

Report on a Study of Lao Gambling, Substance Use, and Help Seeking Attitudes
Funded by Northstar Problem Gambling Alliance 2016 to 2018**

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Data Note: The data contained herein are derived from a convenience sample and are not a representative sample of the Lao population. Therefore, inferences about overall rates of behaviors, attitudes or demographics of the Lao population or other populations cannot be made from these data.

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I. Executive Summary

Objective and Purpose: Gambling has been identified as a significant concern in the Lao community based on results of community meetings, focus groups, and anecdotal reports. Despite these observations, few (if any) studies have examined gambling in U.S. Lao or Southeast Asian communities. The current report presents results from a study completed in collaboration with Lao Assistance Center of Minnesota, Northstar Problem Gambling Alliance and Serena King, Associate Professor of Psychology at Hamline University on gambling, substance use behaviors, help seeking attitudes and perceptions of gambling among the Lao.

We collected a community convenience sample of around 200 adult participants (sampled more heavily from individuals reaching middle to late adulthood). In this process, we administered quantitative measures of gambling and substance use and reviewed informally-collected and non-systematically collected narrative data. The study aimed to investigate gambling and other addictive behaviors, patterns and problems, community need, help seeking knowledge, and attitudes around gambling. In addition, staff development and training meetings with Dr. King and Lao Assistance Center of Minnesota (LACM) laid the groundwork for data collection, planning and recommendations. The recommendations are a result of reviewing these sources of information. All recommendations were informed by data and the larger picture of ongoing discussions with community members, Lao Center staff, and meetings between the Executive Director (Sunny Chanthanouvong) and staff. Ultimately, the efforts were meant to inform future planning of effective services, intervention, and messaging to the Lao community.

Significance: There are only a handful of studies on gambling in the Southeast Asian population, and previous studies have methodological limitations. There have been very few (if any) studies to examine gambling in a single Southeast Asian refugee community, with many focusing on multiple ethnic or minority groups (Cambodian, Vietnamese, etc) within one study. Other studies have demonstrated markedly elevated risk for problem gambling among Southeast Asian refugee communities (a fuller review of the literature can be found in King et al., 2018). Many previous studies were limited in the scope of gambling data, in sample size and/or number of questions asked about gambling and other addictive behaviors. This is one of the few recent studies of gambling behaviors and help seeking attitudes, perceptions of addiction, and attitudes about treatment for gambling in a Southeast Asian refugee community sample. Despite its methodological limitations, this study represents one of the most current and comprehensive data sets on gambling in the Southeast Asian refugee population nationally (to our knowledge).

Major Findings. Data from the present survey report were drawn from a moderately large-scale convenience sample of Lao individuals recruited from the Lao Assistance Center of Minnesota. Participants were largely Lao refugees, and the sample was relatively evenly balanced by sex (recruitment approach reflected this balance). The majority of participants reached middle to later adulthood. Results revealed a high rate of gambling behaviors and problems in the sample. House betting, slots and casino games were common.

Participants indicated a significant community impact of gambling problems. Many participants gambled a large amount or lost a large amount, especially in the context of average income levels for the sample (\$25,000 range). In addition, a large portion of the sample endorsed five or more gambling symptoms on the South Oaks Gambling Screen (24%; indicative of probable problem gambling). Many participants acknowledged it was possible to have an addiction to gambling. While many indicated some familiarity with common gambling help resources, few reported accessing them or knowing others who accessed these resources. The majority of participants endorsed believing treatment could help with gambling. In addition, a large proportion of the sample reported they knew many people with serious negative consequences of gambling. Despite high reported rates of contact with gambling problems among community members in our sample, few knew individuals who had accessed treatment for problem gambling and a minority of the sample knew where they would access services for gambling. Although rates of problem drinking were not particularly high in this sample (perhaps in part due to ages of participants), problem drinking was correlated with problem gambling. Rates of heavy smoking were high in this sample. The majority of participants thought treatment would help change gambling (about 69%). For further detailed statistics on these findings, consult the data section of report.

Future Directions/Need: The current sample has substantially elevated rates of problem gambling and demonstrates evidence of high personal and community costs. However, there are limitations in what inferences from these data may generalize to larger communities due to the methodologies involved in collecting this non-random convenience sample. Data suggest a critical need for future studies in the community, with attention to more robust and representative sampling techniques. Next phase studies may address a culturally adapted pilot intervention, prevention, education programs rooted in evidence-based methods and other established interventions and prevention techniques. Given our findings, we recommend using representative sampling approaches to surveying the larger Southeast Asian community on acceptable approaches to outreach, treatment and prevention and holding small focus groups to learn more about the community's perspective on treatment and acceptable intervention and prevention approaches. Moreover, adequate research on the Lao and other Southeast

Asian populations in Minnesota and the U.S. is scant, leaving a gap in the knowledge base that may be used to address issues in these communities.

Conclusions/Implications: Our data suggest a need for culturally-sensitive and informed resources in Lao and English Languages and further examining the needs of other Southeast Asian refugee communities. In addition, a multi-layered community-based approach that simultaneously utilizes best practices in addiction prevention, education, outreach and/or intervention would be ideal to address various levels of readiness to change in the community (perhaps using community centers, clinics, educational outreach opportunities, prevention approaches, treatment facilities, helplines, and pop up clinic and screening approaches).

Further training for gambling treatment providers on working engaging with the Lao and other Southeast Asian communities may be useful and effective. Greater attention to reducing the health disparities in accessing treatment for gambling is warranted. This may involve work with providers, helplines, and community centers around best approaches to connecting Lao and SE Asian communities to services and increasing cultural competency for providers. A clear method to address language and interpreter needs among clients who seek gambling treatment may help bridge these disparities. Efforts will need support with possible monetary commitment by treatment providers, grants, Minnesota Department of Human Services or other mechanisms in order to be most effective and sustainable.

While the current study did not explore possible intervention or prevention approaches, quantitative and narrative data suggest that a peer-based approach using cultural informants or community members may be more acceptable to community members in this context. Many members were very resistant to seeking out formal education or prevention in the community or with existing treatment models. Therefore, a culturally-adapted, multi-tiered model of prevention and intervention seems most likely to be successful.

Recommendations:

- Further detailed study and analysis of Lao and other Southeast Asian populations is warranted given rates of problem gambling found in this convenience sample. Careful examination of trends in various forms and types of gambling (casino, house betting, lottery, internet, sports) will be useful in understanding best approaches for prevention. Future research may benefit from expanded resources and time and staffing and a randomly selected research sample.
- Communities may benefit from a small research-based, culturally-informed intervention or prevention program using the following steps:
 - Focus groups with key community members and elders.

- Presentation of data to elders in the community and community feedback.
- Ground-up discussion and facilitated conversations about intervention, prevention and outreach both with community members and gambling intervention experts.
- A written report of the results of the conversation and a plan moving forward integrating the feedback from the focus group.
- Based on the results of the pilot and outreach, expanded resources for the SE Asian Population around gambling might be warranted.
- An empirically-supported and culturally-adapted educational program may be piloted or implemented and it may be valuable to engage in conversations about gambling, and methods for assistance for those who seek or desire treatment or intervention.
- Development and testing of methods to engage community leaders or health workers on how to recognize, obtain resources, screen and refer individuals who they encounter with possible problem gambling.
- Knowledge, trust and stigma may affect the degree of gambling treatment seeking and access in Southeast Asian populations. In addition, cultural conversations among leaders and community members revealed that shame may prevent people from accessing care.
- One method to address the gap in services is to provide support for community centers and resources for Lao individuals. These efforts may be in collaboration with centers like LACM or other SE Asian community groups. *Efforts may be best planned and implemented in consultation with the communities they serve. Involving LACM or other community groups in planning and implementation may be essential for community buy-in and success, as these groups likely have the trust of the members of the community. With this in mind, the present recommendations are only tentative, and not necessarily the best path forward.*
- Possible avenues may involve a dedicated staff training program aimed at connecting community gambling needs with gambling resources. In addition, training at least two Lao individuals (man and woman) as resource counselors and facilitators to help navigate treatment for individuals may improve trust among community members. These individuals could be linked to the state gambling helpline, or administered via a centralized source of gambling support. Publicizing the availability of this resource to communities would be a key step. Possible approaches may include mentors, peer navigators, or staff health coordinators for gambling. This person or persons could be funded on an as-needed basis or hourly, depending on resources. Ideally, this may involve complete training and support from resources from DHS or another source. One larger goal may be training and credentialing a Lao language/Lao chemical dependency or gambling counselor would improve access to care. Efforts may need to be extended to other Southeast Asian communities affected by problem gambling.

- Tendencies for community members to not seek out or access mental health or addiction services may make connecting individuals to care more challenging. A multi-tiered approach that makes use of the following resources may be useful:
 - Community leaders
 - Culturally-informed and bilingual addiction counselors (resources for continuing education, conferences, and training in culturally specific approaches to gambling addiction)
 - Community centers
 - Elders in the community
 - Health care settings that service Lao and other SE Asian refugee communities
 - A culturally informed triage, access and referral approach for the gambling help line, SE Asian languages on call translation or scheduled phone calls. It may be that some members do not call the helpline anticipating they will be unable to speak someone who is fluent in their language or understanding of their culture.
 - Pop-up clinics on gambling assessment, resources, and brief screening and referral clinics (specific days publicized) offered in collaboration with chemical dependency and gambling addiction counselors and community leaders and community centers may be useful. These may be offered in combination with mental health screening pop-up clinics. Advertising and publicizing these opportunities could be useful. These clinics could be located at key community centers. This is similar to blood pressure (BP) screening clinics.

II. Introduction, Background, and Overview, Scope of Problem

Background and Need for Current Report and Research Project

Despite a critical need, there are few research-based reports of gambling in minority or underserved communities in Minnesota and on a national level, significantly limiting data available to develop and guide intervention efforts for these communities. As evidence of this shortage of research and policy, the National Center for Responsible Gambling this year (NCRG) made funding policy-based research on health disparities in problem gambling prevention and intervention a top priority. This report represents one of the few (or only) current research efforts in Minnesota to systematically examine gambling concerns in an at-risk, underserved minority community.

The current body of literature on the area is very limited in size, scope, and sampling methods. Only a handful of studies exist nationally and internationally to examine the issue in the Southeast Asian refugee community, a population considered at significant risk for problem

gambling. Southeast Asian refugee communities demonstrate relatively high rates of other mental health concerns and trauma, and may underutilize mental health care due to limitations in access, language and financial concerns (see King et al., 2018). In addition, there are cultural barriers and stigma that limit community member engagement with mental health treatment. Thus, research on the community allows for a finer-grained analysis of trends and patterns, barriers to care, and provides a foundation for empirically based prevention, intervention and prevention efforts. Data presented in this report are best understood in the wider context of cultural variables and socioeconomic factors affecting the Lao community.

Relatively little is known about gambling habits, perceptions, practices, and culturally-specific patterns of gambling in the Lao population or the Southeast Asian community at large. Without an understanding of gambling behaviors in the community, intervention and prevention are difficult. Emerging behavioral trend data on gambling types in the U.S. population (including sports betting and online betting) are changing over time, and it is therefore critical to define risk patterns of behaviors in at-risk minority communities. This knowledge may lead to better access to care, effective treatment and prevention methods, and more efficient and tailored allocation of problem gambling resources. Moreover, data may be used to inform intervention, prevention and outreach efforts to communities and help in the design and implementation of effective, culturally- adapted interventions.

Results of a small, non-quantitative study of research (led by the state of Minnesota) in some Southeast Asian communities in the mid 1990's showed elevated rates of problem gambling. Despite this observation, few systematic or published investigations to date have examined gambling in this population. In other states, studies examined the issue in Southeast Asians and findings suggested a very high rate of risk for problem gambling ranging from 13% to 59% percent in a couple community samples (population rates of gambling disorder nationally range from 1 to 5%). In a collaboration between the Minnesota Department of Human Services (DHS) and the Lao Assistance Center of Minnesota, there was a series of listening sessions with members of the Lao community around gambling in 2014 to 2015. Members in the listening sessions expressed concerns around gambling in the community. Results of these meetings revealed that community members were concerned about problem gambling, yet there was a perceived resistance to accessing help and various culturally-specific expectations surfaced around discussing and defining problem gambling in the Lao community.

During the sessions, community members discussed the personal and community impact of gambling problems in adult and youth populations. Results of these meetings are found in a report written by Russell Herder. Conversations at community meetings reflected some community-wide hesitance (or resistance) to admitting to gambling problems and seeking out

treatment for concerns. Community listening sessions yielded largely narrative data and summaries of brief personal histories and reflections were added to the report by Russell Herder. Data from the sessions were not systematically documented or analyzed (with the exception of a written report by Russell Herder). As a result of these listening sessions, several recommendations were offered by Russell Herder. Data from the sessions was narrative in nature. There were several impressions of Russell Herder based on these sessions.

These recommendations/observations included:

- 1) A need for gambling interventions that focused on the family unit.
- 2) Smaller group interventions were considered to have more potential than mainstream awareness approaches like billboards or helplines.

In sum, the extant data on problem gambling in the Southeast Asian refugee community is limited, but the little data that exists suggests a significant need in accessing care, and addressing health care disparities in intervention, prevention and outreach.

III. Introduction of Current Study

The Lao Assistance Center of Minnesota (LACM) partnered with Dr. Serena King (funded by Northstar Problem Gambling Alliance) to plan and implement a study of gambling in the Southeast Asian Lao community. The grant was funded with several goals. Phase one was intended to plan, execute and deliver a summary of data from a community-based sample of Lao surveyed on gambling, attitudes, and substance use. Phase two was intended to lay groundwork for piloting a culturally-sensitive intervention using empirically-supported tools adapted to a peer self help model implemented by trained staff in the community. In the process of preparing trainings for the study and intervention phases, there were several key discussions, meetings and interviews with staff and the Executive Director of LACM, Sunny. Out of these discussions, we developed a comprehensive research plan to obtain a sample. In the process of learning about the community, Dr. King discussed the concerns and the perspective on problem gambling in the Lao community with LACM staff, Sunny, and community members. Dr. King attended several of the previously mentioned Russell Herder meeting with the community and DHS. As a result of the collaboration between Dr. King and Sunny, a partnership was formed to address the concerns and study the problem in the community.

Dr. Serena King partnered with LACM staff and Sunny to evaluate a survey interview for participants. This interview was designed using established methods, measures and techniques in the field and included the South Oaks Gambling Screen (SOGS), a measure of problem gambling. In the process of consultation with Sunny and his staff, we developed an acceptable

interview influenced by steps in the translation process, and modified to optimize length given limited staffing and financial resources. In this process, Dr. King educated the staff on gambling and gambling disorder, common behaviors associated with gambling, and psychological interviewing techniques that were useful for interviewing in psychological research. In this process, LACM and Dr. King consulted on best approaches to the survey, adapting it to a culturally appropriate format and working together to provide appropriate language translation.

IV. Survey Process and Procedure

Work of LACM (as summarized by Dr. Serena King). As a part of the collaboration between Dr. King and LACM, Dr. King and Sunny met several times to discuss cultural elements to gambling in Lao culture. As a result of these conversations, Dr. King and Sunny shared concerns about challenges in reaching and messaging the Lao community with traditional means of communication (social media, videos, or posters, as had been discussed during meetings with Russell Herder). Sunny also raised concerns there would be trouble recruiting study populations for the study and the process of recruitment may be challenging. However, he and the staff expressed a commitment to engaging the community and recruiting on a rigorous basis through populations that accessed the Lao center. We also planned to use social media, word of mouth and personal recruitment of participants.

As part of the procedure and development of the survey, multiple group meetings with Lao staff and Sunny were held to discuss the nature of the survey and to create a culturally accessible format for the survey. In addition, we spent time developing a verbal translation protocol intended to assist in the development of an oral translation for the survey. LACM staff met with Dr. King to answer questions about gambling assessment, resources, and interviewing techniques.

Collaboration and Learning. In the process of developing the survey method and interviewing techniques, Dr. King and LACM staff met frequently to discuss the nature of gambling in the Lao community and potential cultural challenges to interviewing and recruitment issues. Some concerns and views expressed by staff and leaders included: 1) the potential shame in the community around reporting the extent of one's gambling in the survey and 2) measurement issues in gathering amounts of money spent on gambling. In addition, staff expressed concerns that participants may be hesitant to share personal data and specifics about money spent on gambling. We discussed methods of assuring the confidentiality of and the anonymity of the data with participants. Staff became more comfortable with survey techniques and methods to maximize the ability to gain accurate data.

In the process, LACM staff and Sunny inquired about methods of intervention, prevention, and outreach. This process was collaborative and instructional, and involved several formal and informal meetings with staff. We discussed the nature of gambling addiction, symptoms of gambling addiction, resources in the community on gambling addiction, and staff encounters with those struggling with gambling problems. From these meetings, we collectively concluded that Lao language and culture-specific gambling resources would be most accessible to the community. Staff also raised concerns that those affected by problem gambling may be hesitant to utilize existing resources due to language barriers, trust and stigma.

Several key training meetings took place with the entire LACM staff. In addition, several meetings with Lao Center leadership addressed perceived concerns in the community. Dr. King offered strategies for staff to share with concerned community members to initiate conversations around gambling problems with friends and family members. We also discussed strategies that may be useful in the community in trying to reduce and prevent harms associated with gambling.

Core learning objectives of the informal and formal meetings included:

- 1) Development of competency in understanding problem gambling and in recognizing risk factors for problem gambling.
- 2) Discussing how concerned family members can talk to others about gambling problems.
- 3) Linking staff to resources in the community on problem gambling.
- 4) Understanding the addictive nature of gambling and how to engage community members who may be struggling.

Note: *Indicates a significant portion of the method and results presented here are also presented in identical format in a paper currently under peer review for a special issue on addictions at *Professional Psychology: Research and Practice*, a journal of the American Psychological Association. The journal manuscript is currently under review as of the writing of this report, and is considered confidential and may be supplied upon request. Much of the data presented there is presented in this report in nearly identical format. Background literature and discussion of the results, however, are different.

Sampling Method and Limitations

Limits to recruitment methods, resources, staffing and outreach resulted in non-representative sampling techniques in the current study design. As noted throughout our report, this limitation needs to be considered in interpreting the data presented here. Alternative, representative

sampling techniques were discussed with Lao staff and leadership, but given resources and time, we were unable to implement a more comprehensive survey sampling method. Given our findings, it would benefit future studies to utilize a more comprehensive sampling technique to better estimate prevalence rates. As it stands, our current study cannot make any claims to evaluate or address incidence or prevalence rates due to its limited sampling design.

*Recruitment and Interviewing**

Participants were recruited via staff outreach or peer nomination from those seeking assistance at the Lao Community Center (in person, social media, referrals, and community outreach at temples, parties and other venues). We used a convenience sample, which may lead to limitations in generalizability. Around 250 potential participants were approached and 200 agreed to participate. Approximately 90% were recruited at the center, and 10% via community outreach or word of mouth, social media and other sources.

Due to logistic reasons, most interviews were completed immediately after recruitment. Around 25% of interviews were conducted in the home. Participants were read an informed consent in either Lao or English. Approximately 53% reported limited English abilities, 33% indicated fluency in English, and approximately 14% reported advanced English abilities. Participants were invited to ask questions and oriented to the purpose of the study (presented as study of health behaviors). Two center staff who self-identified as culturally and ethnically Lao (a male and female) administered interviews, recruitment and outreach. Interviewers were fluent in Lao and English and conducted interviews in person. While we did not analyze interviewer effects, there was non-random assignment of participants because interviews took place immediately, typically by the recruiter. One staff member completed a larger portion of the interviews (around 75%). Participants were paid a modest fee for their involvement.

Interviewers were trained on the research protocol and managing an interview. Efforts were made to standardize a Lao interpretation of the interview. Approximately 39.3% of participants received a Lao language interview, 27.7% English only, and 33% in both languages. Interviewers determined the language based on self-reported fluency level. Participants interviewed in both languages tended to have resided in the U.S. longer, had greater English fluency, and required translation at various points in the interview. Participants fluent in English (self-reported and then verified by interviewer impression of abilities) received an English version. Interviewers consulted regularly to assure consistency. Unfortunately, due to the English-Lao translation process and limited study resources, there was not a standardized translation-back translation approach.

A written translation was completed by a certified trained interpreter (Sunny, Executive Director, Lao Center). In consultation with staff, the research team and interpreter concluded that oral administration was preferred due to various levels of reading fluency. Interviewers reviewed written and oral translations to clarify meaning. Prior to the study, interviewers attended sessions with a lead researcher to standardize interview language and ask clarifying questions. Interviewers reached consensus on words or phrases which were difficult to translate. Agreement was reached on a standard Lao translation.

*Sample**

Participants were recruited from the Lao Assistance Center, a community-based organization serving the metropolitan Minneapolis-St. Paul area. The study focused on those who identified as culturally or ethnically Lao. The organization serves up to 12,000 community members in Minnesota is centrally located, and offers assistance with basic skills, financial, educational, health and other needs. Minneapolis and St. Paul are home to the third largest Lao population in the country and to large populations of other Southeast Asians (Hmong, Thai, Vietnamese, Karen, and others).

The study was approved by a university institutional review board and data collection was in compliance with the American Psychological Association ethical standards for the treatment of human participants. Participants were 200 [51% male ($n=101$), 49% female ($n=97$); 2 participants' sex data were unintentionally missing] Lao individuals, with many residing in the Minneapolis/St. Paul metropolitan area (approximately 97%). Average age range of participants was 45 to 54 and participants ranged in age from 18 to 24 to 65 and up (data were collected in ranges, not years). Average years of education was 11 ($SD=1.8$), with approximately 40% reporting less than a high school education (14.2% had no formal education) and 7.6% with a college degree or higher. Approximately 85% came from Laos. Around 71.5% were refugee and 14% immigrants. Most participants lived in the U.S. greater than 15 years (80.4%) or were U.S. born (12.9%). Average household income was in the \$25,000 to \$34,999 range, with 38 % earning less than \$15,000 a year. Participants' number of children ranged from 0 to 7 or more, with most having 2 to 3 children (42.5%).

*Measures**

Demographics. Questions assessed marital status, educational attainment, years of education, number of children in the family, self-reported English language abilities, immigrant or refugee status, family origin from Laos or elsewhere, years in the U.S., occupation and household income.

Gambling Behaviors and Problems. Because our investigation focused on gambling problems and behaviors, the assessment was more comprehensive than substance use. We assessed frequency of a variety of types of gambling behaviors (cards, animal betting, sports, online gambling, dice/craps, casino, lottery, slots, games of skill, non lottery games, pulltabs, bowling/pool). Gambling behaviors and experiences included: frequency of casino attendance, home betting, online gambling, largest amount gambled in a day, largest loss in a day, frequency of going back to win money lost, frequency of casino attendance, and money spent at the casino. In addition, we assessed whether individuals believed they had a gambling problem.

Gambling problems were assessed via the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987), a widely used standardized instrument for problem gambling. Questions on the SOGS ranged from frequency and quantity measures of gambling to a list of problem gambling behaviors that align with criteria for problem gambling (see Table 2 for full list) from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013). All scorable items we summed to compute a SOGS score (there was a range of 0 to 20). Cronbach's alpha reliability estimate for this sample was adequate ($\alpha=.81$). A score of 5 or more was indicative of likely problem gambling. More than 2 suggested a moderate level of problem gambling. SOGS data were also presented in a semi-continuous fashion, using total SOGS scores.

Substance Use Behaviors. Frequency and quantity measures of cigarette, alcohol, marijuana and problem alcohol behaviors were included (see Table 4). We measured frequency and quantity of alcohol use in the past twelve months, drinking six or more drinks at a time, and alcohol problems. We multiplied frequency and quantity to produce a scale on alcohol and cigarette use.

The alcohol problem scale was a sum of the following items: 1) How often have you failed to complete what was normally expected of you due to your drinking? 2) How often do you need a morning drink? 3) How often do you feel guilt or remorse after a drinking session? 4) After a drinking session, how often can you not remember the night before? 5) Have you or another been injured due to your drinking habits? 6) Has a friend, doctor, or health provider suggested a decrease in your alcohol consumption? Items 1 through 4 used a 1 to 5 scale (1 = never, 2 = less than once a month, 3 = monthly, 4=weekly, 5 =daily or almost daily), while items 5 through 6 used a 1 to 3 scale (1=no, 2= yes, but not in the past year, 3=yes, during the past year).

Help-Seeking Attitudes, Perceptions of Gambling, and Community Impact of Gambling. We included perceptions of gambling as an addictive behavior, help seeking and community

impact. Participants were asked if they would seek out help with gambling if needed, and types of resources they would use for help with gambling (friends, family members, community organizations, health care, or spiritual leaders). Participants were asked whether they knew of others who had received professional help with gambling in the community. We included questions on gambling as an addiction, and perceptions about whether treatment can change gambling. Participants were asked to estimate how many people in the Lao community they knew with a gambling problem, whether others had come to them concerned about their gambling (participants' behavior), and whether the Lao community needs help with gambling. Individuals were asked about resources where they would seek help with gambling: "Which of the following people/organizations would you reach out to seek help about gambling (check all that apply)?" We used a measure of familiarity with those significantly impacted by gambling problems in the community (including bankruptcy, divorce, unemployment, and separation issues).

V. Findings*

Gambling Problems and Behaviors

We examined frequency of various types of gambling behaviors (cards, horse/animal, sports, online, dice, casino, numbers/lottery, stock or commodities, slots, and bowling/pool). Within the total sample ($N=200$), the three most frequently endorsed types of gambling behavior occurring at least weekly were: casino (12.5%), slots (10.5%), and cards (8.0%). For problem gamblers (those with a SOGS score higher than 5; $n=48$), the top three forms of gambling occurring at least weekly were: casino (22.9%), slots (18.8%), and cards (14.6%). In the overall sample, the three most preferred types of games were: slots (39%), house betting (16.5%), and cards at a casino (15.5%). Approximately 19% of the sample ($n=37$) endorsed betting on sports at least weekly or more.

The SOGS was administered only to those who had ever gambled ($N=165$). Results from the SOGS are presented by problem gambling group and sex in Table 1. In addition, we present endorsement rates (and number of participants) for all scorable SOGS items (see Graph 1; $N=200$; percents reflect all participants in the sample, not only those who were administered the SOGS). We then computed various groupings of SOGS scores (0 problems, 1 to 2 problems, 3 to 4 problems and 5 or more problems). Men had a significantly higher SOGS score ($M= 3.67$, $SD=3.19$) than women ($M= 2.32$, $SD=2.47$) [$t(1,161)=2.99$, $p<.005$]. No significant differences were found on SOGS scores between immigrants, refugees and U.S. born participants ($F(2,162)=.29$, $p=n.s.$). We found that 24% of the sample (29.1%; $n=48$; of those who were administered the SOGS) had a score of five or more, indicating a probable gambling problem.

Twenty one and a half percent of the sample endorsed zero problems on the SOGS (26.1%; $n=43$ of those administered the SOGS). Around 24% of the sample reported a past or current problem with gambling (18% yes, and 5.5% yes in the past, but not now). About a quarter of the sample had someone talk to them concerned over their (participant's) gambling (25.5%, $n=51$). Around 32.0% ($n=64$) talked to friend or family about concerns around gambling (others' gambling). A large majority agreed that it was possible to have an addiction to gambling (86.5%, $n=175$).

We examined a variety of self-reported gambling behaviors in problem gamblers and the entire sample overall. Responses to individual SOGS items are presented in Figure 1. In problem gamblers, the largest amount lost in one day was between \$1,000 to \$4,999, compared to \$100 to \$1,000 dollars in the overall sample. For the entire sample, the average amount of money spent at a casino for gambling in a typical day was \$500 to \$999, whereas for the problem gambling group the range was \$1,000 to \$3,999. The largest amount gambled in one day (for all types of gambling combined) was \$100 to \$1,000 for the entire sample, but \$1,000 to \$10,000 for the problem gambling group.

Help Seeking, Community Impact, and Perceptions of Gambling

Perceptions and attitudes about gambling and help-seeking were examined in problem and non problem gambling groups (SOGS score of five or greater). The problem gambling group did not differ from the non-problem group in rates of yes responses to the question: "Can treatment change gambling?" (63.8% ($n=30$) of non problem gamblers, 69.3% ($n=79$) for problem gamblers, $\chi^2(1, n=161) = .46, p=n.s.$). Problem gamblers were more likely than non-problem gamblers to respond yes to the question: "Has anyone talked to you concerned over your gambling?" [64.6% ($n=31$) vs. 16.7% ($n=19$), $\chi^2(1, n=162) = 36.35, p<.0001$]. Problem gamblers were more likely to respond yes to the question: "I know where I could get help with gambling" [36.2% ($n=17$) versus 18.1% ($n=21$), $\chi^2(1, n=163) = 6.11, p<.001$].

Participants were asked: "On a scale of 1 to 10, how much would you say gambling is a problem within the Lao community (where 1=no problem to 10=very big problem)?" The average score on the item was 6.7 ($SD=2.32$). Almost a third of the sample (30%) indicated knowing five or more people with significant life issues as a result of gambling (bankruptcy, unemployment, children taken away, divorce, separation issues with significant other, etc).

Participants endorsed a willingness to seek help from groups or organizations (categories were provided for participants to check all that apply): a trusted family member or friend (20.5%, $n=41$), religious or spiritual leader (9.5%, $n=19$), community based organizations (3.0%, $n=6$),

health care provider (2.0%, $n=4$), gambling helpline (9.5%, $n=19$), Lao assistance center (20.5%, $n=41$), and none of these resources selected (6.5%, $n=13$). Among those with a gambling problem (5 plus score on the SOGS, total $n=48$), the three most highly endorsed resources were 1) Lao Assistance Center (37.5%, $n=18$), 2) trusted family member or friend (25%, $n=12$), and 3) gambling helpline (16.7%, $n=8$). A minority said they knew where they could get help for gambling (20.5%; $n=41$). Of those who scored a five or above on the SOGS, 35.4% ($n=17$) said they would seek help if it were available for gambling, whereas 20.8% ($n=10$) were not sure. Only 6% ($n=12$) endorsed yes to the following: “I know of people in the Lao community who received professional help for gambling.” In the sample overall, 20.5% ($n=41$) endorsed that they knew where to receive help with gambling, and 35.4% ($n=17$) of those with problem gambling endorsed the item.

Substance Use Behaviors and Associations with Gambling

Rates of substance use behaviors are reported in Figure 2. Frequency of drinking in the past twelve months was low, with 6.5% endorsing drinking two or more times a week, and 14% reporting 5 or more drinks on a typical drinking occasion in the past 12 months. The frequency of heavy drinking was also low, with 9% of the sample reporting heavy drinking occasions (6+ drinks at one time) at least once a month or more. Alcohol problem items were summed and centered around zero, with five as the original floor of the scale. In this sample, the alcohol problems score ranged from 0 to 8, with an average of 1.48 ($SD=1.30$). Smoking behaviors were common, with 21.5% of the sample endorsing daily smoking in the past twelve months and 8.0% endorsing a pack or more per typical smoking occasion. Frequency of marijuana use was low, with 2.0% endorsing using at least weekly or more.

A sum of gambling problems (SOGS) and alcohol problems were positively correlated ($r=.33$, $p<.001$). Although alcohol use and problems were generally low in the overall sample, the group with five or more gambling problems (problem gambling group; SOGS score =5+) scored higher ($M=1.63$, $SD=1.48$) on past twelve month alcohol use (frequency multiplied by quantity) ($t(157)=-2.54$, $p<.01$) than those without problem gambling (SOGS score lower than 5; $M=1.07$, $SD=1.19$). Similarly, those with a gambling problem had a higher score ($M=1.25$, $SD=.93$) on the alcohol problems scale ($t(161)=-4.31$, $p<.001$) than those without ($M=2.21$, $SD=1.93$). The gambling problem group also had a higher score ($M=1.63$, $SD=1.48$) on a computed frequency times quantity measure of smoking ($t(147)=-3.11$, $p<.001$) than those without ($M=1.07$, $SD=1.19$). The alcohol frequency times quantity score was more strongly associated with SOGS total score ($r=.27$, $p<.001$) than the association between SOGS scores and frequency (only) of marijuana use in the past 12 months ($r=.17$, $p<.05$).

VI. Summary of Key Findings

Gambling Behaviors:

- Commonly endorsed gambling types were casino, slots, cards and house betting.
- Weekly (or more) sports betting was endorsed at 19% in the sample.
- Men scored higher on the problem gambling scale (SOGS) and a ***problem level score on the SOGS (5 or more) was endorsed by 24% of this sample***. This is substantially higher than estimates in typical population based studies (which range in 1 to 5%), although the current study cannot be compared to these studies, as it was not a representative sample. Due to study limitations, the current investigation cannot serve as a population prevalence rate due to sampling procedures and study method.
- A large proportion of the sample reported that others spoke with them about problem gambling (25%) and a third of the sample had talked to others about their problem gambling.
- The top most commonly endorsed problem gambling items on the SOGS were: guilty from gambling (44%), gambling more than intended (40.5%), and could not stop betting (32.5%).
- The majority of participants endorsed it was possible to have an addiction to gambling (greater than 86%).
- The largest amount gambled in one day (for all types of gambling combined) was \$100 to \$1,000 for the entire sample, but \$1,000 to \$10,000 for the problem gambling group.
- In problem gamblers, the largest amount lost in one day was between \$1,000 to \$4,999, compared to \$100 to \$1,000 dollars in the overall sample.

Perceptions of Help Seeking, Gambling, and Community Impact of Gambling:

- The majority of participants thought treatment would help change gambling (about 69%).
- Gambling was seen as a concern in the Lao community and around 30% of the sample knew five or more people in the community with significant life issues and problems due to gambling.
- Among those with a gambling problem (score of five or more on the SOGS, total $n=48$), the three most highly endorsed resources were: Lao Assistance Center (37.5%, $n=18$), trusted family member or friend (25%, $n=12$), and gambling helpline (16.7%, $n=8$).
- A minority of the sample said they knew where they could get help for gambling (20.5%; $n=41$). Of those who scored a five or above on the SOGS, 35.4% ($n=17$) said they would seek help if it were available for gambling, whereas 20.8% ($n=10$) were not sure.

- Only 6% ($n=12$) endorsed yes to the following: “I know of people in the Lao community who received professional help for gambling.”

Substance Use Behaviors and Associations with Gambling

- The frequency of heavy drinking was low, with 9% of the sample reporting heavy drinking occasions (6+ drinks at one time) at least once a month or more. Additionally, rates of alcohol problems were low in the sample.
- Smoking behaviors were common, with 21.5% of the sample endorsing daily smoking in the past twelve months and 8.0% endorsing a pack or more per typical smoking occasion.
- Frequency of marijuana use was low, with 2.0% endorsing using at least weekly or more.
- Those with a gambling problem had a higher score on the alcohol problems scale than those without.
- The alcohol frequency /quantity score modestly associated with SOGS (problem gambling) total score.

VII. Informal Narrative Interview Data Sampling

As a part of post-study discussions with Lao Staff, the research team (directed by Dr. King) met with staff and conducted file reviews of select cases of moderate to higher level problem gamblers (as evidenced by scores on the SOGS). Individual cases were discussed in more detail using information gathered by the interviewers. It should be noted that case material included here was not systematically derived or sampled. In a series of three, three-hour long meetings with Dr. King’s research team and two members of Lao staff, we explored several interviews in more detail (19 interviews) to obtain a finer-grained picture of individuals affected by problematic gambling in our sample.

For cases reviewed in more detail, the interviewer on a given case was asked follow-up questions by Dr. King in order to understand greater detail about the participant and patterns of gambling behaviors. These discussions were conducted in a room with a student taking dictation and Dr. King summarizing the findings. A large proportion of files reviewed revealed betting done as a social activity with others in the community. In many cases, there was acknowledgement of excess gambling, but ambivalence about receiving treatment for gambling. There was interest in accessing services by some participants. The process of interviewing during our study may have prompted some self reflection on gambling behaviors

in some participants. Among those files reviewed, there were several stories of significant involvement in gambling leading to effects on health, happiness, family, and serious financial peril.

Overview and Observations/Summary of Select Narrative Data

From our observations and discussion of case material, we observed that some participants were interested in seeking help where appropriate, accessible and available. In addition, there were a variety of types of gambling represented in our problem gambling groups, including exclusive lottery, casino, slots, and house betting. Description from the narratives revealed some degree of social betting and many people reporting betting to gain financial freedom and improvement in life circumstances. In addition, several participants were very open about the nature and extent of their gambling and related problems that gambling caused themselves and others. There was interest among some participants in learning more about available services which could help gambling for Lao community members.

VIII. Conclusions and Implications

As a result of data reviewed and engagement with the Lao Center on gambling and intervention and outreach, there were several key conclusions:

- 1) Data demonstrated an elevated rate of problem gambling (24%) in this convenience sample. Because this was not a representative sample of the Lao community in the Twin Cities, we cannot make conclusions based on these results other than to observe rates of problem gambling in this sample are high. Based on these data and work in the community, the rate of problem gambling in this non-random convenience sample is higher than would be expected by chance and may be elevated due to a variety of factors impacting our sampling as well as community factors. We found when culturally trained Lao language interviewers were able to discuss gambling with participants in a structured format, most participants offered more detail on their gambling and experiences. Many participants spoke openly about their experiences with gambling personally and in the community. This research experience raises greater confidence in our ability to engage community members in open and candid conversations on gambling behaviors, possibly paving the way to developing trust around intervention, prevention, or behavior change.
- 2) Rates and levels of spending on gambling are elevated in the sample, and are particularly notable in light of the average overall household income for the sample.

Some community members may benefit from education and resources to assist in reducing risk for problem gambling and psychoeducational tools on responsible gambling. These methods may need to be tested to determine effective approaches to reach this community (using culturally sensitive methods and translation techniques).

- 3) Our findings around perceptions of gambling and help seeking suggest community members tended to be aware of the negative and significant impact that problem gambling may have on the Lao community. Given this awareness, there may be an opportunity to engage concerned community members. It may be useful to use a peer to peer teaching approach that involves motivated community members concerned about gambling in a family member, friend or acquaintance. Another possible method is a “first responder” approach using a peer-to-peer helping method with those who are ambivalent to change, or those who are ready to change. Based on our conversations with participants, there were several individuals who were aware of their gambling problems and expressed readiness to change, however, access and motivation for help was a barrier.
- 4) In the community, there some awareness of various gambling help venues and resources, but little utilization of the methods available. While it was unclear why resources were not utilized (particularly among those with a gambling problem), we believe that cultural and language barriers including the lack of Lao language counselors and culturally sensitive resources are a major hurdle to accessing services for the population.
- 5) While problem gambling and alcohol use and smoking were associated, the rates of problem drinking in our sample were not notably high. However, rates of smoking were high. The older average age range of our participants may have affected substance use rates in this sample. It is unclear from these correlational data to what extent problem or heavy drinking contributes to problem gambling in this community, or if the correlation is causal. However, this represents one of the few studies to examine gambling and substance use together in a Southeast Asian refugee community sample. Addressing behaviors such as gambling and smoking together may offer a greater health impact on the community.

Recommendations:

- 1) Given the findings of the current study, there is evidence that a sub-population of Lao in our sample were affected by problem gambling and may benefit from gambling

education, prevention and intervention resources. However, it is yet unclear what a best path forward may look like. Many members of the community acknowledged the impact of problem gambling, and many were significantly affected by their own and others' problem gambling and related consequences. Current gambling help resources may not be regularly utilized due to suspicion or lack of perceived access. In this context, it would be useful to reduce barriers to care and normalize conversations about gambling and its related consequences using non-pathologizing language. Importantly, offering resources that are simple and culturally appropriate (via peer mentorship, consultation or education) and creating a structure of gambling prevention or intervention led by culturally knowledgeable peers or staff will be essential in creating trust and reducing suspicion and stigma.

- 2) Training front line staff at community centers on methods to identify, screen and refer to treatment may be essential in developing a clear pathway toward accessing care for those affected (clinical care models may benefit from off site work with a liason (such as LACM) or may include a one day per week clinic referral and screening clinic hosted by a community center). However, given cultural perceptions around treatment and concerns about confidentiality raised by many community members, these services may be best delivered by a trained Southeast Asian licensed professional counselor or counselors. Coordinating efforts with other Southeast Asian refugee communities affected by problem gambling may prove easier through the pooling resources and expertise.
- 3) Development and pilot of a small, research based culturally informed intervention or prevention program may involve the following:
 - Focus group engagement with key community members and elders.
 - Presentation of data to elders in the community.
 - Ground-up discussion and facilitated conversation about methods to approach intervention prevention and outreach.
 - A conversation and a plan moving forward that integrates the feedback from the focus group.
 - Based on the results of the pilot and outreach, expanded resources for the SE Asian Population around gambling might be warranted.
- 4) Informed by data presented here and results of a focus group, an empirically supported, yet culturally adapted educational program (at a community level) would assist in starting conversations about gambling, and finding help for those seeking treatment or intervention.

5) Development and testing of methods to engage community leaders or health workers in how to recognize, screen and refer individuals they encounter with problem gambling.

6) Knowledge in the community around treatment, prevention and risk reduction may be limited. In addition, shame may prevent people from accessing care. Providing community centers with a dedicated staff training program that helps connect gambling needs with gambling resources. In addition, having at least two Lao individuals (man and woman) who can be resource counselors and trainers that are able to facilitate and help navigate treatment for an individual would help community members feel safer accessing services. These resources could be linked to the gambling helpline for the state, or administered via a centralized gambling resource.

Publicizing the availability of resources to communities may be an important step. Resources may include a mentor, peer navigator, staff health coordinator for gambling. This person or persons could be funded on an as-needed basis.. They would need to complete training and be supported by resources either from DHS or another source. Training and credentialing a Lao chemical dependency or gambling counselor would improve access to care.

7) Providing resources for the needs of the Lao and potentially other Southeast Asian refugee communities around gambling needs may be a significant challenge.

A multi-tiered approach using the following resources may be useful:

- Community leaders
- Culturally informed addiction counselors (resources for continuing education, conferences, and training in culturally specific approaches to gambling addiction)
- Community centers
- Elders in the community
- Health care settings that service Lao and other SE Asian refugee communities
- A culturally-informed triage, access and referral approach for the gambling help line, call translation or specialized call-back services. Some members may not call the line because they may not be able to speak to someone fluent in their language or knowledgeable about their culture.

- Pop-up clinics on gambling assessment, resources, and brief screening and referral clinics (certain days publicized) located at key community centers may be useful. These may be offered in collaboration with chemical dependency counselors, community leaders and community centers. This could be combined with mental and chemical health screening pop-up clinics. Advertising and publicizing these opportunities to the community would be useful. These clinics could be located at key community centers.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

King, S.M., Doppler, G., Wollmuth, A., Wasberg, S., & Prementine, C. (2018). Gambling, Substance Use, and Help Seeking in a Community Sample of Lao Refugees, Immigrants, and U.S. Born Citizens. Under review at *Professional Psychology: Research and Practice*.

Table 1. South Oaks Gambling Screen Results by Sex Among Participants Endorsing Lifetime Gambling and SOGS Item Endorsement Rates.

	SOGS Group			
	0 problems <u>% (n)</u>	1 to 2 problems <u>% (n)</u>	3 to 4 problems <u>% (n)</u>	5+ problems <u>% (n)</u>
Men	16.8 (17)	19.8 (20)	16.8 (17)	32.7 (33)
Women	25.8 (25)	23.7 (23)	14.4 (14)	14.4 (14)
Total (N=163)	21.5 (43)	21.5(43)	15.5 (31)	24.0 (47)

Note: The tabled data includes only individuals (n=163; around 82.5 of the entire sample) who were administered the SOGS after endorsing having ever gambled. The average SOGS score for men (n=87) was 3.67 (SD=3.19) and for women (n=76) was 2.32 (SD=2.47). Column totals in zero problems column have one added case due to due to the fact sex was a missing data point.

*Figure 1. SOGS Item Endorsement Rates (percents below are on full sample, not only those who were administered the SOGS)**

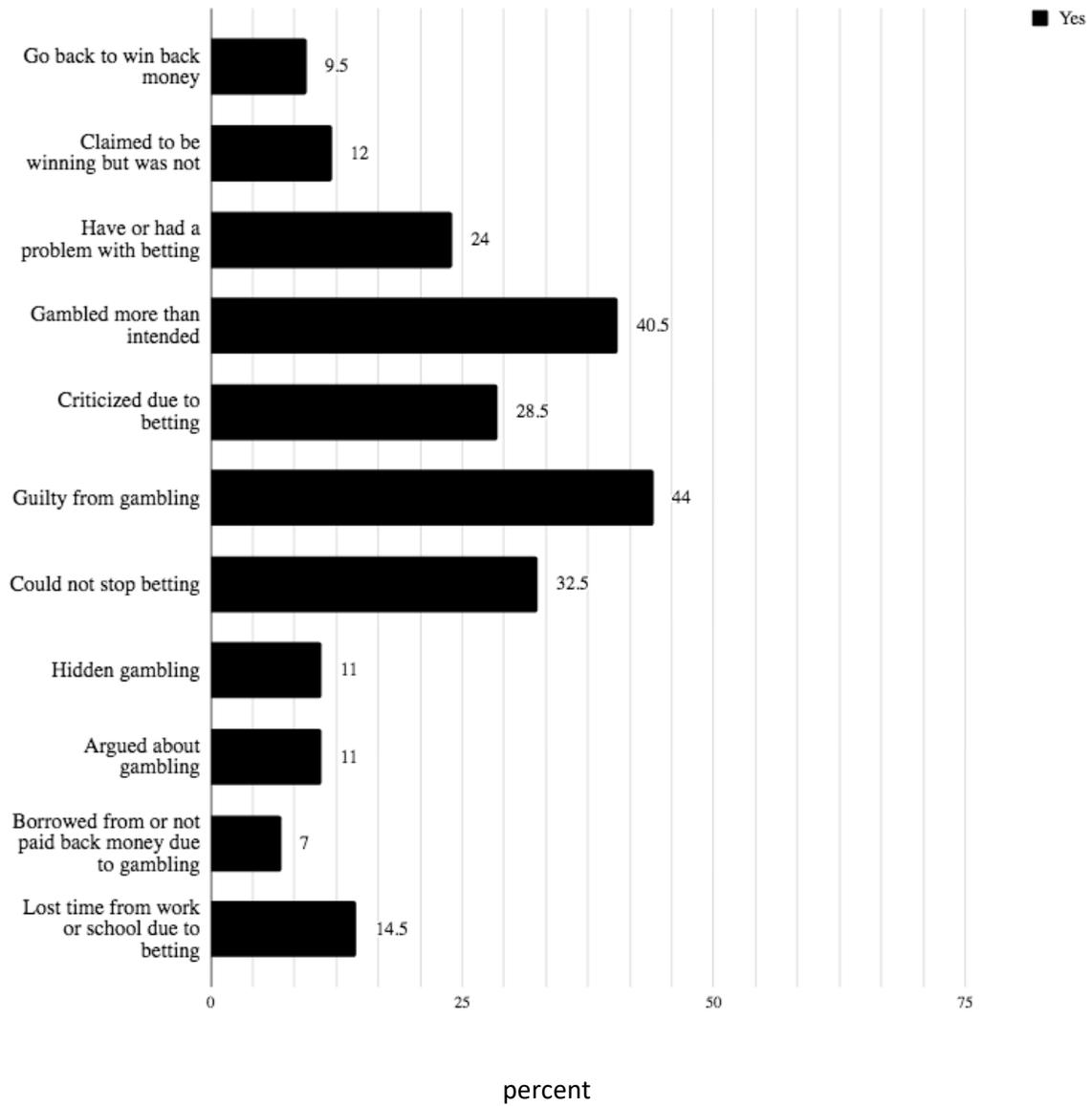
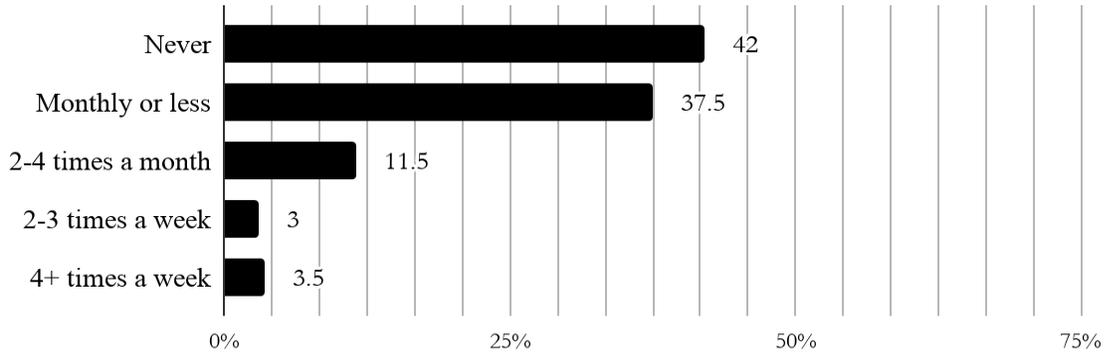


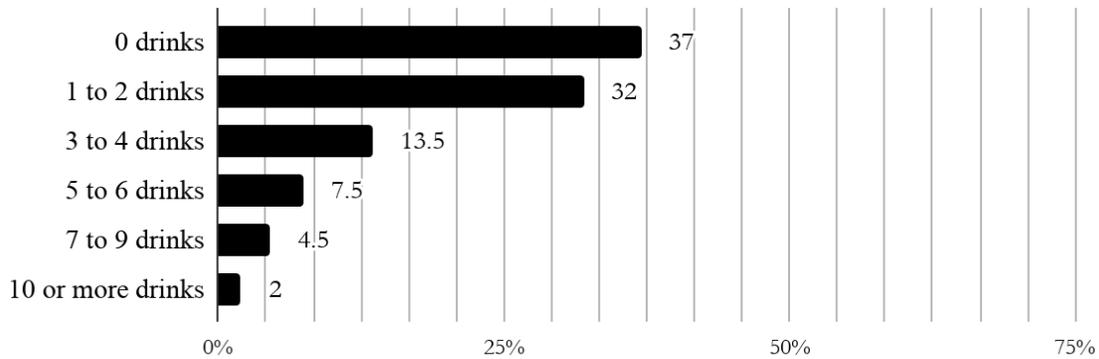
Figure 2. Substance Use Frequency, Quantity and Problems Among Substance Users.

Alcohol, Smoking and Marijuana Use

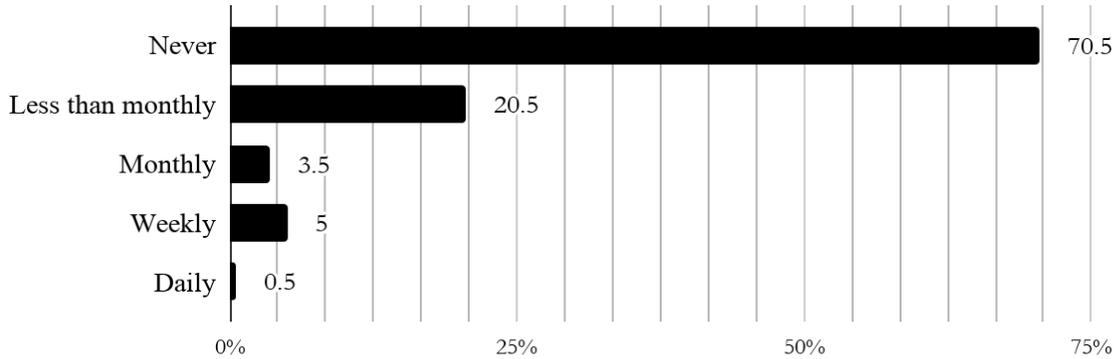
How often do you typically drink alcohol (past 12 months)?



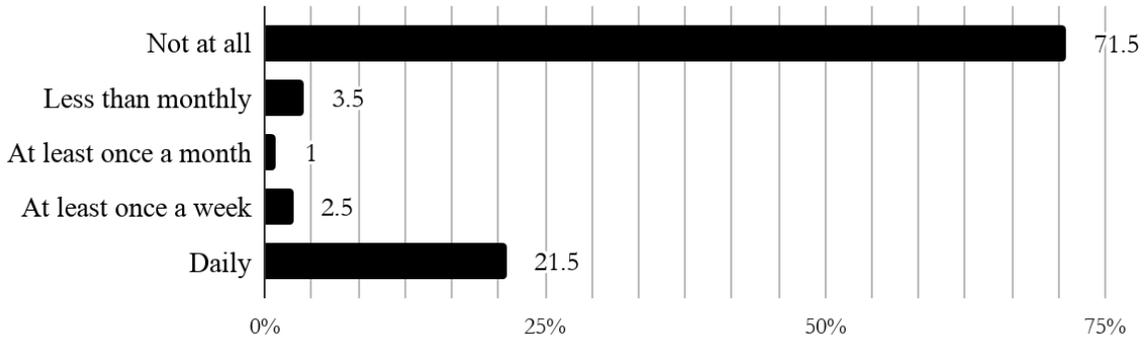
*How many drinks do you typically drink (past 12 months)?**



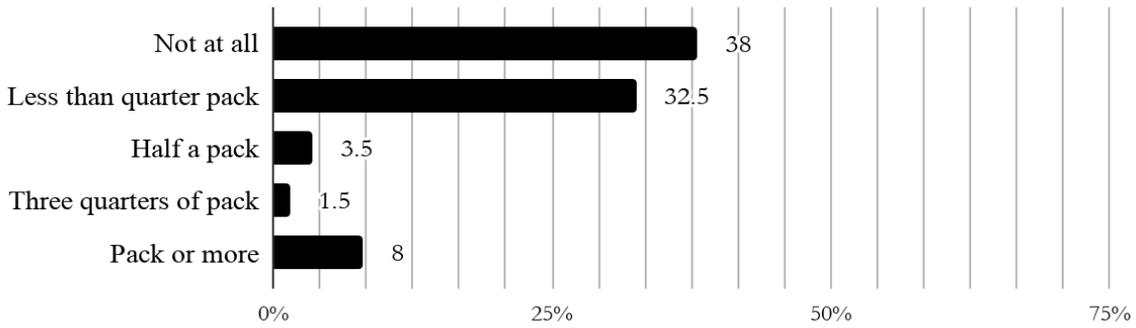
How often do you drink six or more drinks at one time?



How often do you smoke cigarettes?



*When you smoke cigarettes how much do you tend to smoke?**



*How often do you use marijuana (graph range 0 to 100 percent)?**

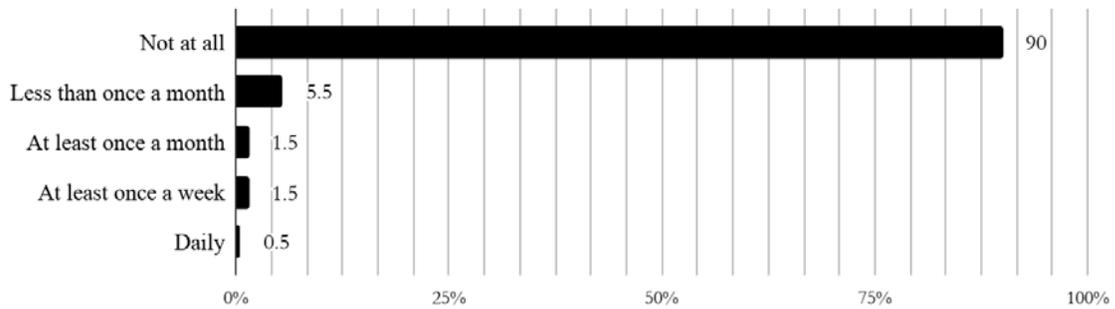


Table note. * Bars do not add up to 100 percent on items where there were missing data.