022.

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 (56%) were the most frequently selected gambling venues from the options provided.

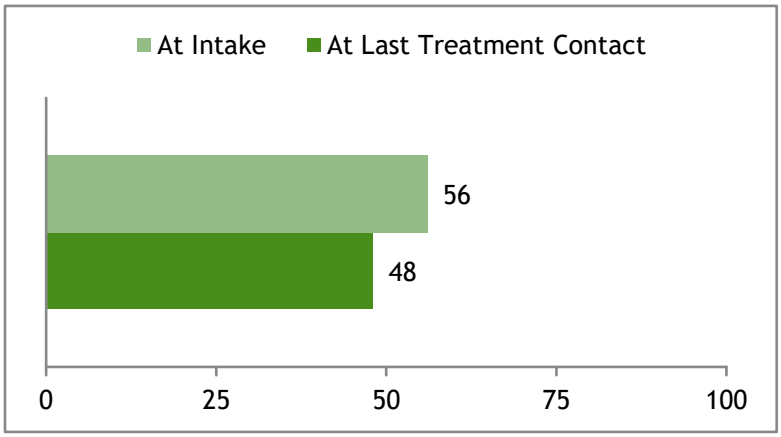
Clients were queried about the type of gambling they took part in at each of the major gambling venues. Across all venues, slot machines, sporting events, blackjack, and poker were the most commonly selected gambling activities.

- At **tribal casinos,** clients most frequently stated that they played slot machines (31%), blackjack (13%), and poker (6%).
- At **other casinos,** clients most frequently reported playing slot machines (44%), blackjack (25%), poker (13%), and baccarat (13%).
- At **cardrooms,** clients most often reported playing blackjack (19%) and poker (6%).
- On the **Internet**, clients most often indicated playing blackjack (13%), slots (6%), and other internet gambling (25%).
- Finally, clients reported gambling on sporting events (38%) and Lottery (6%).

Intake to Last Treatment Contact Outcomes

Intake to last treatment contact data is available on the 16 clients who entered residential treatment in FY 2021-22. By the end of treatment, the average rating of interference by gambling with normal activities decreased by 8 points among RTP clients (**Figure 14**). Client reports are made on a scale from 0-100, where higher scores indicate a greater impact of gambling on normal activities.

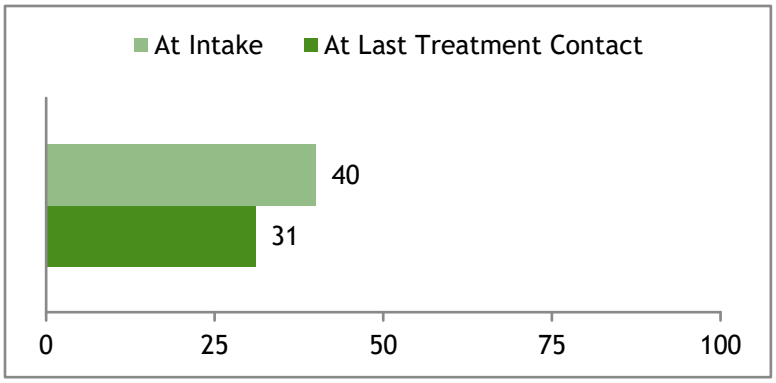
FIGURE 14. RTP GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=16, LTC N=15.

Among RTP clients, the intensity of the urge to gamble, on average, 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 (**Figure 15**).

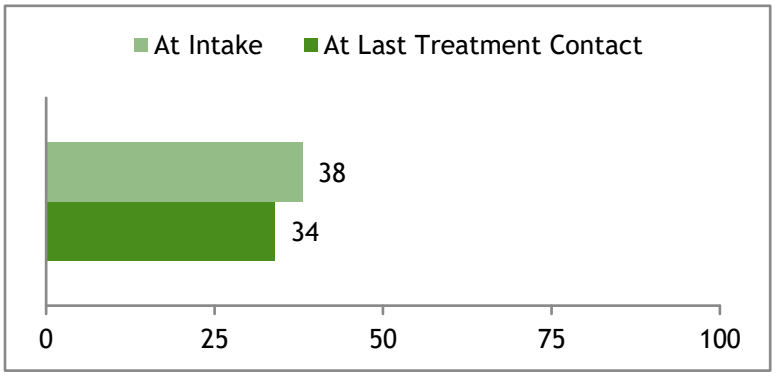
FIGURE 15. RTP GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=16, LTC N=15.

In FY 2021-22, RTP clients entered treatment with lower ratings of life satisfaction compared to Outpatient or IOP clients. Over the course of treatment, RTP clients reported a decrease of 4 points on average in overall life satisfaction (**Figure 16**). As above, life satisfaction was measured on a 100-point scale.

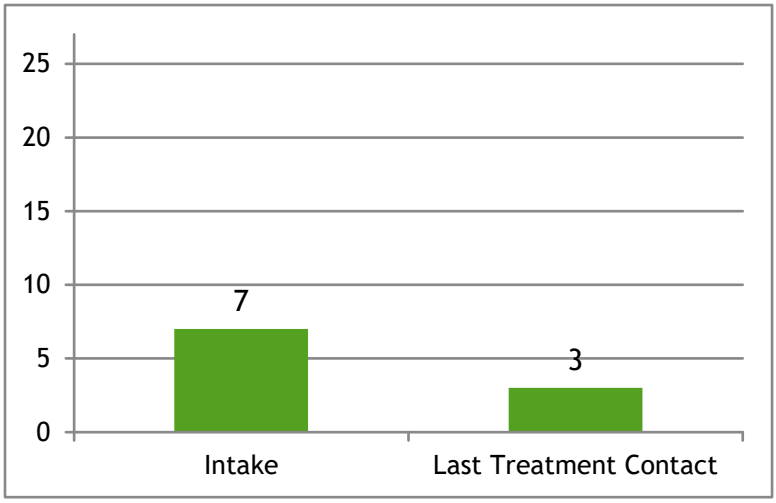
FIGURE 16. RTP GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=16, LTC N=15.

During FY 2021-22, RTP participants' levels of depression were measured using the PHQ-9 both at Intake and LTC. They showed, on average, an improvement in depression from mild depression at Intake to below the threshold for depression at last treatment contact (**Figure 17**). About 25% entered treatment with moderate depression.

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

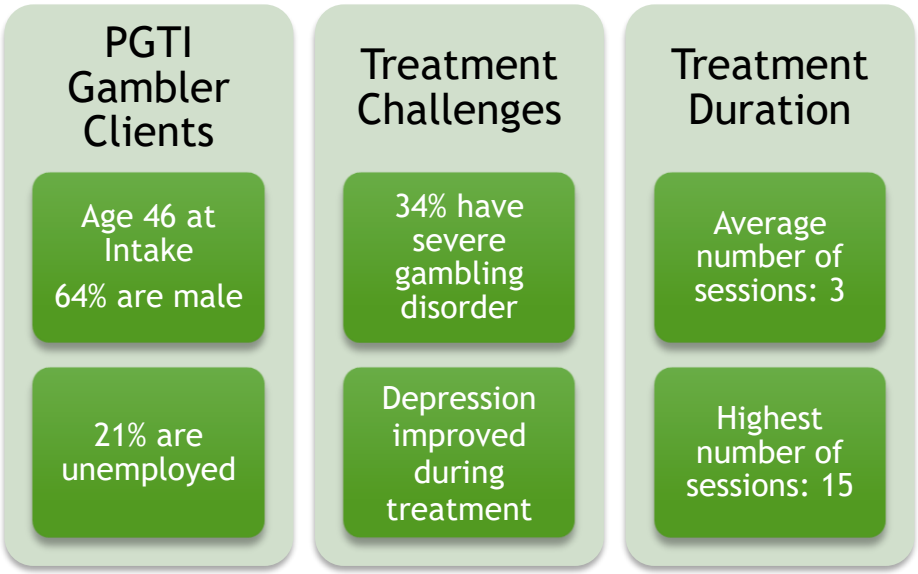


Note: Intake N=16, LTC N=15.

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 18. 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 229 gambler clients enrolled at Intake during FY 2021-22. Of the 229 total clients assessed at Intake, 150 received further treatment services.

Clients participating in PGTI (n=229) most often reported being referred by the Helpline (1-800-GAMBLER) (71%). Referrals also came via former CalGETS clients (7%); California Council on Problem Gambling (5%); casino signage (5%); family or friends (4%); the media (television, radio, newspapers, billboards) (3%); UCLA Gambling Studies Program (2%); OPG website (2%), Gamblers Anonymous (2%), and health professionals (1%).

PGTI clients (n=229) participated in three treatment sessions on average, with a maximum of 15 sessions in total.

Demographics

Gamblers in PGTI treatment were, on average, 46 years old and predominately male. Household income varied widely, but 18% had yearly household incomes of less than $35,000. Among PGTI clients, 31% were White, Non-Hispanic only, followed by 30% Asian/Pacific Islander only, 20% Hispanic/Latino only, 11% African American only, 3% another race/ethnicity only, and 4% Multiracial/Multi-ethnic. (See the appendix for more detailed gender and race/ethnicity information.) In addition, nearly 70% had completed some college or more (**Table 7**).

TABLE 7. PGTI GAMBLER: DEMOGRAPHICS

Age	(n=229)
Mean Age	46 years old
Gender	(n=229)
Male	64%
Female	36%
Transgender	0%
Race/Ethnicity (for those reporting a single category only)	(n=227)
White, Non-Hispanic only	31%
Asian/Pacific Islander only	30%
Hispanic or Latino only	20%
Black or African American only	11%
American Indian/Alaskan Native only	0%
Other race/ethnicity only	3%
Multiracial or Multi-ethnic	4%
Education	(n=227)
Less than High School	8%
High School	22%
Some College	34%
Bachelor's Degree	26%
Graduate/Professional Degree	9%
Household Income	(n=227)
Less than $15,000	6%
$15,000-$24,999	5%
$25,000-$34,999	7%
$35,000-$49,999	12%
$50,000-$74,999	17%
$75,000-$99,999	18%
$100,000-$149,999	15%
$150,000-$199,999	7%
$200,000 or more	5%
Decline to state	19%

Gambling Severity

Of those enrolled in PGTI services, 96% could be classified as having mild to severe gambling disorder (**Table 8**).

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

Severity	NODS Score	N	%
Problem gambling behavior	1 to 3	9	4%
Mild gambling disorder	4 to 5	61	27%
Moderate gambling disorder	6 to 7	77	34%
Severe gambling disorder	8 to 9	78	35%

Note: N=225

Gambling Behaviors

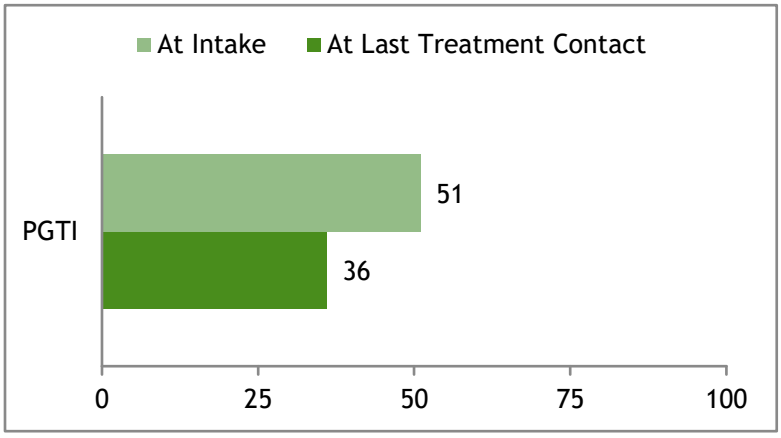
PGTI clients were asked at Intake to describe their gambling behaviors and the types of gambling activities they had engaged in over the last 12 months. Typical gambling locations included casinos, mentioned by 71% of clients, Internet (20%), and food/convenience stores for Lottery tickets (16%). Across all venues, the most common gambling activities were slot machines (44%), poker (21%), blackjack (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 (39%), blackjack (16%), and poker (15%). The other major gambling activities were the Lottery (11%) and other gambling activities (12%).

Intake to Last Treatment Contact Outcomes

At Intake, PGTI clients' average rating of interference by gambling with normal activities (**Figure 19**) 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.

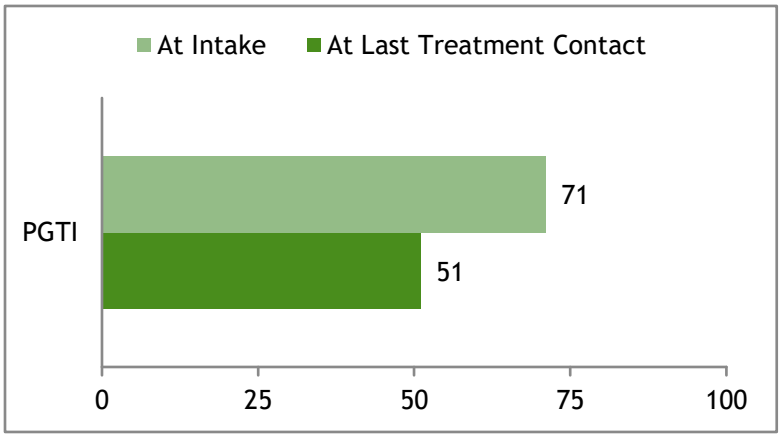
FIGURE 19. PGTI GAMBLER: AVERAGE RATING OF GAMBLING INTERFERENCE WITH NORMAL ACTIVITIES AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=225, LTC N=150 (79 missing).

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 (**Figure 20**).

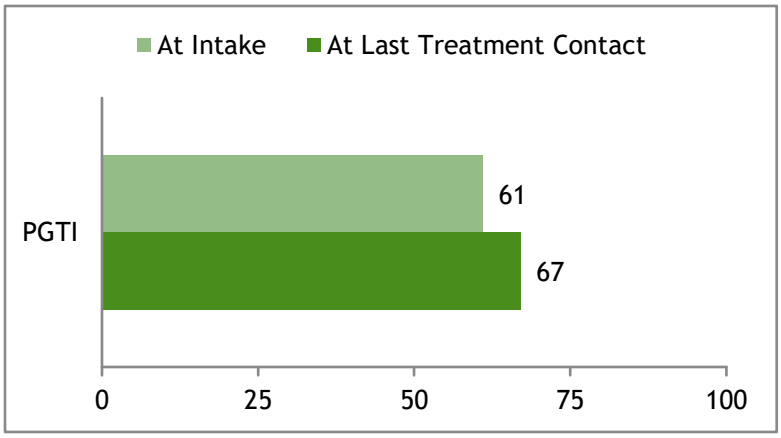
FIGURE 20. PGTI GAMBLER: AVERAGE RATING OF INTENSITY OF GAMBLING URGE AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=225, LTC N=150 (79 missing).

PGTI clients reported higher levels on average in overall life satisfaction at last treatment contact compared to Intake (**Figure 21**). As above, life satisfaction was measured on a 100-point scale.

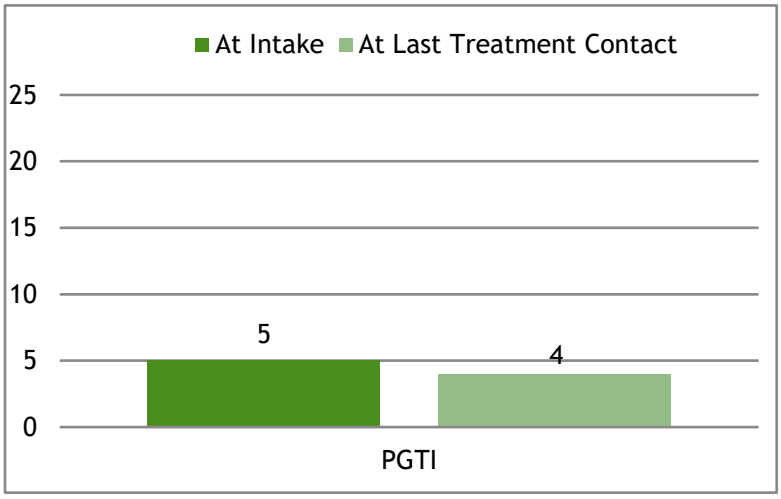
FIGURE 21. PGTI GAMBLER: AVERAGE RATING OF OVERALL LIFE SATISFACTION AT INTAKE AND AT LAST TREATMENT CONTACT



Note: Intake N=225, LTC N=150 (79 missing).

During FY 2021-22, PGTI participants' levels of depression were measured using the PHQ-9 both at Intake and at the last treatment contact. Clients showed, on average, mild depression at Intake and subclinical levels of depression at the last treatment contact (**Figure 22**).

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



Note: 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.

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

Service Level	Self-Reported Hypertension	Self-Reported Diabetes	Self-Reported Obesity	Obesity Calculated from BMI [13]
Outpatient (N = 439)	18%	11%	11%	34%
IOP (N = 68)	12%	16%	19%	44%
RTP (N = 16)	0%	0%	6%	6%
PGTI (N = 225)	12%	10%	4%	24%

- The most commonly self-reported co-occurring health related conditions were hypertension, diabetes, and obesity. Self-reported percentages for obesity are lower than those calculated from body mass index (BMI). Using BMI standards, approximately 34% of CalGETS Outpatient clients are obese, slightly higher than the percentage for California adults (28%).[14]
- 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 12%.[15] Among RTP clients, 13% reported smoking in FY 2021-22. Of IOP clients, 16% reported smoking. Among PGTI clients, 19% reported smoking.
- About 31% of gamblers across the treatment services network reported their health as fair or poor (38% in Outpatient, 27% in IOP, 6% in RTP, and 20% in PGTI). This compares to 16% of adults in California reporting their health as "fair or poor" in 2020, according to the CDC.[16]
- High percentages of clients in all treatment modalities reported having health insurance (Outpatient 87%, IOP 91%, RTP 94%, and PGTI 86%). A somewhat smaller percentage report that they currently have a physician that they can access for primary care needs (Outpatient 79%, IOP 87%, RTP 94%, and PGTI 77%).

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[13] 4 PGTI clients had missing data for the BMI calculation.

[14] 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/.

[15] California Department of Public Health, California Tobacco Control Program. California Tobacco Facts and Figures 2021. Sacramento, CA: California Department of Public Health; November 2021.

[16] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online], 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 and anxiety (**Table 10**).

TABLE 10. 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 = 439)	19%	4%	20%	4%	1%	6%
IOP (N = 68)	50%	3%	21%	3%	2%	6%
RTP (N = 16)	81%	13%	6%	0%	0%	0%
PGTI (N = 225)	18%	2%	6%	0%	1%	2%

Anxiety, Depression, and ADHD Symptom Screening

As seen below, 2 to 3 times more clients report anxiety symptoms in the screener than have received treatment for this disorder in the year before treatment entry.

- At treatment entry, 41% 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, 50% of IOP, 19% of RTP, and 14% of PGTI clients scored above the cutoff on the GAD-2 anxiety screener.
- 42% of CalGETS Outpatient clients, 49% of IOP, 25% of RTP, and 10% 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 in the past year.[17]
- 3% 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, 6% of IOP, 0% of RTP, and less than 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: 38% among IOP clients, 0% among RTP clients, and 41% among PGTI clients.
- Of Outpatient clients, 25% 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, 7% reported binge

[17] SAMHSA, Center for Behavioral Health Statistics and Quality, *2019-2020 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 30) [accessed Feb 4, 2022]. URL https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates.

drinking in the past month; no RTP clients, and 16% of PGTI clients reported binge drinking in the past month. This is compared to the 24% of California adults reporting any binge drinking in the past month.[18]

After alcohol, cannabis was the most frequently reported substance used in the past month across the treatment services network, with 18% 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 2020.[19] Approximately 9% of IOP, 6% of RTP, and 10% of PGTI clients reported cannabis use in the past month. However, clients also reported use of other substances (**Table 11**).

TABLE 11. GAMBLERS: SUBSTANCE USE IN THE PAST 30 DAYS

Service Level	Cocaine	Cannabis	Methamphetamine	Opiates
Outpatient (N = 439)	3%	18%	2%	3%
IOP (N = 68)	0%	9%	0%	2%
RTP (N = 16)	0%	6%	0%	0%
PGTI (N = 225)	<1%	10%	<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.

[18] SAMHSA, Center for Behavioral Health Statistics and Quality, *2019-2020 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 14) [accessed Feb 4, 2022]. URL https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates.

[19] SAMHSA, Center for Behavioral Health Statistics and Quality, *2019-2020 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)* (Table 3) [accessed Feb 4, 2022]. URL https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates.

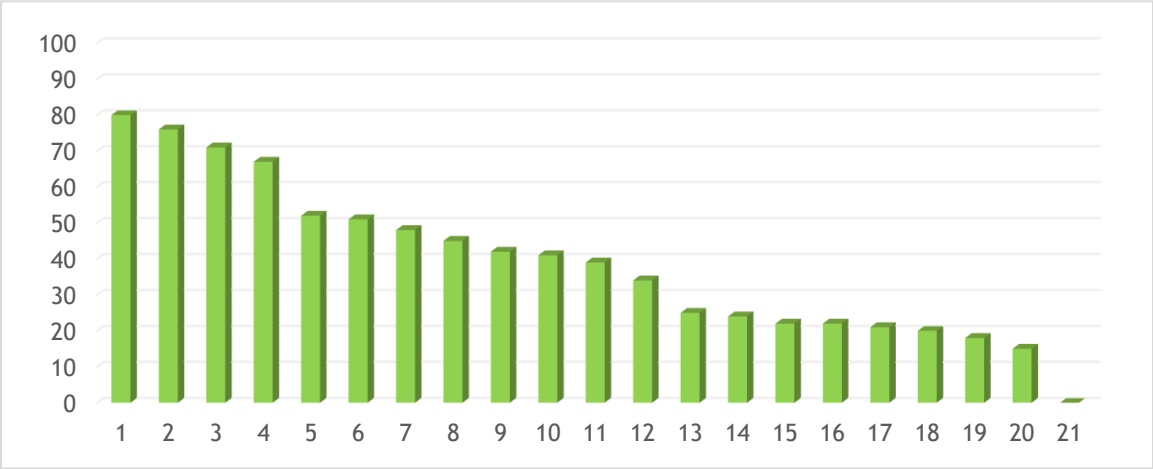
5. AFFECTED INDIVIDUALS DEMOGRAPHICS AND TREATMENT SERVICE OUTCOMES

This section summarizes key findings from FY 2021-22 data that were available from the DMS on AIs' demographics and treatment service outcomes. The data were collected on forms completed by clients at Intake, during treatment, and at the last treatment contact or from the End of Treatment form.

Treatment Service Provision

Data were available at Intake from a total of 233 AI clients. Most (94%) were served as Outpatients (n=220). The remaining 13 clients received treatment from PGTI. The number of Outpatient treatment sessions AIs attended ranged from 0 to 21. AI attendance in Outpatient was greater than 50% during the primary treatment sessions (sessions 1-5) (**Figure 23**).

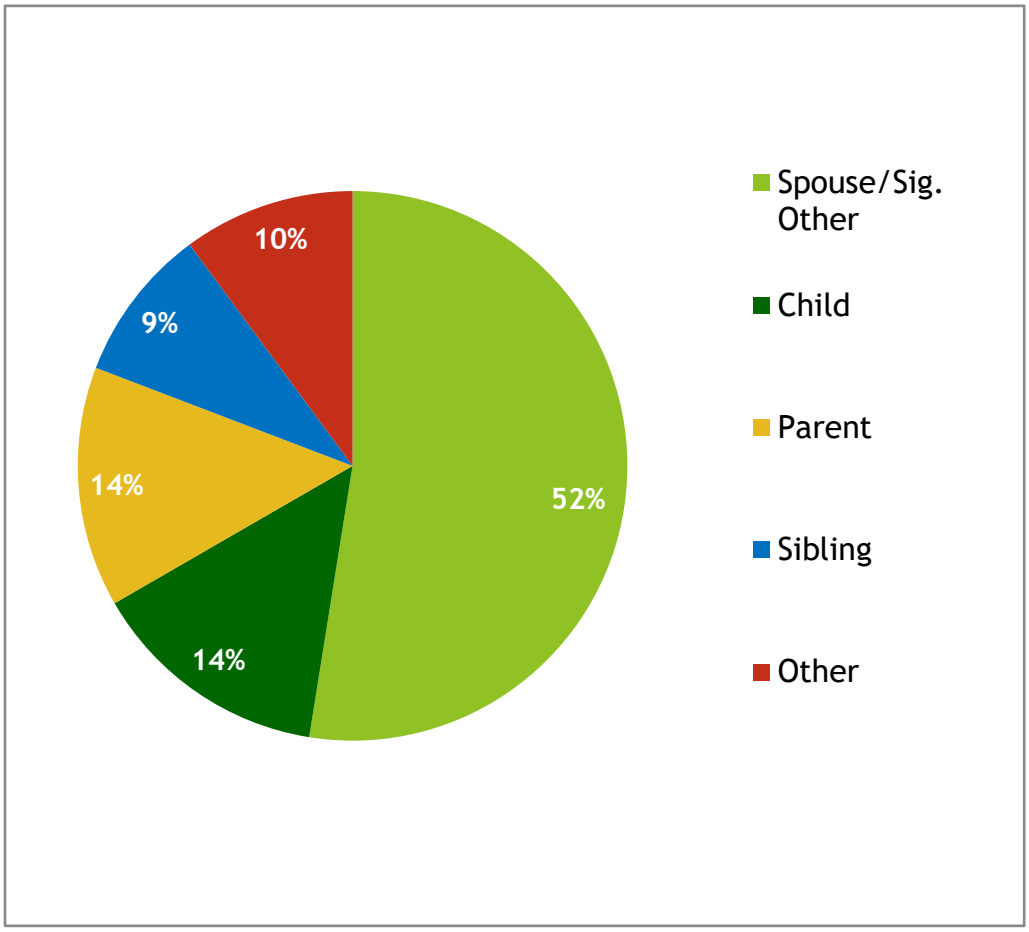
FIGURE 23. OUTPATIENT AFFECTED INDIVIDUALS: PERCENT ATTENDING EACH TREATMENT SESSION



Note: N=220

Of the 220 Outpatient AI clients, about half (52%) identified as a spouse or significant other of, 14% as a child of, 14% as a parent of, and 9% as a sibling of a gambler (**Figure 24**).

FIGURE 24. OUTPATIENT AFFECTED INDIVIDUALS: RELATIONSHIP TO GAMBLER



Demographics

AIs in Outpatient treatment were 44 years old, on average, and predominately female (79%), whereas about two-thirds of gambler clients are male. About 40% were White, Non-Hispanic, followed by 22% Hispanic/Latino, 13% Asian/Pacific Islander, 9% African American, 1% American Indian/Alaska Native, 11% another race/ethnicity, and 4% Multiracial/Multi-ethnic. Similar to Outpatient gamblers, Outpatient AIs have widely varying household incomes and high education levels, but 44% report a household income of less than $35,000 per year. A high percentage (82%) report having some college education or higher (**Table 12**).

TABLE 12. OUTPATIENT AI: DEMOGRAPHICS

Age	n=220
Mean Age	44 years old
Gender	n=220
Male	21%
Female	79%
Transgender	0%
Choose not to disclose	0%
Race/Ethnicity (for those reporting a single category only)	n=220
White, Non-Hispanic only	40%
Asian/Pacific Islander only	13%
Hispanic or Latino only	22%
Black or African American only	9%
American Indian/Alaska Native only	1%
Other race/ethnicity only	11%
Multiracial or Multi-ethnic	4%
Education	n=220
Less than High School	5%
High School	12%
Some College	29%
Bachelor's Degree	35%
Graduate/Professional Degree	18%
Household Income	n=220
Less than $15,000	29%
$15,000-$24,999	5%
$25,000-$34,999	10%
$35,000-$49,999	19%
$50,000-$74,999	16%
$75,000-$99,999	10%
$100,000-$149,999	5%
$150,000-$199,999	3%
$200,000 or more	3%
Decline to State	0%

Treatment Service Findings

Intake to Last Treatment Contact Outcomes

As seen in **Table 13**, AIs, on average, have mild depression scores at Intake and lower depression scores at their last treatment contact (PHQ-9 range is 0 – 27). Average life satisfaction scores (measured on a scale from 0 to 100) are moderate at Intake and at LTC are slightly higher. Both 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 13. OUTPATIENT AI: INTAKE TO LAST TREATMENT CONTACT OUTCOMES

Outcome Indicator	Intake Mean	Last Treatment Contact Mean
Depression (PHQ-9) score	8	5
Life satisfaction	62	66
Degree to which problem gambler's behaviors have interfered with normal activities	47	34
Feel responsible for gambler's treatment and recovery	39	28
Percentage of time spent dealing with the consequences of problem gambling	45	35

Note: Depression Intake N=196, LTC N=183; life satisfaction Intake N=196, LTC N=183; interfere with normal activities Intake N=196, LTC N=183; feel responsible Intake N=196, LTC N=183; percentage of time Intake N=196, LTC=200.

Health Information on Affected Individuals

Co-occurring health diagnoses reported by AIs were similar in prevalence to gamblers; however, a smaller percentage (26%) of AIs participating in the outpatient program reported that their health was fair or poor. Health problems reported by 5% or more of Outpatient AI clients were hypertension, diabetes, chronic respiratory disease, obesity, and heart disease. Twenty-six percent of Outpatient AIs had a body mass index indicating obesity. The percentage of Outpatient AIs reporting smoking was 4% in FY 2021-22, lower than the percentage of smokers among Californians (12%).[20] Also, 78% reported that they had health insurance.

Also of note was the percentage of Outpatient AIs who reported current drinking (42%) relative to Outpatient gamblers (55%). Cannabis use in the past 30 days was reported by 11% of

[20] California Department of Public Health, California Tobacco Control Program. California Tobacco Facts and Figures 2021. Sacramento, CA: California Department of Public Health; November 2021.

Outpatient AIs, while 4% reported opioid use. This year, no AIs reported use of cocaine and less than 1% reported methamphetamine use in the past 30 days.

In regard to co-occurring psychiatric disorders reported at Intake, 30% of Outpatient AI clients reported treatment in the past year for mood disorders, 24% for anxiety disorders, 2% for attention deficit disorders, 1 % for psychotic disorders, 1% for substance abuse disorders, and less than 1% for personality disorders. Using the PHQ-9 criteria, 12% of AI clients reported moderately severe to severe depression.

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. 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 2021-22, therefore, five attempts were made to reach each client.[21]

Table 14, 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 2021-22. The numbers differ slightly from DMS data because they are based on call logs. UGSP made more than 4,100 attempts to reach clients for follow-up interviews; completing 261 interviews, and ultimately closing 483 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 14. 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	Tot. G	Tot. AI	Grand Total
Attempts	1521	361	**1882**	1013	297	**1310**	744	234	**978**	3278	892	**4170**
Completed	123	21	**144**	62	11	**73**	32	12	**44**	217	44	**261**
Closed	193	47	**240**	78	23	**101**	105	37	**142**	376	107	**483**

Note: G = Gamblers, AI = Affected individuals

[21] UGSP had reduced call numbers during brief periods due to COVID-19 shelter-in-place requirements.

Gamblers and AI: Feedback on Treatment Experiences

At follow-up, clients from across the treatment network were also asked for feedback on the treatment services received. Combining the three follow-up periods, of the 64 gambler clients offering comments on their treatment experiences, 46 (72%) had positive comments, 13 (20%) had negative comments, and 5 (8%) had neutral or mixed comments. Clients expressing positive comments generally had a good connection with their providers, felt as if they benefitted from the treatment they received, and expressed gratitude for the CalGETS program. Those with negative comments most commonly stated that they did not receive all of their treatment sessions because they were unable to get in touch with their provider after missing an appointment. Those with neutral comments either did not connect well with their provider but still found them to be good counselors or they liked their provider but would have preferred in-person sessions rather than telehealth.

Of the 15 AIs who provided feedback on their treatment experiences, 11 (73%) offered positive comments, 2 (13%) had negative comments, and 2 (13%) had neutral or mixed comments. In general, those with positive comments expressed gratitude for the insight provided by their therapists and attributed some of the positive changes in their lives to the treatment they received. Those with negative comments were dissatisfied with their providers and thought they may benefit from switching to a new provider. Those with neutral comments expressed a preference for in-person sessions and a desire for more sessions.

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 2021-22, 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 pilot 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 will implement the outreach protocol for the two target counties. UGSP will assess 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 Lifeworks; and, (3) CalGETS utilization data from the Data Management System.

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. During FY 2021-22, Dr. Timothy Fong of UGSP provided three training sessions to RSBIHC staff members. Dr. Fong provided training 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.

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APPENDIX: DETAILED RACE/ETHNICITY AND GENDER CATEGORIES

TABLE 15. GAMBLERS: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 480	IOP N = 68	RTP N = 16	PGTI N = 227	Total N = 791	CA Population[22] N = 39,237,826
White, Non-Hispanic only[23]	45%	49%	75%	32%	42%	37%
Asian/Pacific Islander only	17%	13%	6%	30%	20%	16%
Hispanic or Latino only	16%	15%	6%	20%	17%	39%
Black or African American only	9%	9%	0%	11%	9%	5%
American Indian/Alaskan Native only	<1%	2%	13%	0%	1%	2%
Other race/ethnicity only	3%	4%	0%	3%	3%	-
Multiracial or Multi-ethnic[24]	9%	9%	0%	4%	7%	4%
Race/Ethnicity (for those reporting single AND multiple categories)	**Outpatient N = 480**	**IOP N = 68**	**RTP N = 16**	**PGTI N = 227**	**Total N = 791**	-
White, Non-Hispanic only or with another race/ethnicity[25]	50%	56%	75%	35%	47%	-
Asian/Pacific Islander only or with another race/ethnicity	20%	16%	6%	31%	22%	-
Hispanic or Latino only or with another race/ethnicity	21%	21%	6%	23%	21%	-
Black or African American only or with another race/ethnicity	10%	9%	0%	12%	10%	-
American Indian/Alaskan Native only or with another race/ethnicity	1%	1%	13%	<1%	1%	-
Other race/ethnicity only or with another race/ethnicity	6%	7%	0%	4%	5%	-

Note: Race/ethnicity percentages for those reporting single AND multiple categories add up to greater than 100% because individuals can select more than one response.

[22] Quick Facts: California, US Census Bureau, accessed 2/5/2022, at https://www.census.gov/quickfacts/fact/table/CA/PST045221.

[23] "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.

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

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

TABLE 16. GAMBLERS: GENDER DETAILS BY TREAMENT MODALITY

Gender – assigned at birth	Outpatient N = 482	IOP N = 68	RTP N = 16	PGTI N = 229	Total N = 795
Male	66%	59%	88%	64%	66%
Female	33%	41%	13%	36%	34%
Unknown	<1%	-	-	-	<1%
Gender – current self-described gender	**Outpatient N = 482**	**IOP N = 68**	**RTP N = 16**	**PGTI N = 229**	**Total N = 795**
Male	67%	59%	88%	64%	66%
Female	33%	40%	13%	36%	33%
Transgender woman	<1%	-	-	-	<1%
Transgender man	<1%	2%	-	-	<1%
Other gender category	<1%	-	-	-	<1%

TABLE 17. AI: RACE/ETHNICITY BY TREATMENT MODALITY AND COMPARED TO THE CALIFORNIA POPULATION

Race/Ethnicity (for those reporting a single category only)	Outpatient N = 220	PGTI N = 13	Total N = 233	CA Population[26] N = 39,237,826
White, Non-Hispanic only[27]	40%	23%	36%	37%
Asian/Pacific Islander only	13%	61%	15%	16%
Hispanic or Latino only	22%	15%	21%	39%
Black or African American only	9%	0%	9%	5%
American Indian/Alaskan Native only	1%	0%	<1%	2%
Other race/ethnicity only	4%	0%	4%	-
Multiracial or Multi-ethnic[28]	11%	0%	10%	4%
Race/Ethnicity (for those reporting single AND multiple categories)	**Outpatient N = 220**	**PGTI N = 13**	**Total N = 233**	-
White, Non-Hispanic only or with another race/ethnicity[29]	49%	23%	48%	-
Asian/Pacific Islander only or with another race/ethnicity	16%	61%	18%	-
Hispanic or Latino only or with another race/ethnicity	23%	15%	23%	-
Black or African American only or with another race/ethnicity	12%	0%	12%	-
American Indian/Alaskan Native only or with another race/ethnicity	1%	0%	<1%	-
Other race/ethnicity only or with another race/ethnicity	5%	0%	5%	-

Note: Race/ethnicity percentages for those reporting single AND multiple categories add up to greater than 100% because individuals can select more than one response.

[26] Quick Facts: California, US Census Bureau, accessed 2/5/2022, at https://www.census.gov/quickfacts/fact/table/CA/PST045221.

[27] "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.

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

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

TABLE 18. AI: GENDER DETAILS BY TREAMENT MODALITY

Gender – assigned at birth	**Outpatient N = 220**	**PGTI N = 13**	**Total N = 233**
Male	21%	0%	20%
Female	79%	100%	80%
Unknown	-	-	-
Gender – current self-described gender	**Outpatient N = 220**	**PGTI N = 13**	**Total N = 233**
Male	21%	0%	20%
Female	79%	100%	80%
Transgender woman	-	-	-
Transgender man	-	-	-
Choose not to disclose	-	-	-

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