Feasibility of Brief Screening for At-Risk Gambling In Consumer Credit Counseling

(Prepublication Version)

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For Published version see:

https://link.springer.com/article/10.1007%2Fs10899-019-09836-1

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WORD COUNT: 4355 text only (No Maximum)

ABSTRACT WORD COUNT: (Max: 250 words) 242

TARGET JOURNAL: Journal of Gambling Studies

FUNDING: National Council on Responsible Gaming (NCRG)

Abstract

Gambling disorder and problem gambling often lead to major suffering in the form of mental health problems, interpersonal conflict, and financial crises. One potential setting for detecting at-risk gambling is credit counseling as gambling problems may manifest themselves in the form of financial distress and bankruptcy. Research studies have not considered those seeking credit counseling as individuals at risk for gambling problems even though gambling may contribute to financial distress. Therefore, the current study sought to quantify the prevalence of at-risk gambling in credit counseling compared with national estimates, to compare at-risk gamblers in this population to lower risk individuals, and to assess the feasibility of gambling screening in these settings. Using a mixed methods approach, the current study found that almost 20% of callers to a national agency reported gambling behavior, and among those who gambled, they reported higher rates of problems related to gambling than the broader U.S. population, thus supporting the idea that screening in credit counseling may help identify those at risk. Low risk gamblers were slightly younger than non-gamblers, but no other differences in sociodemographic and financial status variables were found based on gambling risk status. Results from focus groups and individual interviews suggest that credit counselors and program administrators see the benefit to brief screening within their intake and counseling processes. Our findings suggest that gambling screening is feasible in consumer credit counseling and may be acceptable to staff and administrators at these agencies.

Keywords: gambling disorder, at-risk gambling, consumer credit counseling, Brief Biosocial Gambling Screen, debt

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Introduction

Gambling disorder (GD) may destroy the psychological well-being and financial security of those with the disorder, their families, and others in their social circle (Goodwin et al. 2017; Shaw et al. 2007). GD has been linked with depression (Kim et al. 2006; Petry et al. 2005), other mood disorders (Browne et al. 2017; Kerber et al. 2015), personality disorders (Sacco et al. 2008), substance use disorder (Browne et al. 2017), and suicide (Petry and Kiluk 2002; Black et al. 2015). GD is the most severe manifestation of gambling pathology. A larger number of individuals suffer with fewer gambling problems (i.e., problem gamblers), in which their gambling symptoms do not meet full criteria for GD, but whose gambling is harmful. The term at-risk gambling refers to when an individual displays evidence of a gambling problem but the level of gambling risk requires further assessment (Toce-Gerstein et al. 2003).

Gambling and Risk of Financial Harm

The DSM-*5* (American Psychiatric Association 2013) classifies GD along with substance use disorders (SUD) as "Substance-Related and Addictive Disorders," but GD is unique as a substance use disorder without a "substance". For instance, tolerance is defined in gambling as the "need to gamble with increasing amounts of money in order to achieve the desired excitement (American Psychiatric Association 2013 p. 585)." Similarly, losing money is used as an indicator of a gambling problem by several well-established screening instruments (Lesieur et al. 1987; Lostutter et al. 2013; Slutske et al. 2015; Gebauer et al. 2010).

Those with GD are often (18% based on national estimates) forced to declare bankruptcy due their gambling losses (Grant et al. 2010), and there is some evidence that areas close in proximity to legal gambling venues have higher rates of bankruptcy (Boardman and Perry 2007;

Barron et al. 2002). Gambling losses may lead people to engage in shoplifting, "scamming for money" (Moghaddam et al. 2015 p. 144), stealing, and embezzlement (Binde 2016) to support their gambling habit.

GD by definition often leads one to borrow money either to continue gambling or to pay off gambling debts (Kerber et al. 2015; Moghaddam et al. 2015) with over one quarter of those with GD being delinquent in paying off loans. Several studies have found that financial pressures have been among the most important reasons for help seeking among those with GD (Evans and Delfabbro 2005; Suurvali et al. 2010; Suurvali et al. 2012).

Consumer Credit Counseling: A Setting for Screening

There is a strong body of evidence that GD leads to financial crisis, but very little is known about whether individuals affected by GD access services designed to help those experiencing bankruptcy and severe financial stress. Those experiencing GD related problems may be motivated to obtain treatment as a result of financial problems and bankruptcy (Wieczorek and Dąbrowska 2018; Gainsbury et al. 2014b; Hodgins and El-Guebaly 2000). Consumer credit counseling organizations are one avenue for assistance that persons with GD may seek out to manage or work to resolve their financial problems. Reputable credit counseling organizations are usually non-profit organizations that provide education and hands-on guidance to people who are in debt (Consumer Financial Protection Bureau 2017). These organizations work with individuals to develop realistic payment plans with creditors and provide support to those going through the bankruptcy process. Similar to individuals with alcohol-related injuries and illness who present at emergency departments and outpatient clinics during a crisis, it is possible that individuals with GD present at credit counseling organizations as a means of addressing gambling-related debt when in financial crisis. We are not aware of any study focused

on whether those with GD and/or at-risk gambling (gambling that causes problems but does not meet criteria for gambling disorder) obtain services from credit counseling.

Quantifying the prevalence of at-risk gambling in credit counseling is a valuable first step to understand GD within credit counseling settings. Credit counseling programs may represent an ideal setting for Screening and Brief Intervention and Referral for Treatment (SBIRT) style intervention for those whose debt is a result of gambling or are at current or potential future risk for GD. SBIRT was developed as a population-based approach for screening and providing early intervention for individuals whose use of alcohol presents a risk to their health (Babor and Higgins-Biddle 2000). Typically, SBIRT takes place in medical settings such as primary care and emergency departments providing a possible "teachable moment" in which health effects of substance use can be discussed. Since its early development, SBIRT has been expanded to other venues such as schools (Curtis et al. 2014) and senior centers (Schonfeld et al. 2010) to increase the possibility of identifying and engaging those who are contemplating behavior change and in some cases might enter treatment. Widespread implementation of SBIRT as a public health approach (Barbosa et al. 2015; Barbosa et al. 2017; Horn et al. 2017) has led to calls for adaptation of SBIRT for GD (Gainsbury et al. 2014a).

Still, notable differences exist between gambling and drug and alcohol use. Health effects of substance use are the direct result of drinking and drug use, but the health effects of gambling on health are indirect. As a result, healthcare providers may need to persuade clinicians to ask about finances in the context of a medical or mental health consultation. One potential advantage to screening for gambling in credit counseling settings is that the screening questions about financial losses and gambling spending directly relate to the financial services being sought by the client.

For these reasons, we were interested in evaluating the feasibility of brief gambling screening in consumer credit counseling. Our aims were twofold: 1) to estimate prevalence of at-risk gambling in credit counseling compared to national estimates, and 2) to evaluate the perceived acceptability and feasibility of brief screening for problem gambling behaviors from the perspective of credit counseling professionals and credit counseling administrators. The overall goal of this pilot project is to evaluate the feasibility of a brief intervention, patterned on adapting an SBIRT type screening for consumer credit counseling.

Methods

We utilized a mixed-methods approach for this study. First, we collaborated with a national non-profit, consumer credit counseling organization to implement routine screening for gambling participation and at-risk gambling. The rationale for screening was to quantify the prevalence of gambling to inform feasibility. Having data about the estimated prevalence of at-risk gambling will help determine whether it is efficient to screen in this setting. Second, we convened two focus groups and three key informant interviews to gauge the acceptability and feasibility of gambling screening. Through content analysis qualitative methods (Elo and Kyngäs 2008; Sandelowski 2000), we sought to describe the counselors' perspectives on the implementation of gambling screening into and their experiences using the screening with initial financial assessment and intake of new clients. We also asked administrators the benefits and challenges of implementing this screening into their services and programming.

Quantitative Data collection

Sample

For Aim 1, all callers to a consumer credit counseling agency were screened using the Brief Biosocial Gambling Screen (BBGS) beginning March 1, 2017 until February 28, 2018.

Financial counseling staff conducted 100% of the screenings and de-identified data were provided to the research team. Information on the sociodemographic and financial profiles of callers is provided in Table 1. Clients seeking services were largely female (68.0%) with a mean age of 48 years (*SD* = 14.9). Slightly more than half of callers were African American with 39% being White. There were smaller percentages of Hispanic (5.8%), Asian (3.3%), and Native American (< 1%) clients. More than half of the clients had a college education (57.2%) or higher (9.2%), and almost two-thirds (60.8%) were employed full-time. Median income in the sample was $39,354 with median total debt of $66,294.

Measures

The Brief Biosocial Gambling Screen (BBGS; Gebauer et al., 2010) is a 3-item screening measure designed to assess for at-risk gambling. The screening measure contains the following questions: *During the past 12 months have you become restless, irritable or anxious when trying to stop/cut down on gambling? During the past 12 months have you tried to keep your family or friends from knowing how much you gambled? During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?*

The BBGS was used together with a pre-screening question. Callers were asked if they had gambled five or more times in any one year of their lives. We used this question as a pre-screening item as it is consistent with a national survey (Grant et al. 2003) making it possible to compare prevalence with national estimates. Counselors listed examples of gambling activities including the following: *"Playing cards for money, betting on the horses or dogs or sports games, playing the stock or commodities market, buying lottery tickets or playing bingo or*

KENO or gambling at a casino, including playing slot machines." If a caller answered the question affirmatively, then the counselor would ask the BBGS questions.

All other variables (age, race, education, employment status, marital status, income, and debt) were collected by the credit counseling agency as part of their standard assessment and were self-reported by callers. Age was measured in years and a binary (male/female) response was used for gender. Data on race and ethnicity were derived from two questions, one on race and the other regarding Hispanic/Latino ethnicity. All individuals reporting Hispanic ethnicity were recoded into a separate race/ethnicity category regardless of race based on standard U.S. Census Bureau categories (Grieco and Cassidy 2001). For education and employment status, categories came directly from questions embedded in the credit counseling agency's assessment database. Education categories were *Less Than High School, High School, College,* and *Graduate*. Employment status variables were *Full Time, Part Time*, *Unemployed,* and *Retired*. Data on sources of income and debt were the result of a series of in-depth questions asked by counselors that were then aggregated by the agency and provided to the research team.

At the time of each initial intake phone call, financial counselors entered a primary reason for financial strain or problems. Study team members entered data into one of the following broad categories: *Employment*, *Other Income*, *Health & Medical*, *Family & Personal*, *Home & Environment,* and *Education*. These options were drawn from a larger number of categories (32). *Employment* included the loss of income from job loss, business failure, and under-employment. Responses were coded as *Other Income* if they were not directly job related (e.g., fraud, credit card debt, tax liability, etc.). The *Health & Medical* category encompassed debt related to medical expenses as well as illness that impeded ability to work. It is notable that a small number of individuals directly reported gambling (n = 4) or addiction (n = 5) as the

source of their financial problems. The category of *Family & Personal* included stressors such as divorce, marriage, and death of a family member. Costs related to home ownership (e.g., mortgage, foreclosure, etc.) and automobile expenses were categorized as *Home & Environment*. *Education* included tuition costs and student debt.

Procedure

At the outset of the research study, research team members met in-person with the credit counselors and provided a one-hour training on how to administer the BBGS. The researchers also provided counselors with informational materials about problem gambling and referral sources for gambling treatment, including a 24-hour helpline. Throughout the study, the Counseling Manager listened to a small percentage of random calls to ensure that questions were being asked correctly and the manager provided feedback as needed to counselors if she detected any problems. Over the course of the year, study investigators contacted the agency periodically and provided a booster training.

After the training, the BBGS was incorporated into the standard assessment workflow. As noted, counselors asked the BBGS prescreening question within the process of their overall financial assessment in which questions are asked about personal spending. If a caller responded affirmatively to the pre-screen, they were asked all three screening questions. Callers who endorsed any BBGS item were considered at-risk and were provided with referral options and information on problem gambling. De-identified data were forwarded to project investigators on a monthly basis for a period of one year.

Analysis

Data from the credit-counseling agency were analyzed in three steps. First, univariate analysis was done on the complete sample (Table 1). Based on BBGS responses, we created a

three-level variable. Those who denied gambling five or more times in a year were considered as "nongamblers." Persons who reported lifetime gambling but who did not endorse BBGS items were coded as "Low Risk," and those who answered affirmatively to any BBGS items were considered "At-Risk." To understand the prevalence of gambling in credit counseling, we compared responses to the BBGS to national data reported in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC: Grant et al. 2003). Bivariate models were then analyzed to assess differences in sociodemographic and financial variables based on gambling levels to understand whether there are differences in those seeking credit counseling for whom gambling is an issue. Additionally, we were interested in understanding whether the severity and types of debt among at-risk gamblers were systematically different from other callers. Finally, we estimated a multinomial logistic regression model assessing the odds of low risk and at-risk gambling including both sociodemographic (e.g., age, gender, and race/ethnicity) and financial variables (e.g., income, debt, bankruptcy). Because no Native American callers endorsed at-risk gambling (see Table 3), they were excluded from the multivariate model. Missingness was limited (3.5% of cases) so listwise deletion was used for the logistic regression model.

Qualitative Data collection

Sample

After approximately six months using the BBGS, we conducted two focus groups with credit counselors (n = 8, four counselors in each focus group). The focus groups were designed to assess the experiences of the credit counselors as they were trained to screen for problem gambling in their place of employment using the 4-item Brief Biosocial Gambling Screen (BBGS) and their experience of implementing the screening into their regular intake and assessment work. The researchers also interviewed three credit counseling administrators to

assess their experience of implementing and managing the brief screening, in addition to their views on potential next steps for developing a brief intervention.

Procedure

With the purposes of conducting a qualitative description, the researchers developed, in conjunction with the credit counseling leadership, a semi-structured interview guide. The guide asked counselors how, prior to this training and screening implementation, they talked with callers about potential problem gambling concerns. In qualitative data collection, we utilized a qualitative content analysis approach (Elo and Kyngäs 2008; Sandelowski 2000) with an explicit aim of describing the experiences and insights of credit counselors and agency executives about gambling screening at the agency where data collection occurred. Counselors were asked to describe their experience of asking the screening questions and to describe the reactions by callers to the screening. Additionally, counselors were asked about possible next steps for sustaining the screening in their work after the grant concluded. Participants discussed potential next steps with regard to additional intervention development such as a brief intervention for callers who screen positive or request additional referral resources. The focus groups were recorded and transcribed. Each focus group lasted approximately 75 minutes.

Researchers also conducted key informant interviews with three members of the agency's administrative staff, including the counseling manager. These interviews were designed to ascertain administrators' perspectives on how gambling screening fit into their cadre of services and what they perceive to be next steps for integrating this permanently into their work.

For both the focus groups and the interviews, three researchers analyzed the data independently and used a thematic data analysis approach to code the transcriptions. This method is common for qualitative description as the purpose of the focus groups and interviews was to

describe the experiences of the counselors, not to build or test theory. Patterns and themes were shared with the Principal Investigator (PI) and members of the research team. Results are organized in such a way that they reflect agreement and disagreement among counselors and administrators based on the primary components of the SBIRT intervention model on which this study is based (Kaner et al. 2007; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993). Using the SBIRT model as a framework in which to present results helps with interpreting the potential feasibility and acceptability of screening and referral to treatment, key components of SBIRT, as related to aim one of the current study.

Results

Quantitative Findings

Univariate analyses were conducted to assess the prevalence of lifetime gambling and at-risk gambling over the study period. Among callers, 17.1% reported gambling more than five times in any year of their life (n = 417), a rate lower than the NESARC general population survey. Callers who endorsed lifetime gambling were then asked the three BBGS questions to assess for at risk gambling. Although rates of lifetime gambling participation were lower than in the NESARC, lifetime gamblers in the current sample were much more likely to endorse subsequent problem gambling behavior screening items compared with NESARC estimates. Among callers who reported lifetime gambling, 9% responded affirmatively to at-least one BBGS question, suggesting that they are current at-risk gamblers (see Table 2).

Bivariate models were used to assess for differences in the profile of gamblers based on gambling status (i.e., nongambler, low risk, and at- risk gamblers; See Table 3). Although there were observable differences between the groups based on gambling status, only age was found to be significantly different between the groups. Low risk gamblers were younger than nongamblers (see Table 3).

Multivariate findings were largely consistent with bivariate models. Older people were more likely to be both low risk gamblers (OR_{adj}=1.02; p<.001) and at-risk gamblers (OR_{adj}=1.03; p<.05). For every 10 years of age increase, the odds of being a low risk gambler increased by 18% and the odds of being a high risk gambler increased by 32%. Full time employment was associated with 40% greater odds of being a low-risk gambler (versus a lifetime nongambler), but having any post-secondary (college) education was associated with lower odds of lifetime gambling (OR_{adj}=.78; p<.05); those without any college educational background had 28% higher odds of being a lifetime gambler.

Qualitative Findings

Three primary steps of any SBIRT intervention: screening, brief intervention, and referral to treatment, comprise the framework within which focus group and individual interview results are reported (Kaner et al. 2007). This framework was used as it helps to explain the standardized, universal risk screening in the context of a potential broader, future screening and brief intervention with referral program intervention is being considered by both the researchers and the credit counseling program. After the three researchers independently reviewed the data, they met to finalize emerging themes within the various framework components and a summary of results with supporting quotes are presented in the following section.

Screening

In general, counselors described the screening questions as easily incorporated into the assessment process and intake sessions. However, the screening process was challenged by several factors, including the stigma surrounding gambling and the resultant hesitancy of clients to discuss or divulge gambling related behaviors. As one counselor noted,

> A lot of them [clients] are in denial, or are so embarrassed that they just don't want people to know of their situation, and I feel like sometimes when I ask clients the four questions, I can't say I feel so confident that they're telling the truth 100%, when I hear a hesitation at times.

This sentiment was echoed by an administrator:

> If the individual is having financial problems we're' one of the resources that they would be reaching out to, but I don't' always think that people are forthright with this problem, and I know that our counselors have to do a little sleuthing to kind of put it together."

Adding to the challenge of client self-identification, interviewees noted the lack of a common definition of gambling. For example, the purchase of lottery tickets might be viewed as "entertainment" and not gambling behavior, even if the client could not afford to play the lottery according to their budget. Some counselors reported using the language of "entertainment" as an approach to destigmatizing a variety of gambling activities. Potentially due to the stigma associated with gambling as well as the lack of a common definition, problem gambling was identified at multiple points throughout the counseling session. Interviewees reported that gambling behaviors might be discovered during the process of reviewing financial documents or when a budget discrepancy was identified. One counselor described it this way:

> Well, they wouldn't' really talk about it, but going through the course of seeing what the charges are, where their charges took place, all cash advances or literally getting cash off the debit card or credit card at the casino. Or when you look at their budget, and they really should be able to pay everything, you'd' have to kind of probe to find out what's causing it.

Brief Intervention

Interviewees provided useful considerations for the design and implementation of a future brief intervention in the context of credit counseling. Counselors expressed some concerns about creating discomfort in or alienating clients by direct discussion of gambling:

> I'm' comfortable with that, it's just if they say yes, it's' the other three questions, because it's' like trying to keep them from getting defensive. You build a rapport with the client, and I feel that once we go that deep you start losing that rapport.

Others noted not always knowing how to effectively address discrepancies when reviewing financial information with clients:

> I remember one that was spending $200 a month on lottery tickets, but when I asked the question, they said no to the initial question, and I didn't feel comfortable enough to say, "Well, wait a minute, how can that be a no? You just said yes."

Interviewees also expressed concern about the time needed for ongoing screening and intervention given the range of financial issues covered during their sessions. As one counselor colorfully noted when the screening project was initially introduced, "I think my first thoughts were another damn screening."

Both counselors and administrators noted the importance of addressing the mental health component of problem gambling as it presented a potential barrier to successful financial counseling.

> They had done it again, and they're coming back to us for another payment plan on the debt, and still really not doing anything of treatment to help them with the gambling, just stopping the gambling long enough to get the credit cards or debts into a payment plan, to get financially stable but not actually doing anything to help themselves.

Further, it was important to interviewees that there was clarity regarding the scope of both financial and mental health counseling. As one administrator noted, “Our folks are trained on that stuff [finances], but they’re’ not really trained to change somebody’s gambling behavior.”

Referral to Treatment

While both counselors and administrators did not perceive problem gambling to be a widespread concern for their clients, they expressed an interest in having additional resources, as “the referrals right now for gambling, they’re sort of limited,” consisting primarily of Gamblers Anonymous. Several counselors provided ideas for additional referral resources with one counselor specifically addressing potential stigma:

> I refer people to Maryland Community Services Locator and the United Way. Both of them have websites that list all kinds of services, and I think that websites for something like that [problem gambling] are very nice for people to use, because there’s less embarrassment.

Further, several counselors noted the limited nature of follow-up and the lack of a long-term relationship with clients (that prevented reinforcement of action steps). Despite the time-limited nature of the financial counseling, one administrator suggested the potential for counselors to provide a more direct connection of clients to resources.

> Certainly, I think a follow up would be helpful. A soft hand-off…to connect them directly to the resource that can help them schedule an appointment. You know one of the key action items, one of the things a client walks away with as a result of our counseling sessions is a summary, what we call an action plan of next steps. So, it’s accountability that they are going to follow up.

Both the administrator interviews and counselor focus groups were instrumental in identifying some of the challenges of the screening process as well as the potential benefits to clients of effectively identifying problem gambling. Counselors expressed the need for strategies to talk about and define gambling behaviors that would effectively fit within the time constraints of the session. And while gambling was not identified as the most common problem experienced by callers that led to financial crisis or distress, counselors and administrators alike expressed interest in having a wider variety of resources for inclusion within action plans.

Discussion

Based on results from the present study, gambling screening is feasible in consumer credit counseling based on rates of gambling that approximate those in the general population. Feedback from credit counselors and administrators suggests that standardized screening for gambling is supported or warranted; however, both counselors and administrators note that screening efforts need to clearly operationalize gambling behavior. A brief intervention developed in this setting should be cognizant of the boundary of financial counselors' roles and their specific training. For example, counselors were not comfortable providing clinical intervention for gambling, but did express a desire to be more supportive. Administrators also supported the notion that any additional support through a potential brief intervention should be developed and designed to stay within the clear boundary of services offered by a credit counseling organization and not a behavioral health provider or organization. Furthermore, any future brief intervention should also address time constraints that financial counselors face in working with individuals in financial distress. Even very brief interventions, such as brief advice (about a 10 minute intervention), including immediate feedback about gambling as compared to the general population and education about possible alternative behavioral choices to gambling

can significantly reduce gambling behavior among people with problem gambling behavior who are not actively seeking treatment (Petry et al. 2008). While gambling is important in this setting and has significant implications on the outcomes potentially achieved by clients, the counselors are working to collect a large volume of information during intake that relate to broader financial stability and goals, in addition to other stigmatized causes of debt including but not limited to substance use, medical debt, relationship problems, and more.

The Gambling Screening Process

In the focus groups, counselors expressed concerns about stigma among clients and underreporting of gambling behaviors. Counselors tried to address this by attempting to use less stigmatizing language, including "entertainment" instead of "gambling." In training sessions on the BBGS screen, the study team emphasized the listing of gambling activities, but this may have come across to the counselors as onerous and time consuming. The effect of a euphemism to describe gambling may have decreased stigma experienced by individuals calling the credit counseling center, but it could also have affected the reliability of the screening items in that it may have created some confusion. While the importance of staying true to the questions in the screener was stressed in the initial training and during the booster sessions, there is clearly a need to balance implementation of standardized screening with questions that help to build rapport and trust among the callers. A sense of rapport building prior to asking screening questions was reported in one of the only published peer-reviewed studies of screening and brief intervention for problem gambling (Nehlin et al. 2016). This study, of primary care personnel in Sweden, conducted a few interviews with care providers who also reported an observed uptick in patients agreeing to participate in the screening and subsequent brief intervention, after a relationship was built with them that increased trust. The providers also had suggestions to the researchers to alter

the wording used in the standardized screening measure so that their patients would better understand what was being asked.

Prevalence of Gambling in Credit Counseling

Our findings suggest that gambling behavior (i.e., lifetime gambling) may be less common than it is in the general population, but among lifetime gamblers, rates of at-risk gambling are higher than national estimates (Petry et al. 2005). These differences may be the result of confounding factors such as sociodemographic or gambling related differences between the overall population and callers to the specific credit counseling organization. For instance, most individuals in the sample were from Maryland and nearby states, where there are ample opportunities for gambling at casinos, horseracing, and public lotteries. Conversely, a majority of callers were women, typically a lower risk group based on population estimates (Petry et al. 2005). Nonetheless, our first aim was to characterize the prevalence of gambling among individuals receiving financial counseling. Our pilot study suggests that at-risk gambling is prevalent and that financial counseling may be fertile ground for the development and implementation of a brief intervention for gambling.

Multivariate correlates of at-risk gambling were consistent with older age being associated with gambling participation and risk. Population based research (Petry et al. 2005) has identified higher percentages of individuals with pathological gambling (39.4%) among those aged 45-64 than the percentage of individuals in the general population (31%). Cunningham-Williams and colleagues (2005) identified younger age as being associated with decreased risk of gambling participation. Nonetheless, research in this area is mixed in that other studies have found decreasing risk of gambling participation, gambling problems, and disordered gambling among older individuals (Petry 2005). It is possible that older age and gambling in the current

sample is a function of help seeking rather than gambling. Studies of treatment seeking gamblers have consistently found that younger individuals with gambling problems are underrepresented in treatment settings (Petry 2005).

The fact that those with higher levels of education were less likely to be lifetime gamblers is also in line with other studies. A study of recreational gamblers identified trends toward increased odds of regular gambling (>2 times a week) among individuals with less than a college education (Okunna et al. 2016). Data from the NESARC study suggest that after adjusting for mental health correlates (e.g. personality disorder, depression), there is not an association between disordered gambling and education (Petry et al. 2005).

It is possible that the association between full time employment and lifetime gambling participation results from the ability of some callers to have regular income that is substantial enough to support gambling activity. In describing treatment seeking gamblers, Petry (2005) described the typical profile of the treatment seeking gambler as "middle-aged, married, and employed". It is possible that those who contact credit counseling and gamble fall into a similar profile.

Although quantitative findings are analyzed with rigor, the study is limited in its ability to compare a purposive sample of individuals seeking help for financial problems with a national probability sample. Bivariate comparisons were conducted, but our analysis did not include comparisons, controlling for sociodemographic differences in the two samples. Due to the low rates of at-risk gambling in both samples and the wide differences in sample size, multivariate analyses were not feasible. Moreover, the multivariate comparisons (i.e. Table 4) represent comparisons within a theoretical population of persons receiving credit-counseling services rather than the population of at-risk or problem gamblers or the general population of adults. In

the current study, we framed our findings within the extant literature with the knowledge that the current study sample has no direct comparison in the literature.

Conclusion

In conclusion, while rates of gambling among credit counseling clients are aligned with national averages, for clients who report gambling behavior, the self-reported problems from gambling are more prevalent. Gambling has the potential to derail even the best-laid plans for rebuilding credit and overall financial stability within credit counseling programs, in addition to the potential for serious gambling behavior to ruin lives and lead to significant behavioral health and health consequences including death (Black et al. 2015). This study supports the inclusion of gambling screening embedded in the credit counseling process as one method to identify individuals at risk or struggling with gambling and to provide a new avenue for connection to recovery resources. By helping individuals with their gambling in this setting, credit counseling has the opportunity to play a critical role in improving not only the financial future of clients and their families, but their overall quality of life.

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Table 1: Sociodemographic Characteristics of Credit Counseling Clients *N*=2,438

	n (%)	M (SD)
Female Gender	1,657(67.99)	
Age (in years)		48.61(14.95)
Race		
White	919(38.94)	
Black	1219(51.65)	
American Indian/Alaska Native	8(0.34)	
Asian/Native Hawaiian/Pacific Islander	77(3.26)	
Hispanic/Latino	137(5.81)	
Education Level		
Less than High School	31(1.27)	
High School	788(32.33)	
College	1393(57.16)	
Graduate	225(9.23)	
Marital Status		
Married or living as Married	757(31.06)	
Formerly Married	639(26.22)	
Never Married	1041(42.72)	
Employment Status		
Full Time	1481(60.77)	
Part Time	247(10.14)	
Unemployed	347(14.24)	
Retired	362(14.85)	
Financial Status		
Bankrupt	411(16.86)	
Gross Income		$47,350.39($44662.39)
Median Income		$39,354.00
Total Debt		$133,883.29($170,613.06)
Median Debt		$66,294.48
Reported Reason for financial strain		
Employment	1071(44.11)	
Other Income	466(19.19)	
Health & Medical	247(10.17)	
Family & Personal	307(12.64)	
Home & Environment	265(10.91)	
Education	72(2.97)	

Table 2: Endorsement of BBGS items and At-Risk Gambling compared with NESARC

	Credit Counseling *N*=1,904	NESARC *N*=42,038	*F*	*p*
STEM QUESTION: Have you ever gambled at least 5 times in any one year of your life?	17.1%	27.8%	135.58	<.001
Brief Biosocial Gambling Screening Questions	*n*=417	*n*=11,138		
BBGS 1: During the past 12 months, have you become restless, irritable or anxious when trying to stop or cut down on gambling?	6.3%	1.2%	1234.40	<.001
BBGS 2: During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?	6.1%	0.42%	304.26	<.001
BBGS 3: During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?	6.1%	0.11%	986.49	<.001
At-risk gambling (among lifetime gamblers)	9.0%	1.8%	117.54	<.001

Table 3: Gambling Risk by Sociodemographic Characteristics and Financial Status

	Nongambler (*n*=2019; 92.98%)	**Low Risk (*n*=376; 15.45%)**	**At-Risk (*n*=38; 1.56%)**	***p***
Age (in years)	**48.14**†	**50.4**†	**51.3**	**.001**
Male gender	627(31.05%)	137(36.44%)	15(39.47%)	.07
White Race	766(39.28%)	139(37.67%)	13(35.14%)	.75
Latino Ethnicity	121(6.21%)	15(4.07%)	1(2.70%)	.20
African American Race	995(50.03%)	199(53.93)%	22(59.46%)	..37
Asian Race	61(3.13%)	15(4.07%)	1(2.70%)	.64
Native American	7(0.36%)	1(0.27%)	0%	--
Any College Education	1358(67.26)%	232(61.70%)	25(65.79%)	.11
Never Married	867(42.94%)	154(40.96%)	18(47.37%)	.55
Formerly Married	531(26.83%)	96(25.53%)	12(31.58%)	--
Married	621(30.76%)	126(33.51%)	8(21.05%)	--
Employed Fulltime	1218(60.33%)	242(64.36%)	18(47.37%)	.07
Income	$46,913.80	$49,613.17	$49,127.05	.54
Declared Bankruptcy	343(16.98%)	57(15.16%)	9(23.68%)	.36
Total Debt	$132,624.25	$141,849.58	$124865.10	.60
Reason for debt				
Employment	889(44.08)	166(44.15)	15(42.86	.98
Other Income	391(19.39)	68(18.09)	6(17.14)	.80
Health & Medical	213(10.56)	29(7.71)	5(14.29)	.79
Family & Personal	241(11.95)	58(15.43)	6(17.14)	.12
Home & Environment	218(10.81)	44(11.70)	3(8.57)	.79
Education	61(3.02)	11(2.93)	0	.58

†sig. difference based on Tukey (HSD) Test