National Centre for Social Research

Gambling Harms and Coping with Marginalisation and Inequality

Marginalisation, Isolation and Criminalisation in Great Britain

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1. Executive summary

1.1 Overview of the research

Gambling harms are defined as the adverse impacts from gambling on the health and wellbeing of individuals, families, communities, and society. These harms impact people's resources, relationships, and health (Gambling Commission, 2020), and can be created, influenced, or exacerbated by broader societal structures and inequalities (Gordon et al., 2019; Levy et al., 2021).

This report is the collation of findings and analyses of six scoping reviews, which were conducted to synthesise and critically appraise existing evidence on gambling harms among communities in Great Britain who are subject to disproportionate marginalisation, social exclusion, and / or subject to moralisation and / or criminalisation. These reviews focused on understanding rates and drivers of gambling harms as well as barriers and facilitators to treatment and support. Our method for identifying and analysing relevant evidence drew on a rapid evidence assessment (REA) approach to enable efficient data collation, review, synthesis, and appraisal.

The six communities discussed in this report are:

- Criminalised and / or moralised communities (including people who use drugs) **(Chapter 5)**
- Migrants in vulnerable circumstances (e.g., asylum seekers) and transient communities **(Chapter 6)**
- People living with disabilities, neurodiversity and / or mental health challenges **(Chapter 7)**
- People with experience of unemployment, peripheral employment, or insecure employment **(Chapter 8)**
- People who experience or are at risk of homelessness **(Chapter 9)**
- Older people **(Chapter 10)**

1.2 Key findings

Rates of gambling harm

Overall, there was limited evidence identified about rates of gambling harm among the six communities of interest. With the exception of data routinely collected through national gambling-focused surveys (e.g., age), available evidence tended to be from small, local / discrete samples (often from outside Great Britain). While this would be expected given that the communities were often small and underrepresented in large-scale quantitative research (and are often experiencing other challenges and harms due to structural inequality which may have received more attention in previous research), it makes it challenging to conclude on rates across the communities as a whole and make comparisons with general population figures on gambling harms. Previous research has also focused on rates of 'problem gambling', 'pathological gambling' or 'gambling disorder' (with the most common measure used being PGSI (Problem Gambling Severity Index)) rather than explicitly focusing on gambling harm (e.g., harms to resources or relationships). When exploring findings based on these 'proxy' measures of harm, there was some evidence of high rates of gambling harm for some specific groups – in particular, communities of people experiencing homelessness and poverty (including those on low incomes and those living in deprived areas),[1] people with experience of migration, some people with experience of drug use, people living with certain mental health challenges and people with attention deficit hyperactivity disorder (ADHD). However, the findings from these reviews have emphasised that this type of quantitative data provides

[1] Authors used various measures of area deprivation including Indices of Multiple Deprivation (IMD) and the Carstairs index.

only one part of the picture of gambling harms for these communities. For example, nationally representative surveys have demonstrated lower rates of ‘problem gambling’ among older people yet there are unique challenges within this community which can drive engagement with gambling and gambling harms.

Drivers of gambling and gambling harm

Evidence for the six communities reviewed most commonly focused on drivers of gambling participation (reasons for communities taking part in gambling activities) rather than drivers of gambling harm (pathways to communities experiencing gambling harm such as financial, social or health harm), or did not distinguish between the two. Although the reviews identified a wide variety of drivers, there were a number of experiences which impacted people across multiple communities such as:

- **Use of gambling as a mechanism to cope with difficult emotions or experiences**, including mental health challenges, or stress related to the process of migration / acculturation, unemployment / challenges relating to job security and conditions, homelessness, discrimination, or poverty. Such challenges were often linked to the inequitable societies in which communities included in these reviews live.
- **Factors influencing the need for entertainment / social connection** (e.g., loneliness / isolation, changes to day-to-day routines / responsibilities). This includes isolation and loneliness related to experiences of migration, racial discrimination, homelessness or mental health challenges, as well as changes to day-to-day routines due to retirement or leaving prison.
- **Gambling / gambling venues being perceived as accessible and inclusive when compared to other options for social connection or entertainment / stimulation which excluded people from these communities** (due to physical mobility / health, language barriers etc.). For some people (e.g., those experiencing homelessness) these venues could also provide a safe, warm space. There was some evidence of these drivers being exacerbated by the actions of the gambling industry (e.g., marketing techniques), however this was not considered in Great Britain specifically.
- **Financial motivations**, linked to low incomes / pensions and financial responsibilities (e.g., caring for dependants in another country). However, the relationships between financial resources and gambling are complex, with (limited) evidence suggesting that lower income can both exacerbate and mitigate the risks of gambling harm.

Although experiences vary across and within the communities of interest, key underlying drivers are affecting multiple groups and leading to higher levels of gambling participation and gambling harm. Many of these factors are linked to wider societal issues including structural inequality, accessibility of public / social spaces, financial exclusion and poverty, social exclusion, discrimination, and criminalisation. This relationship also has a geographic and spatial element, with more deprived neighbourhoods in Great Britain having a higher concentration of gambling venues (Rogers et al., 2019; Bramley et al., 2020) and marginalised, isolated or criminalised communities being more likely to live in deprived areas in Great Britain due to socioeconomic disenfranchisement (for example, people who use drugs (Scottish Government, 2023), people living with mental health challenges (Marmot et al., 2010), people experiencing social exclusion (Boardman et al., 2022) and disabled people (ONS, 2023)). Stigma was also identified as contributing to experiences of gambling / gambling harm and access to support and treatment. Many people in the included communities will be experiencing compounding stigma (for example, related to drug use, homelessness, or mental health challenges all intersecting with one another in various compounding ways).

All communities considered in this review are broad and heterogenous and many findings come from small, discrete qualitative studies. These findings on drivers of gambling and gambling harm should therefore be taken as indications of the types of challenges faced, rather than an exhaustive list.

Service and healthcare provision

Overall, there was limited evidence about specific service and healthcare needs for communities experiencing marginalisation, isolation, or criminalisation. Although a small number of named programmes or services were identified that aimed to reduce gambling harm within specific groups, very little (if any) detail was given as to why and how the innovative nature of the services appeared to have led to positive outcomes for the community in question. There was also a lack of evidence about the outstanding needs of these communities in Great Britain in relation to existing provision. Many authors cited in these scoping reports highlighted the **potential benefits of integrated and joined up service delivery** as part of a public health approach to tackling gambling harm. This ranged from improving knowledge of and awareness of gambling harms in healthcare, social care services, and the charity sector, signposting or screening for gambling harm in other services or institutions (e.g., within prisons or mental health services) or **integrated services which aim to tackle often closely linked issues simultaneously** (e.g., gambling harm alongside poverty, housing insecurity, drug-related harm, or mental health challenges). Research also highlighted **barriers to accessing gambling support related to shame and stigma**, which was often exacerbated by intersecting stigmas related to wider factors (e.g., drug use, homelessness, sexuality) and fears driven by previous negative experiences accessing wider healthcare / support services.

Authors of the included studies have noted that policies and interventions related to gambling harm tend to focus on individual responsibility (such as responsible gambling tools or individual treatment plans), and often do not address the **wider and social economic factors** that are involved in gambling harm (Rogers et al., 2019). This is the case with some evidence identified in these reviews, with suggestions for service and healthcare provision tending to focus on individual treatment plans, often in clinical settings, without recognition of broader influencing factors (such as access to support or experiences of stigma and discrimination). It is also important to recognise that the communities included in these reviews are not homogenous and service and healthcare needs will not be the same within groups. Services must instead be accessible, inclusive, and adaptable to various needs. This may require services to adapt or change current provision, and subsequently may require additional resources (e.g. for staff training or expansion of current provision).

1.3 Recommendations

Overall, these reviews have shown that there is an urgent need for further research in Great Britain to explore gambling harms among communities experiencing marginalisation, isolation, or criminalisation due a lack of current evidence and a clear indication that these communities bear disproportionate burdens of harm that is not appropriately met by available services. Specific recommendations pertaining to each community can be found in Chapters 5-10 and our overarching recommendations for research in this field are set out in Chapter 11. Recommendations involve:

- **Quantitative exploration** of rates and patterns of specific harms within some communities (e.g., older people), particularly where this analysis would be enabled by existing or forthcoming nationally representative surveys (e.g., the Gambling Survey for Great Britain). In other cases, we have advised that the limitations of conducting quantitative studies (as clearly seen in existing evidence) would outweigh the likely insights gleaned and future research should focus on gathering in-depth qualitative insights.
  - Future quantitative research in this area should apply **gambling harms measurement tools** to explore the full range of potential gambling harms including financial, social, and health harm to allow more robust measurement of gambling harm and allow researchers to explore patterns related to types of harm (e.g., financial vs social harms).

- **In-depth qualitative studies** have been recommended in most cases to strengthen the evidence base surrounding drivers of harms and barriers to support within these communities (e.g., accessibility of leisure activities, loneliness and isolation, and financial harms within the context of low-income communities).
  - Highlighting limitations of existing research, we have emphasised that it is vital that future qualitative studies **explore the drivers of harm through an intersectional lens** and give explicit consideration to how social factors such as structural discrimination, stigmatisation, inequality, isolation, poverty relate to different facets of people's lived experience (e.g., age, migration status, living circumstances) and interact to drive / exacerbate gambling harm.
- **Consultations with stakeholders / those with lived experience** of gambling harm to inform the direction and shape of future research; in particular where existing evidence was extremely limited or posed questions about how future studies should be approached (e.g., the desirability of grouping particular communities).
  - More broadly, we have highlighted an urgent need to centre and meaningfully **involve people from within marginalised, isolated and criminalised communities in the design and interpretation of this research** to ensure that studies explore the right questions, are insightful, do not stigmatise or make assumptions, and benefit the communities in question. This will involve working collaboratively with trusted organisations who have existing relationships with communities.
- **Exploration and evaluation of potential / existing approaches to providing holistic and accessible support for those experiencing gambling harms** within these communities in Great Britain in the context of wider day-to-day challenges (e.g., mental health challenges, housing, drug use, unemployment, exclusion and language barriers).
  - This would involve **research with communities, gambling support services and wider healthcare / support providers** (e.g., providers of services for people experiencing homelessness) to better understand gaps in service provision and facilitators / barriers to improvement.
  - **Any new approaches should be robustly evaluated**, with sufficient focus given to *how* the intervention(s) achieve better outcomes for the communities in question.

Given the limited evidence (specifically with regard to treatment and support) these recommendations focus on the need for further research to inform policy and practice rather than direct recommendations for practitioners.

2. Glossary

This glossary focuses on terminology related to gambling and research methods which are used throughout the report. Terms which are specific to the different communities included in this review will be described in each chapter.

Term	Definition
Academic literature	Papers published in academic journals.
Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)	A screening instrument based on criteria from the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV). This is a tool created for diagnosis by clinicians of 'pathological gambling'. An adapted version of the DSM-IV has been used in survey settings to measure 'problem gambling'.
Gambling disorder	'Gambling disorder' (also referred to as 'compulsive gambling' or 'pathological gambling') is a term which has been used by medical professionals to describe harm from gambling. In the DSM-V gambling disorder is described as *'Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress'*. While still used in medical practice, these terms carry stigma and are not in line with a public health approach to gambling research. These terms are only used in the report if necessary to accurately report previous research.
Gambling harms	The preferred term within this research, 'gambling harms' refers to any adverse impacts from gambling on the health and wellbeing of individuals, families, communities, and society. This can include impacts on people's resources, relationships, and health.
Grey literature	Papers which are not published in academic journals.
Intersectionality / Intersectional approach	An approach to research which recognises that multiple forms of inequality or disadvantage can intersect or compound to create obstacles.
NODS	The National Opinion Research Centre DSM Screen for Gambling Problems (NODS) is a screening measure based on the DSM-IV which identifies 'gambling problems'.
Pathological gambling	See definition of 'gambling disorder' above.
Problem and Pathological Gambling measure (PPGM)	A measure of 'problem gambling' which is a 14-item assessment employing a 12-month timeframe.
Problem Gambling Severity Index (PGSI)	An index of 'problem gambling' which gives scores from 0-27. The measure is widely used and in the UK is used in the Health Survey for England, Scottish

	Health Survey, and the Welsh Problem Gambling Survey. A public health approach to gambling harms has moved away from this conceptualisation because definitions of 'problem gambling' stem from a mix of risk factors and outcomes and are inappropriate proxies of harm. Within the research discussed in this report, there was some discrepancy in the terminology used to capture different PGSI scores. We will use the terminology below and highlight measurements which did not align with this approach: **PGSI score of 0: Those experiencing no problems with their gambling** (*often referred to in wider literature as 'non-problem gamblers'*). **PGSI score of 1-2: Those experiencing a low level of problems with their gambling** (*often described in wider literature as being at 'low risk' of negative consequences and loss of control*). **PGSI of 3-7: Those experiencing a moderate level of problems with their gambling** (*often described in wider literature as being at 'moderate risk' of negative consequences and loss of control*). **PGSI of 8+: Those experiencing 'problem gambling'** (*defined in the PGSI as being gambling which leads to negative consequences and a possible loss of control*). **PGSI of 1+: Those experiencing any level of problems with their gambling / those experiencing gambling problems.** *In wider literature, those considered 'low-risk' and 'moderate-risk' are also labelled as being 'at-risk' of negative consequences and loss of control.* These terms are only used in the report in reference to PGSI. In each case, apostrophes are used to demonstrate that the language is being quoted from earlier research and is not the preference of the report authors or GambleAware.
Quasi-experimental design	A type of research design which aims to evaluate interventions. A comparison between groups is made but no random assignment of participants to groups occurs.
Short Gambling Harms Screen (SGHS)	A widely used screening tool for gambling harms. There are various versions including a 10, 18 and 20 item version.
South Oaks Gambling Screen (SOGS)	A measure of 'pathological gambling' developed in the 1980s which is based on DSM-III criteria. The screen is a 20-item questionnaire which may be self-administered or administered by interviewers. Scores are determined by scoring one point for each question that shows the 'at risk' response indicated and adding the total points (maximum score=20). SOGS classifies individuals into one of three categories: No Problem with Gambling (score=0), Some Problems with Gambling (score=1-4), Probable Pathological Gambler (score=5 or more).

3. Introduction

3.1 Background to the research

Gambling harms are defined as the adverse impacts from gambling on the health and wellbeing of individuals, families, communities, and society. These harms impact people's resources, relationships, and health. Harms can be experienced by people who gamble, those who are connected to them (including family, friends, and employers); as well as communities and society more broadly (Gambling Commission, 2020). Gambling harms have often been viewed as a personal issue, with research focused on individual or behavioural drivers (e.g., impulsivity) and treatment (Bramley et al., 2018; Price et al., 2021). However, the past decade has seen an increasing shift towards a public health perspective on gambling harms (Price et al., 2021), highlighting that these harms do not exist in isolation and can be created, influenced, or exacerbated by broader societal structures and inequalities (Gordon et al., 2019; Levy et al., 2021).

Six scoping reviews were conducted to synthesise and critically appraise existing evidence on gambling harms in communities in Great Britain who are often marginalised, socially excluded, or subject to moralisation and / or criminalisation. The six communities of interest are listed below, alongside some context explaining why these groups were chosen for this research. The terms 'community' and 'communities' are used throughout the report to capture people whose experiences or characteristics fall within these groupings. However, it should be noted (and will be stressed throughout the report) that these are diverse and heterogeneous groups of people with a wide range of experiences, and should therefore not be conflated or generalised. What these groups have in common however is the inequitable context in which they live in postcolonial Great Britain. This is a context in which power and privilege are both gained and maintained through the process of constructing certain communities as 'other' (Said, 1978) – be that due to race, age, disability, social class or employment. Each review will consider factors which may be specific to / more common in these communities while considering this wider context. While it is important not to broadly link stigmatised conditions or behaviours (Pliakas et al., 2022), it is also important to acknowledge that vulnerability to gambling harms for some people in these communities will be driven by compounding inequalities, stigma, exclusion, and discrimination. From the outset we recognise that any disproportionate burdens of gambling harm experienced by these communities are not because of anything inherent and immutable about these communities. Instead, as discussed throughout these reviews, these burdens are due significantly to the contexts in which these communities live.

The six communities of interest for these reviews are:

1. **Criminalised and / or moralised communities (including sex workers and people who use drugs)** – There is evidence to show that criminalised and moralised communities, such as sex workers and people who use drugs, are subject to a higher level of health inequality (Aldridge et al., 2018). Furthermore, these groups are subject to high levels of social stigma, which can prevent people from accessing health services (Lloyd, 2012; Toubiana, 2022).

2. **Migrants in vulnerable circumstances (e.g., asylum seekers) and transient communities** – These groups are more likely to experience adverse health outcomes compared to both the broader migrant and non-migrant population in the UK (Reino, 2020a; Friends, Families & Travellers, 2022; BMA, 2023). These communities are also subject to discrimination, which can affect access to health and support services (Millan and Smith, 2019; Reino, 2020b).

3. **People living with disabilities, neurodiversity and / or mental health challenges** – There is significant evidence to suggest that that people living with disabilities, neurodiversity and mental health challenges experience inequalities in health outcomes and are subject to stigma and discrimination (Public Health England, 2018; Niedzwiedz, 2019; NICE, 2021; Weir et al., 2022; Mencap, 2024). Furthermore, these communities are likely to experience inequalities pertaining to other important social determinants of health, such as socioeconomic status, education and loneliness (Emerson and Hatton, 2008; Banks et al., 2023; Quadt et al., 2023).

4. **People with experience of unemployment, peripheral employment, or insecure employment** – There is some evidence to suggest that people with experience of unemployment or insecure employment are more likely to experience physical or mental health challenges (Norström et al., 2014; Balogh et al., 2023). Unemployment has also been linked to social stigma which can lead to long-term challenges with mental health and wellbeing (Mousteri et al., 2018).

5. **People who experience or are at risk of homelessness** – People who experience homelessness are frequently subject to stigma and discrimination, which has a detrimental impact on their ability to access support services (Omeroy et al., 2019; Reilly et al., 2022). There is also evidence that some people in this community are at high risk of experiencing mental and physical health challenges, and isolation (Hertzberg and Boobis, 2015; Sanders and Brown, 2015).

6. **Older people** – Many people will experience higher health and care needs in older age, however the number of older people in the UK with unmet care needs is rising (Reeves et al., 2023). Changes in circumstances (e.g., retirement) and ageism (discrimination based on a person's age) can also result in wide-ranging inequalities, including in relation to social connection, healthcare, finances, and employment (Age UK, n.d; Luanaigh and Lawlor, 2008).

These reviews aim to take an intersectional approach,[2] recognising experiences of intersectional stigma[3] which can exacerbate negative impacts on the health and wellbeing of people from these communities (Pliakas et al., 2022, p.18). Within the communities above, there will be experiences of intersecting inequalities and stigma (e.g., relating to homelessness and drug use (Cornes et al., 2011) or unemployment and disability (Marmot et al., 2010)), which then further intersect with stigma linked to gambling. Although this report presents findings related to each of the above communities separately, the impacts of intersecting factors will be brought out throughout the findings so far as the evidence allows.

3.2 Research questions

The research aimed to address the following research questions in relation to the six communities of interest:

- What is known about rates of gambling harm among these communities?[4]
  - How do these rates compare to the general population?

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[2] The term intersectionality refers to the ways in which multiple forms of inequality or disadvantage can intersect or compound to create obstacles (Crenshaw, 1989).

[3] Intersectional stigma refers to the intersection of "multiple stigmatising forces" (including health-related stigma, stigma based on sociodemographic characteristics and / or related to behaviours or experiences such as gambling or drug use).

[4] In answering this question, we have specifically focused on *rates* of gambling harm within these communities (and, importantly, how these rates compared to the general population). In some cases, authors have cited wider literature which looks at associations between gambling / gambling harm and factors relevant to these communities (e.g., drug use as a risk factor for problem gambling) to acknowledge that such links have been made. However, this should not be interpreted as a detailed summary of the research in these areas (as this was not a primary aim of these reviews).

- What are the underlying drivers of gambling and gambling harms experienced by these communities?
  - Is there any evidence to suggest these drivers differ to drivers in the general population?
  - What role (if any) do stigma and discrimination play in gambling harms in these communities?
- What (if any) are the protective factors within these communities which reduce or prevent gambling harms?
- What (if any) barriers to accessing services and healthcare provision for gambling do these communities experience?
- To what extent have the needs of these communities been considered in existing provision and support for gambling harms?
- Are there any innovative or promising programmes or services which can support people from these communities who are at risk of gambling harms?

3.3 Use of data and terminology in the report

These reviews focused on identifying evidence about gambling harms, as described above. However, there is little available evidence on specific harms (e.g., harms to resources or relationships) within the communities of interest. Therefore, evidence about 'problem gambling', 'gambling disorder' and 'pathological gambling' (as measured by the Problem Gambling Severity Index (PGSI), the South Oaks Gambling Screen (SOGS) or clinical diagnoses using DSM criteria (Diagnostic and Statistical Manual of the American Psychiatric Association)) has been included as a proxy of harm, in the absence of other more relevant data. These approaches have been widely used in previous research and their criteria often capture elements of harm (e.g., PGSI scoring captures health and financial challenges resulting from gambling) (Close et al., 2023). In Great Britain, the most recent nationally representative survey commissioned by the Gambling Commission found that 0.2% of the general population were experiencing 'problem gambling' (Gambling Commission, 2023). While direct comparisons were rarely possible due to limitations of the data, this figure will be used in the report where appropriate to illustrate how rates of gambling harms in specific communities may compare to rates in the general population.

Throughout this report, we will discuss findings using the language in which they were reported to ensure that previous research is accurately represented and to provide context on the measurement of gambling harms and theoretical approaches. However, we acknowledge that in many contexts these terms have been used in a way which is disempowering for people experiencing gambling harm, pathologising, and can re-enforce stigma (Pliakas et al., 2022). Throughout the chapters, we will consider and appraise the language used in the included papers to discuss both gambling activity / harms and the communities of interest.

3.4 Report structure

The report is divided into the following sections:

- **Chapter 4** provides an overview of the methodology for the evidence review, including evidence identification, screening, selection and synthesis.
- **Chapters 5 to 10** report on findings from the six scoping reviews, providing an overview of the evidence identified, limitations and gaps in the evidence and recommendations for future research, service provision and policy.
- **Chapter 11** provides a conclusion and recommendations. This chapter covers key findings from across the six scoping reviews, compares the key findings and gives cross-cutting recommendations.[5]

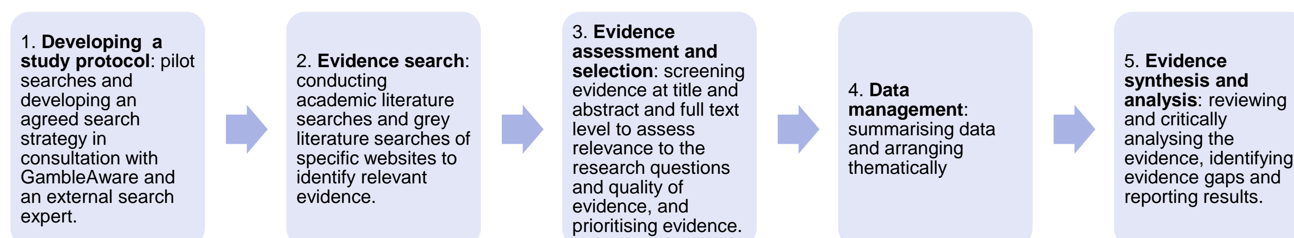
[5] Recommendations are focused on Great Britain, as GambleAware's work covers England, Scotland and Wales.

4. Methodology

4.1 Overview of the methodology

Our method for identifying and analysing relevant evidence has drawn on a rapid evidence assessment (REA) approach to enable efficient data collation, review, synthesis, and appraisal. A REA "is a tool for getting on top of the available research evidence on a policy issue, as comprehensively as possible, within the constraints of a given timetable" (GSR and EPPI Centre, 2008). REAs sit between literature reviews and systematic reviews: they aim to follow rigorous and explicit methods for searching, screening, assessing and synthesising evidence, whilst making informed compromises on aspects of the systematic review process to deliver findings quickly.

The six reviews were conducted in five stages:



4.2 Evidence identification

The study involved separate approaches for identifying evidence from academic papers and from grey literature (publications, reports or policies not published in peer reviewed journals). The search strategy was developed in consultation with GambleAware and an external search expert.

Academic literature was located by searching academic databases *Scopus*, *PsychInfo*, *PubMed* and *Sociological Abstracts*. Search strings (see Appendix 1) were developed in relation to the inclusion and exclusion criteria (set out in Appendix 2). The search strings for the review examining people living with disabilities, neurodiversity and / or mental health challenges (see Table 1 in Appendix 1) were piloted in *PubMed* on the advice of our search expert as the most relevant database for literature around mental health and psychology. All other search strings were piloted in *Scopus*, as our search expert identified this database as most relevant for the communities of interest. After the search strings were finalised, the search was run again in all databases (*Scopus*, *PubMed, PsychInfo, and Sociological Abstracts).*[6] The results from the four databases were then merged and duplicates removed.

We conducted simplified keyword searches of organisational and research websites to identify high quality, relevant grey literature (papers which are not published in academic journals) (see Appendix 3). Key terms included 'gambling' and words to represent the communities of interest (drawn from the search strings in Appendix 2). Where the website search function was limited, Google Advanced Search allowed searches on the websites using search strings.

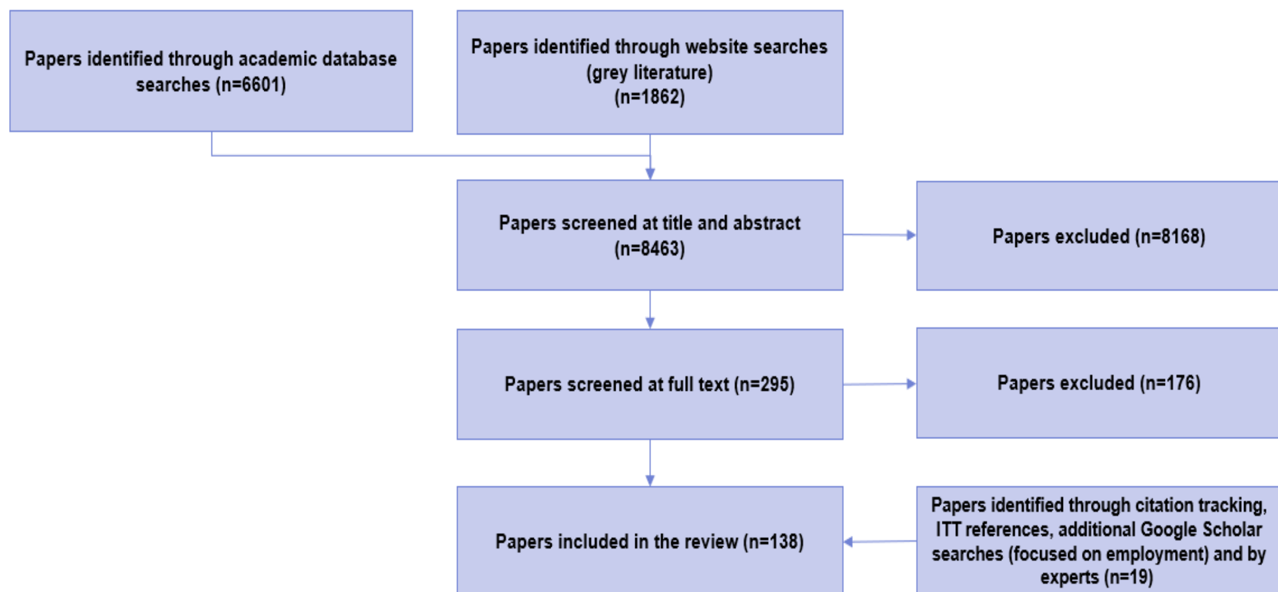
[6] The final search was conducted on 21st June 2023.

4.3 Evidence screening and selection

Evidence assessment and data management were carried out using a screening and evidence review tool called Covidence. Covidence is a web-based software that supports and manages each stage of the review process and exports findings to Excel.

Papers were screened in two stages, title, and abstract, and full text. Figure 1 below illustrates the search and screening processes undertaken, and the total number of studies included and excluded.

Figure 1. Papers included in the review (Flowchart: screening process)



- **Title and Abstract:** The titles and abstracts of all the papers were screened against the inclusion and exclusion criteria and were excluded if they did not meet the criteria. Key inclusion criteria were relevance to the research questions, papers being published in 2010 or later, and evidence being from Great Britain or comparable policy contexts (OECD countries). Papers that appeared to be relevant were included for full-text review. Grey literature papers were screened at source (i.e., on each website). Where papers did not have an abstract, researchers reviewed a suitable summary or conducted a brief review of the full text. Across academic and grey literature, and following de-duplication, 8,463 papers were screened at title and abstract level by six reviewers, and 295 papers were taken forward for full text review.
- **Full text screening:** The full text of each paper included at the title and abstract screening stage was assessed against the full text screening tool (see Appendix 4). Papers were assessed and scored by a team of seven reviewers to identify their relevance to the research questions and were excluded if they did not meet the inclusion criteria. Each paper was scored by one researcher, before being reviewed by senior researchers to ensure consistency in scoring. As part of the full text screening tool, quality of evidence was also assessed using a Weight of Evidence (WoE) tool, based on the approach first developed by the EPPI-Centre (Evidence for Policy and Practice Information and Coordinating Centre) which can be applied in the analysis of both quantitative- and qualitative-based research (Gough, 2007). Through this process, papers were scored based on factors such as clarity and accuracy, appropriateness of methods and ethical considerations. Papers with

lower WoE scores were not necessarily automatically excluded from the evidence reviews,[7] but care was taken when including them in the analysis.

Following the screening process, the papers which met our inclusion criteria were shared with subject matter experts who have expertise conducting research on gambling harms and / or with the communities of interest. Experts were asked to identify any key, relevant papers that had been missed. This process identified 11 further papers. From our finalised list of papers, we also employed backward citation tracking (i.e., from the references list) and forward citation tracking (i.e., later work that had cited these publications) which identified six further papers. The results produced a final set of 138 papers. Of these papers, 21 related to criminalised and moralised communities, 24 related to migrants in vulnerable circumstances or transient communities, 44 related to people with disabilities, neurodiversity and / or mental health challenges, 10 related to people with experience of unemployment, peripheral employment, or insecure employment, 17 related to homelessness and 38 related to older people. Some papers looked at the experiences of multiple communities of interest and were therefore included in all relevant reviews.

4.4 Narrative synthesis and critical analysis

To bring the literature together, a data extraction tool (see Appendix 5) was developed to carry out a narrative synthesis using NatCen's 'Framework Method' (Ritchie et al., 2013). This approach facilitates robust data management and analysis by case and theme within an overall matrix. The columns in the matrix represented one key sub-theme (for example, rates of gambling harms or barriers to accessing services) and the rows represented the papers. The papers were closely read, and relevant information was extracted into the corresponding cells of the extraction framework. The tool captured key findings of relevance to the research questions including rates of gambling harm among communities of interest, drivers of gambling and gambling harms, and findings related to gambling harm support services and healthcare. The tool also captured limitations of the papers including any stigmatising language used or generalisations made about communities, as well as the involvement of communities of interest in the research.

[7] Ten papers with a WoE lower than 3/5 were included in the evidence reviews.

5. Gambling harms among criminalised and moralised communities

Key findings

- While there is some quantitative research which explores relationships between 'problem gambling' (measured using the SOGS and the PGSI) and aspects of criminalisation (specifically specific types of drug use and criminal conviction), there was not sufficient data to draw any meaningful conclusions about rates of gambling harm among criminalised / moralised communities.
- Evidence suggested that there may be some relationships between gambling activity and drug use or experience of the criminal justice system, for example these factors can influence engagement with gambling as a form of entertainment or a mechanism for dealing with difficult life events. Within these studies (primarily in the context of prisons), there was some consideration of factors which could merit further exploration in the contexts of criminalisation and marginalisation (e.g., violence and reduced access to services).
- There was a lack of evidence regarding services and healthcare provision for these communities, but researchers have suggested there may be value in talking therapies (e.g., Cognitive Behavioural Therapy (CBT)[1]) focusing on interrelated harms, better service integration and improving knowledge and support options for gambling harms within the criminal justice system.
- Despite wider searches being made with support of subject matter experts, this review located no substantive evidence on gambling harms within other criminalised or moralised communities (e.g., sex workers).

5.1 Overview of evidence identified

Overall, this review included 21 papers with relevant evidence about gambling harms among people from criminalised and moralised communities. The aim of this review was to examine the experiences of these communities through the lens of criminalisation and moralisation, noting that some people within these groups are likely to experience compounding stigmas as a result of their engagement in gambling and other criminalised or moralised activities such as drug use (people who use controlled, illegal and / or illicit psychoactive drugs) or sex work (communities of people who exchange sexual services for renumeration of money or goods) (INPUD and NSWP, 2015; Pliakas et al., 2022). However, there was very little available evidence that captured these experiences. Many of the papers (15) that met our inclusion criteria focused on people with experience of drug use (predominantly focused on cocaine use) but did not consider the impacts of being criminalised or moralised. Six papers related to people convicted of an offence (including formerly imprisoned people).[8] While there is some literature which mentions the intersection between sex work and gambling (e.g., sex work within casinos) (Brents and Hausbeck, 2007; Brents and Hausbeck, 2009; Ferentzy, and Turner, 2009), there was no evidence identified which shed light on the experiences of sex workers in relation to gambling harms.

[8] Papers solely focused on communities currently in prison were excluded due to the unique circumstances of these communities, both in relation to access to gambling and support provision.

Most of the evidence identified was qualitative (eight papers), with a smaller number of quantitative studies (six papers, including surveys and analysis of existing survey data), evidence reviews (three papers), randomised / non-randomised trials (two papers), and mixed method studies (two papers). Out of the 21 papers, only three were focused on the UK. The rest of the papers were focused on evidence in the USA (five papers), Canada (five papers), Poland (two papers), Italy (one paper), Norway (one paper) and Australia (one paper). Three papers were evidence reviews which included evidence from multiple countries.

5.2 Terminology used to describe gambling harms and the communities of interest

Most papers framed gambling harms in clinical terms, focusing on measurements of 'problem gambling' using the Problem Gambling Severity Index (PGSI) or 'pathological gambling' using the South Oaks Gambling Screen (SOGS). No quantitative papers identified used specific gambling harms measurement tools.

Similarly, to the gambling terminology applied, many terms used to describe criminalised or moralised communities were individualising and in some cases stigmatising (e.g., 'prisoner', 'problematic drug use', 'addicts' or references to 'delinquent behaviour'). Use of this type of terminology can be inaccurate and damaging (Blagden et al., 2014). Some language appeared to be putting the blame on individuals for their gambling harms rather than framing harms as a public health issue and there was no critical discussion of the language used to describe people who experience gambling harms, or the terminology used to describe community members. Language used to describe people convicted of an offence should recognise that people with a criminal conviction and those in prison are part of society, not separate or separated from it (Winder et al., 2021). Those with experience of drug use should be described using 'person-first' language to maintain the integrity of individuals as human beings and avoiding equating people to their behaviours or experiences (Scottish Drugs Forum, 2020). The terms 'drug abuse' or 'drug abuser' have also been found to have a high association with stigma and discrimination. Such terms define people who use drugs solely by their consumption and designate them as 'others' – inferior or morally flawed individuals. This extends to conceptions of those in recovery as 'clean', implying that they were previously unclean or dirty (Kelly and Westerhoff, 2010; Global Commission on Drug Policy, 2017). Within the evidence there were some generalising statements about the community of people who use drugs, and their relationship with gambling / gambling harms, such as "drug addicts are consistently seeking new and alternative ways to gain the funds necessary to preserve their high or get high again" (Skylar et al., 2010, p.156). In this review, we will aim to use 'person-first' language as far as possible, except where it is necessary to use other terms to ensure that findings are accurately represented or to discuss the language used in papers.

5.3 Rates of gambling harm

This review found very limited evidence about rates of gambling harms among the communities of interest:

- **People with experience of drug use:** There is some evidence about rates of 'problem gambling' (measured using the SOGS and the PGSI) among groups of people with experience of drug use. One quantitative study with a sample of 424 participants who used cocaine in Canada reported that 10.6 % were at 'moderate-risk' (experienced moderate problems with gambling) and 7.8% experienced 'problem gambling' according to PGSI (Dufour et al., 2016). Another survey of 684 individuals in the USA undergoing residential treatment for 'substance-use disorders' found that 17.0% were classified as 'lifetime probable *pathological* gamblers', and another 4.0% were classified as 'lifetime probable problem gamblers' using the SOGS[9] (Leavens et al., 2014).

[9] Scores are determined by scoring one point for each question that shows the "at risk" response indicated and adding the total points (maximum score=20). SOGS classifies individuals into one of three categories: No Problem with Gambling (score=0), Some Problems with Gambling (score=1-4), 'Probable Pathological Gambler' (score=5 or more).

Both studies highlight that these figures are high in comparison to the general population. However, both used non-representative, discrete samples so these figures cannot be generalised to a larger population of people with experience of drug use. There was no evidence identified about rates of gambling harms among those with experience of drug use in the UK. It should be noted that wider studies have examined associations between illicit drug use and gambling / 'problem gambling', often focusing on whether one operates as a 'risk factor' for the other (e.g., Peters et al., 2015; Rogers et al., 2019; Allami et al., 2021; Girard et al., 2023). While this research does not demonstrate rates of gambling harm (and, therefore, is not detailed here), we acknowledge that wider associations have been demonstrated between 'problem gambling' and certain experiences of drug use.

- **People with experience of the criminal justice system:** There was no recent evidence on rates of gambling harms for groups with experiences of the criminal justice system in the UK, although it is estimated that over 3,000 people in UK prison have committed an offence associated with 'problem gambling' (Public Health England, 2019). Research from May-Chahal (2015, cited in The Howard League for Penal Reform, 2023) found that five percent of men in prison and three percent of women in prison linked their current sentence to gambling. There was some wider, international research which examined associations between gambling harm and criminal convictions. One recent study from Finland explored relationships between gambling and criminal convictions in the context of sociodemographic factors (e.g., gender, education, employment status, income and receipt of state benefits) in a survey of 7,186 people (including 123 with a relevant criminal conviction in the past five years)[10] (Lind et al., 2021). Gambling severity was measured using the 14-item Problem and Pathological Gambling Measure (which has three categories: 'past-year recreational gambling', 'past-year at-risk gambling' and 'past-year problem or pathological gambling') and self-reported lifetime gambling problems ('perceived lifetime gambling problems)'. This analysis initially found that 'past-year problem or pathological gambling' and 'perceived life-time gambling problems' were associated with having a conviction; however, these associations did not remain significant when accounting for sociodemographic factors. Another paper cited very high rates of 'gambling disorder' (19-33%) found in older data (1998 - 2005) about people involved in the criminal justice system in the USA (Rosen et al., 2020).

5.4 Drivers of gambling and gambling harm

Gambling and drug use as interlinked sources of entertainment or stimulation

A survey of 1,834 students attending one university in the USA found that cannabis was used by some respondents before or while gambling for multiple reasons, including to enhance their entertainment (Cronce et al., 2017). Similarly, during focus groups with young people (aged 16-19) attending a residential drug treatment service in Canada some participants highlighted ways in which gambling and drug use were interrelated in their lived experience. This included financial links (use of gambling as a way to raise money to buy drugs / gambling with drugs rather than money) and the use of gambling and drug use as interchangeable or interrelated sources of entertainment and stimulation (Sklar et al., 2010). The authors argued that these findings showed that gambling can be an "integral part of drug culture" (p.156) and highlighted prior research which posits that certain 'personality types' can be associated with both gambling and drug use. This framing conflates people as individuals and their behaviour and experiences, which can lead to stereotyping and stigma (Global Commission on Drug Policy, 2017). During interviews with clients and counsellors in a methadone maintenance treatment in the USA, counsellors also expressed the view that that the 'thrill' associated with gambling can be similar to that achieved through drug use (Wall et al., 2018). However, in addition to being small-scale, this body of research

[10] This excluded petty fines. The most common types of criminal offence among the sample were property and financial crimes.

did not give any consideration to the context in which these 'cultures' or behaviours are formed (e.g., availability of other sources of entertainment or stimulation, socio-economic drivers and stigma / marginalisation).

There was some limited consideration of these types of societal factors in studies which explored links between gambling and imprisonment. A UK mixed methods study (including assisted questionnaires, interviews, and in-depth interviews), which included 104 participants (90 people in prison, 24 prison staff, 17 family members of those in prison and ten people with lived experience of prison), found that gambling was used by some people in prisons to bring excitement in an environment with limited options for education and employment (Penal Reform Solutions, 2023). Some participants who had been formerly imprisoned described gambling as a way to "escape" from the prison environment and bring a sense of "normality" (p.34) and highlighted how gambling was an activity in prison that was often not restricted by staff provided it did not lead to "problematic" behaviour (p.47). This finding is consistent with other scoping reviews in this report; while experiences differ across and within communities, there have been examples of gambling participation as a way to cope with difficult circumstances or events, in this case related to imprisonment.

Conflict associated with gambling

In the same Penal Reform Solutions study (2023), UK prison residents described witnessing acts of violence due to non-payment of gambling debts which would not be reported to prison staff. The threat of violence extended to families, who may also be threatened or pressurised to settle gambling debts. While this issue was only discussed very briefly it would merit broader consideration across criminalised communities, who may feel they are unable to seek support from the police / public services in the event of experiencing gambling related conflict or violence.

Impact of mental health or difficult life events

There is also some evidence linking gambling / gambling harms to mental health challenges or experiences of difficult life events among groups of people with experience of drug use or imprisonment. An Australian study described within an evidence review highlighted the complexity of issues people were facing in an impoverished area in Australia, including challenges with mental health, drug-related harm, stigma, and discrimination, and suggested that gambling was used as a 'coping mechanism' for social and health needs (Holdsworth and Tiyce, 2012 and 2013 *cited in* Hahmann et al., 2021). A UK study that included a literature review and interviews with a range of stakeholders (academics, policy makers, industry, treatment providers and legal professionals) highlighted that once people are released from prison, they are more likely to live on low incomes and may be socially excluded and stigmatised and consequently may look to gambling to relieve such stressors (Wardle, 2015). A longitudinal cohort study involving a questionnaire with 424 participants who regularly used cocaine in Canada found that participants experiencing a moderate level of problems with gambling or 'problem gambling' (measured using PGSI) were more likely to gamble in response to painful life events than those experiencing no / low levels of problems with gambling (Dufour et al., 2016). This suggests that, among this sample of people who use cocaine, gambling in response to difficult life events was a driver for gambling harms.

Criminalisation

Criminalisation / conviction for an offence due to gambling is regarded as a gambling harm (Langham et al., 2015). Authors have highlighted that some groups (e.g., minority ethnic communities) are more likely to be criminalised generally – therefore, these groups may be at greater risk of being criminalised for gambling related crimes (and consequently experiencing gambling related harm) (Shankley and Williams, 2020; Ministry of Justice, 2021 *cited in* Brown et al., 2023). We include this observation to highlight that the same processes of discrimination and marginalisation which result in people becoming part of a criminalised community may also increase their risk of experiencing gambling harms through criminalisation. Given that people from minority

ethnic communities are particularly over-represented in the criminal justice system, authors suggested that a clearer understanding of how these communities may be criminalised for gambling related crimes and their experiences of the criminal justice system is needed in order to reduce this form of gambling harm (Brown et al., 2023).

Wider research / links between drug use and gambling

While there is wider research exploring links between gambling and drug use, this has taken a largely individual and biological approach which was outside the scope of this review. For example, one Canadian study explored the behaviours of 373 pairs of genetically identical and non-identical adolescent twins to explore whether gambling and drug use were a result of genetic or environmental factors (such as parent or peer behaviour) (Vitaro et al., 2019). There was also some further evidence identified about the links between drug use and gambling, arguing that people using drugs and 'problematic gamblers' shared some common underlying features, including “poor attention and concentration”, greater “impulsivity”, and reduced social anxiety (Walther et al., 2012, *cited in* Leavens et al., 2014; Lloyd et al., 2014). This framing conflates people as individuals and their behaviour and experiences, which can lead to stereotyping and stigma. Such notions align to common assumptions about people who use drugs, including the view that ‘problematic drug use’ is an individual issue solely related to personality and individual characteristics, which ignores wider societal factors (Global Commission on Drug Policy, 2017).

There was no evidence identified on protective factors for gambling harms among criminalised and moralised communities.

5.5 Service and healthcare provision

Barriers to accessing services and healthcare provision for gambling

A qualitative study with clients and counsellors in a methadone maintenance treatment clinic in the USA found that clients found it hard to discuss their experience with gambling harm with others due to feelings of guilt and shame (Wall et al., 2018). However, the discussion focused on the stigma surrounding gambling harm and did not discuss the broader context of participants also receiving support for drug use (which can carry a separate stigma).

There may also be a missed opportunity to signpost some people experiencing gambling harms to support at the point when they come into contact with professionals about criminalised activities. In a UK qualitative study, some people with experience of prison highlighted that links between gambling harm and crime were not identified when they were arrested / convicted (and therefore were not taken into consideration within the criminal justice process) (Brown, 2023). A Polish qualitative study also highlighted a lack of guidelines for healthcare and support provision for those with experience of drug use and gambling harm (Wieczorek and Dąbrowska, 2020). While this evidence comes from Poland, similar challenges may be present within the British system. GambleAware and GamCare now offer resources for healthcare professionals to support identification, understanding and support for people experiencing gambling harms.[11] However, this review found no further evidence on this topic.

UK qualitative studies have also highlighted wider barriers in the specific context of prisons, including limited relevant information about support opportunities, lack of awareness among police / staff about gambling harms /

[11] Developing a question to identify gambling harms to individuals or affected others and piloting it in three local authorities - King's College London (kcl.ac.uk) Health & Social Care Gambling Support Resources (begambleaware.org).

support services and inability to access services (e.g., support lines not working when using prison phones) (Brown, 2023; Penal Reform Solutions, 2023).

Innovative or promising programmes and approaches

There was very little evidence on innovative or promising programmes or services to support people from criminalised and moralised communities who are at risk of gambling harms. There is some evidence to suggest that Cognitive Behavioural Therapy (CBT*)* and Motivational Enhancement Therapy (MET)[12] may help to reduce gambling harms among those who use drugs (Petry et al., 2016; Yarbakhsh et al., 2023). These findings are in line with wider literature that has highlighted that CBT[13] can be an effective approach for reducing gambling harms (Petry et al., 2016). Unfortunately, papers provided little detail on how these approaches may specifically help those who use drugs, aside from detailing a brief psychoeducation intervention about gambling (including basic information about gambling, types of gambling and relationships between gambling, drug use, moods, and legal problems) (Petry et al., 2016). Similarly, Rosen et al. (2020) discuss an advice intervention provided to people on probation or parole, but it was not clear how this was targeted at the specific group. There was also discussion of clinical treatments (e.g., repetitive transcranial magnetic stimulation in a clinic in Italy)[14] which aim to reduce both gambling and drug use (Cardullo et al., 2019).

Authors also made some suggestions to improve support for some criminalised and moralised communities based on their findings (e.g., relating to barriers to support). Some papers highlighted the importance of integrated healthcare and support approaches to address gambling harm, drug and alcohol related harm, and mental health challenges in a holistic way (Skylar et al., 2010; Leavens et al., 2014; Ethier et al., 2020; Wieczorek and Dąbrowska, 2021). It was felt that this may include enhancing the knowledge-base about gambling harms and support options within drug treatment services and specifically tailoring gambling support for those using drugs (Dufour et al., 2016; Wieczorek and Dąbrowska, 2021). However, these studies took place outside the UK and so further exploration of support is needed in the UK-context to better understand this opportunity (see recommendations). Similarly, it was suggested that there is a need for increased education about, recognition of, and support for gambling harms within prisons and the wider criminal justice system (Penal Reform Solutions, 2023).

5.6 Recommendations

Given the limited evidence on gambling harms among criminalised and moralised communities, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: There is some suggestion that factors specific to criminalised and moralised communities may drive gambling and gambling harms. However, there was an overall lack of evidence exploring gambling harms in the context of criminalisation and moralisation. Available evidence focused on people with experience of drug use and the criminal justice system (specifically prisons), but drug use in particular was framed as an individual challenge and there is little consideration of stigma and discrimination or any other social factors (such as mental health, financial factors, and cultural factors) that may impact experiences of gambling harms. Furthermore, only three papers about gambling harms among criminalised and moralised communities involved data from the UK.

[12] An approach to therapy which focuses on improving an individual's motivation to change. It has most often been used for those experiencing drug or alcohol related harm.
[13] It is important to note that CBT interventions tend to focus on individuals rather than systemic change.
[14] Repetitive transcranial magnetic stimulation is a non-invasive form of brain stimulation which uses pulsing magnetic fields to activate or suppress the brain centres associated with medical or psychiatric disorders.

Recommendations:

- Given the lack of evidence, a **stakeholder consultation involving those with lived experience** should be conducted to determine next steps for this research. This should involve communities highlighted in this review (i.e., people with experience of drug use and people with broader experience of the criminal justice system). Consideration should also be given to wider criminalised and moralised communities, who may face similar challenges but have not yet been considered in research (e.g., sex workers). Researchers would need to engage and work collaboratively with third-sector and representative organisations, along with people with lived experience and service providers (e.g., within the criminal justice system) to develop a better understanding of how gambling harms are currently viewed in these communities / spaces, key areas for exploration relating to criminalisation and marginalisation and preferred / sensitive approaches for further research.
- Future research would be dependent on the outcomes of the consultation. However, we recommend **consideration of in-depth qualitative research methods** (e.g., 1-1 interviews, peer interviewing and lived experience panels) to build trust and ensure appropriate / sensitive lines of enquiry and reporting of findings. We would stress the importance of understanding taking an **intersectional and longitudinal** approach to better understanding how challenges faced within these communities (e.g., financial constraints, violence, homelessness, mental health, stigma and reduced access to public services) intersect with gambling harms.
- Research should also explore how (if at all) services which regularly interact with criminalised / moralised communities (e.g., drug treatment services, criminal justice organisations) understand gambling harms and where there may be opportunities for improving support.

6. Gambling harms among migrants in vulnerable circumstances or transient communities

Key findings

- There was evidence identified (from the UK, Australia, New Zealand and Spain) that some migrant communities experience higher levels of harm compared to non-migrant communities, despite having lower rates of gambling participation. However, there was limited consideration of migrants in vulnerable circumstances (e.g., asylum seekers or refugees) in quantitative studies.
- Experiences of migration (particularly for those in more vulnerable circumstances) can lead to stress and trauma, as well as reduced social networks and financial challenges. There was evidence that these factors can motivate gambling participation and exacerbate gambling harms. Some research considered the wider social context, for example highlighting that gambling can provide an accessible opportunity for entertainment and social connection in a context where there is a lack options which are inclusive, culturally appropriate and / or accessible for those who speak little of the local / dominant language.
- Barriers to accessing services among these communities included low awareness of support options, a lack of culturally competent services and fears about ramifications of seeking support (e.g., impacts on migration status). It was suggested that migrant groups could be better supported through services which consider the specific needs of communities (including but not restricted to language needs), through community run organisations and provision of holistic services which address wider challenges (e.g., financial / employment issues).
- There was no evidence identified about gambling and gambling harms among transient communities (e.g., Gypsy, Roma and Traveller communities).

6.1 Overview of evidence identified

Overall, this review included 24 papers with relevant evidence about gambling harms among migrants in vulnerable circumstances, including asylum seekers[15] and refugees.[16] We defined vulnerability in a broad sense and included evidence about those with increased vulnerability due to the specific situations which compelled them to leave their country of origin, the circumstances of their travel, the conditions they might face upon arrival in their country of destination, as well as considering any personal characteristics that might heighten vulnerability such as age, gender identity, race, disability, or health status. As the literature on the topic was somewhat limited, we have also included findings about wider experiences of migration / migration background (e.g., 'second-generation' migrants or people with at least one parent born outside of their country of residence) where these were relevant to vulnerability or related to issues of importance to this study (e.g., stigma,

[15] Someone who has fled their own country due to risk of human rights violations or persecution but hasn't yet been legally recognised as a refugee and is waiting to receive a decision on their asylum claim.
[16] Someone who has fled their own country due to risk of human rights violations or persecution. Refugees have a right to international protection.

marginalisation, accessibility of services). Some included papers also focused more broadly on experiences of minority ethnic groups, which included both individuals with and without a migration background. Where papers did not specifically focus on migrants in vulnerable circumstances, particular care was taken to only include information in this review that was specific to migrants and relevant to the research questions. Despite being in scope for the review, there was no evidence identified about gambling or gambling harms among transient communities (Gypsy,[17] Roma, and Traveller communities).[18]

Across the 24 papers included, specific areas of focus varied. Five papers focused on experiences of older migrants, three papers focused on younger migrants (teenagers and students), and two on experiences of migrant workers. Only one paper identified explicitly examined the experiences of asylum seekers and refugees. Apart from evidence reviews, there was a clear split between papers that focused on experiences of migration more broadly and examined the experiences of people who had migrated from various countries (eight) and papers that focused on one specific migrant community (ten). The majority of those papers looked at East and Southeast Asian communities, and one paper focused on Pacific Islanders in Australia. Most of the papers focused on rates of gambling harm and drivers of gambling (and gambling harms) rather than on healthcare and support service barriers and uptake.

There was a variety of methodologies used across the papers included, with five evidence reviews, eight qualitative papers (depth interviews and focus groups), four quantitative papers, and seven mixed-methods papers. Of the 24 included papers, five provided evidence solely from the UK. The remaining evidence was from the USA (five), as well as two each for Australia, Canada, Italy, and Germany, and one each for South Korea and New Zealand. The remaining five papers were evidence reviews and contained evidence from multiple countries.

6.2 Terminology used to describe gambling harms and the communities of interest

Most papers framed gambling harms in clinical terms and used measures of ‘problem gambling’ or ‘gambling disorder’ as a proxy measure of harm (for example using the Problem Gambling Severity Index (PGSI) or South Oaks Gambling Screen (SOGS) or diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM)). Papers therefore also used the terminology associated with the measures, such as ‘at-risk’ and ‘problem gambler’ or ‘pathological gambler’. Some papers also framed gambling harms through the lens of ‘gambling addiction’ (Kang and Shin, 2019). There was some critical discussion of the language which has been used in research to describe gambling harms. Brown et al. (2023) discussed learnings from research and lived experience input on the best terminology, identifying that some terms such as ‘problem’, ‘compulsive’, ‘pathological’, and ‘disordered’ gambling can be problematic due to the potential stigma that may be attached to them. These terms may be particularly harmful among communities who are already constructed as ‘other’ due structures of racism (Tse et al., 2004). Wider recent papers (from the UK and Australia) were also more conscious of the terminology they used and discussed ‘gambling-related harms’ (Bramley et al., 2020a; Bramley et al., 2020b), ‘gambling problems’ (Wardle et al., 2019) and ‘people who gamble’ (Cox et al., 2022). These authors discussed how research should move away from a clinical approach and the term ‘gambler’ (which puts

[17] The term ‘gypsy’ is commonly used by policymakers and researchers to refer to gypsy communities (such as English Gypsies, Welsh Gypsies, and Scottish Gypsies / Travellers) and is generally considered appropriate to use according to stakeholders from the community (Scottish Government, 2022).
[18] Gypsy, Roma and Traveller communities are a diverse group with varied experiences and choices surrounding nomadic or settled lifestyles (ONS, 2022). We have referred to these communities within our focus on ‘transient communities’ to highlight the historical nomadic lifestyles led by Gypsy, Roma and Traveller communities, and the subsequent stigma attached, but note that many in these communities will have settled lifestyles.

the onus on individual responsibility) towards looking explicitly at gambling harms as a public health issue (Wardle, 2015; Rogers et al., 2019; Brown et al., 2023).

While discussing migrant communities, papers usually defined groups of people by their country or region of origin, their legal status in their current country of residence, and wider elements of their experiences that were relevant to the study (e.g., 'undocumented migrants', 'Asian migrants', 'Laotian refugees', 'older Korean immigrants' and 'immigrant workers'). While some papers looked at specific contexts of migration (e.g., looking at migrants or refugees from a specific country and settling in a specific city), other papers looked at experiences of migration in general and did not differentiate by wider factors that are likely to shape experiences (e.g., country of origin, ethnicity, religion / culture, specific reason for migration, or by region in country of destination). However, this generally appeared to be due to methodological considerations (e.g., sample size) and all papers included in this review acknowledged this diversity within and among migrant communities and the low generalisability of their conclusions as a result.

6.3 Rates of gambling harm

There is some evidence that migrant groups are less likely to gamble than the general population, but more likely to experience gambling harms. In the UK, analysis of the Health Survey for England (2012 and 2015)[19] found that individuals who were non-White and non-British born were the least likely of all groups to have gambled in the previous year (34.5% compared to 54.4% for non-White and British-born individuals). However, this group experienced the highest rates of 'problem gambling' measured using PGSI (7.2% of individuals who gambled in the past year experienced 'problem gambling' among compared to 4.7% of non-White and British born individuals)[20] (Bramley et al., 2020b). The comparison is even more stark when comparing with White, British-born individuals, who had a 0.8% rate of 'problem gambling' among those who had gambled in the previous year, despite being the most likely group to have gambled in the past year (67.2%).[21] The authors suggested that this difference could partially be explained by the fact that participants from non-White and non-British born groups were less likely to take part in the most prevalent forms of gambling (such as the National Lottery, scratchcards and sports betting) which are associated with lower gambling related harms than other forms of gambling. A similar pattern has been found in New Zealand in the 2012 National Gambling Study (6,251 participants), where they reported that migrant communities were less likely to gamble, but among those who gambled there was a large number of 'high-intensity gamblers'[22] (Abbott et al., 2014b *cited in* Bramley et al., 2020b).

Wider studies in the USA and Germany also found higher rates of 'problem gambling' or gambling severity among some communities with experiences of migration. In a survey of 200 Lao refugees, migrants, and US-born Laotians recruited in a community assistance centre in Minneapolis (USA), the lifetime rates of 'problem gambling' (measured using SOGS) were eight to ten times higher in comparison to lifetime rates of 'problem gambling' in the general population (King et al., 2020). However, authors acknowledged that because they recruited their sample in a community assistance centre, there might have been a disproportionately high proportion of people who were already seeking help for gambling harms. Authors also did not find any differences in rates of 'problem gambling' between those with and without personal experiences of migration. Another study looking at 16-30 years old students in Germany (6,781 participants) found that 'pathological

[19] Gambling questions were asked in the 2012, 2015, and 2016 iterations of the HSE and data from the latest wasn't available at the time of writing for Bramley et al. (2020). Each year, around 8,000 adults are interviewed.
[20] This finding was statistically significant (OR 4.85 (95% CI 2.39-9.83)).
[21] This finding was statistically significant (OR 7.44 (95% CI 2.94-18.86)).
[22] 'High intensity gambling' was defined as taking part in one or more continuous gambling activities in the past week, and therefore only looked at frequency and not specific harms.

gambling' (based on DSM-5 scores) was higher in survey participants with a migration background (defined as having at least one parent born outside Germany) when compared to participants who did not have a migration background (Schulte et al., 2020).[23] However, a German survey with 106 participants both with and without migration backgrounds found no statistical differences by migration background in the rates of specific gambling harms (debt and type of gambling)[24] (Jacoby et al., 2013).

There was some evidence that time spent in the country of destination had an impact on gambling status, with recent migrants (who moved to Australia within the previous five years) having significantly lower rates of 'problem gambling' (measured using PGSI) compared to the general population in a prevalence study of 15,000 adults in Victoria, Australia (Billi et al., 2014 *cited in* Bramley et al., 2020b).

6.4 Drivers of gambling and gambling harm

Due to the unique context of migration and the inequitable and discriminatory structures in which minority communities often live, racism, discrimination, experiences of trauma, and cultural and linguistic barriers, can drive and exacerbate gambling related harms (Brown et al., 2023). These factors vary in different contexts and care should therefore be taken not to generalise experiences of gambling and gambling harms among and within migrant communities. The following section examines existing evidence on some of these drivers.

Stresses related to migration experiences

Adapting to the change in cultural context following migration (a process known as 'acculturation') has been found to be a key driver for gambling and gambling harms in earlier evidence reviews (e.g., Wardle et al., 2019; Bramley et al., 2020b). In a study of 106 people who gambled in Germany (61 with a migration background[25] and 45 without), participants were asked to indicate whether they experienced stress as a consequence of migration and to what degree they were impacted by specific stresses (e.g., emotional stress, language difficulties) on a four-point scale (Jacoby et al., 2013). Through statistical analysis, the study found that stress related to acculturation could predict the 'severity of gambling problems'[26] and 'motivation and craving to gamble'.[27] There is also wider evidence linking acculturation stresses to gambling (although not gambling *harms*). In interviews with Asian-American migrants, participants explained that gambling acted as a stress reliever and a "hopeful solution" (p.6) for poverty and low-wage jobs (Colby et al., 2022). In evidence reviews, Dickins and Thomas (2016) and Wardle et al. (2019) highlighted wider evidence showing that factors such as feeling lonely and isolated / loss of support networks, boredom, frustration, stress associated with moving can all motivate gambling. However, no further detail was provided about the studies cited. Interviews with participants who had experience of migration and gambling related crimes in the UK highlighted that these 'acculturation problems' can occur irrespective of the age at which participants arrive in the UK and the length of their stay (Brown et al., 2023).

There is also some qualitative evidence from interviews with people with lived experience of migration that gambling has been used as a 'coping strategy' by some migrants to forget the trauma and stress that occurred before and during migration (Kang and Shin, 2019; Wardle et al., 2019; Hing et al., 2015 *cited in* Bramley et al.,

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[23] This finding was statistically significant (Pearson's Chi-squared test, $p<0.05$).
[24] Type of gambling has been used as a proxy for gambling harms, as some types (such as Electronic Gambling Machines (EGM)) provide a substantially higher risk of gambling harms (Abbott et al., 2014 *cited in* Bramley et al., 2020b; Cox et al., 2022).
[25] Defined as having at least one parent born outside the country.
[26] Assessed using the 'Short Questionnaire on Gambling Behaviour' (German: Kurzfragebogen zum Glücksspielverhalten (KFG)). The KFG is a widely used German screening instrument that is based on DSM-IV criteria for pathological gambling.
[27] Motivation and craving to gamble was assessed with the Yale-Brown Obsessive-Compulsive Scale adjusted for pathological gambling. Craving is defined as a motivational state leading to (recurrent) gambling and / or relapse in gamblers. The measure is composed of 10 items that concern (1) the time occupied by gambling; (2) interference due to gambling; (3) distress due to gambling; (4) resistance against gambling; and (5) degree of control over gambling; as well as the strength of urges to gamble.

2020b; Bramley et al., 2020b; Brown et al., 2023). There was also conflicting quantitative evidence as to whether acculturation / migration stress may also have an impact on second-generation migrants, although these studies only focus on Italian teenagers (Canale et al., 2017; Donati et al, 2020). Coping in response to difficult circumstances or external events has emerged as a theme throughout these reviews, often grounded in the marginalisation or stigmatisation of certain groups. Migrants using gambling as a 'coping strategy' must be similarly understood in the context of inequitable and discriminatory structures of societies in which minority communities often live (Levy et al., 2020).

Accessible opportunities for entertainment and social connection

Those with experience of migration who took part in qualitative studies in the UK, USA and Australia highlighted that gambling could be a way to address boredom and be entertained (Luo and Ferguson, 2017; Keovisai et al., 2019; Bramley et al., 2020b; Kim and Kim, 2020; Luo, 2021; Wu et al., 2021; Colby et al., 2022; Cox et al., 2022; Luo, 2022). For example, qualitative research with Pacific Islander women living in Australia, found that bingo was a way for them to take part in a communal activity (Cox et al., 2022). A common theme emerging from qualitative studies with migrant communities in Australia, the UK and the USA was that gambling was seen as a way to make new friends or see existing friends in a context where there is a lack of inclusive or culturally appropriate venues (e.g., venues without language barriers or offered food or entertainment catering to their cultural needs) (Kang and Shin, 2019; Keovisai and Kim, 2019; Kim and Kim, 2020; Luo 2021; Wu et al., 2021; Colby et al., 2022; Cox et al., 2022; Brown et al., 2023). This theme was also highlighted in evidence reviews (e.g., Dickins and Thomas, 2016; Okuda et al., 2016; Wardle et al., 2019; Bramley et al., 2020b). Some participants identified gambling as a leisure activity with few entry barriers (e.g., requiring no language skills, no admission fees, having extended opening hours) (Okuda et al., 2016; Luo and Ferguson, 2017; Wardle et al., 2019; Bramley et al., 2020b; Luo 2021; Colby et al., 2022; Cox et al., 2022). Qualitative research involving in-depth interviews with Asian-American migrants in the Boston region (USA) found that low English skills acted as a barrier to integrating in society and enjoying typical American pastimes (e.g., watching films and going to bars, theatres, sporting events or concerts) (Colby et al., 2022). Going to a casino was therefore an activity they could do to socialise. Qualitative research with migrants and frontline workers supporting migrant communities in Australia, the UK and the USA highlighted that people with experience of migration were also more likely to work unsociable hours and the extended opening hours of gambling venues was found to accommodate shift workers and offer a safe place at night for migrants who might be living in overcrowded situations (Feldman et al., 2014 *cited in* Bramley et al., 2020b; Bramley et al., 2020b; Luo, 2021; Colby et al., 2022). It should be noted that the social motivations discussed in this section were not specifically linked to gambling *harm.*

Marketing / policy drivers

Qualitative research with migrant communities and frontline workers supporting migrants in Australia, the UK and the USA, as well as multiple evidence reviews, have suggested that gambling activities can be more accessible and available for migrants, some of whom have moved from a country where gambling is illegal or not easily accessible (Dickins and Thomas, 2016; Rogers et al., 2019; Wardle et al., 2019; Bramley et al., 2020b; Brown et al., 2023). Authors have highlighted the high prevalence of gambling venues and gambling advertising in areas of higher deprivation where migrants are more likely to live / areas with more migrant communities (Wardle et al., 2019; Bramley et al., 2020b; Brown et al., 2023). Studies have also highlighted specific targeting of migrants by gambling operators in Australia and the UK (Bramley et al., 2020b; Levy et al., 2020). Moreover, because it is possible to gamble without understanding the language of the country of destination, stakeholders supporting migrants in London and Leeds raised concerns that migrants might be more likely to experience gambling harm by not understanding the risks involved as well as the terms and conditions (Bramley et al., 2020a; Bramley et al., 2020b).

Financial factors

Qualitative studies with people with experience of migration and stakeholders working with migrants in Australia, the UK and the USA highlighted financial motivations for gambling. Some participants viewed gambling as an easy way, or the only way if they were undocumented and unable to work, to make money and support their family (either in the country of destination or by sending remittances back home) (Keovisai and Kim, 2019; Sobrun-Maharaj et al., 2013 *cited in* Bramley et al., 2020b; Bramley et al., 2020b; King et al., 2020; Levy et al., 2020; Colby et al., 2022; Cox et al., 2022; Brown et al., 2023). As explained below, financial circumstances may also exacerbate gambling harm for some people in migrant communities:

- There is evidence that some migrants are more likely to have **limited financial resources** and more likely to live in poverty compared to the general population,[28] which can exacerbate financial and psychological harms. (Wardle, 2015; Kim and Kim, 2020; Colby et al., 2022). For example, qualitative interviews with Asian-Americans highlighted that some participants were using money to gamble rather than pay for food and identified that "the stress, depression, and desperation associated with struggling to make a living led to a vicious cycle of gambling and worsening financial distress" (Colby et al., 2022, p.9).
- Focus groups with migrants in the UK highlighted that **informal support and financial networks** among family and friends can influence the impact of financial losses (Bramley et al., 2020b). In some cases, migrants discussed not having a support network in the UK to help mitigate losses. Other participants highlighted that gambling losses could prevent them from financially supporting others (including in their home country), especially if they were already experiencing financial difficulties. Therefore, financial harms could be extended to the family or wider community.

Cultural / attitudinal factors

While these factors were not specific to the experience of migration, there was some evidence that cultural acceptance of gambling, as well as exposure during childhood, may help shape some experiences of gambling within migrant communities (Luo and Ferguson, 2017; Kim and Kim, 2020; Luo, 2021; Wu et al., 2021; Luo, 2022; Brown et al., 2023). On the contrary, a study of people (both with and without family experience of migration) who gambled in Germany found that while peer and family pressure had a significant impact on 'problem gambling', acceptance of gambling within someone's culture did not (Jacoby et al., 2013). In cultures where gambling was forbidden, stigma and shame could act as barriers to discussing gambling participation or seeking help and result in further gambling harms, although this was raised in the context of minority rather than migrant communities (Dickins and Thomas, 2016; Mazbouh-Moussa and Ohtsuka, 2017; Bramley et al., 2020b).

6.5 Protective factors

There was some evidence that religion and culture, socio-economic status, and social environment all have the potential to protect against gambling harms among some migrant communities.

- **Religion and culture**: In an analysis of 106 people who gambled in Germany, Jacoby et al. (2013) found that religious faith in general had a protective effect on 'gambling severity', and that people with experience of migration were significantly more likely to be religious than German-born participants. However, they also highlighted that religiosity might not outweigh the effects of acculturative stress, the availability of gambling, and the influence of social environments (Jacoby et al., 2013). While the protective effects of religion and

[28] Although authors did not explore this further, this is likely due to multiple likely intersecting factors, including migration status and discrimination preventing people from working or forcing them into lower paid roles, qualifications not being recognised, and language barriers restricting both access to employment and advice and guidance (Pemberton et al., 2014).

culture are not specifically linked to experiences of migration, they may provide context for why experiences may differ between those with and without a migration background.

- **Financial resources:** As highlighted above, limited financial resources can increase vulnerability to gambling harms for some people from migrant communities (Wardle, 2015; Kim and Kim, 2020; Colby et al., 2022). Focus groups with stakeholders working with migrants in London and Leeds reported examples of East European migrants seeing improved financial circumstances after / as a result of moving to the UK – it was felt that these changes increased their wider leisure opportunities (such as holidays) and led to a reduction in gambling participation (Bramley et al., 2020a; Bramley et al., 2020b). Conversely, multiple studies cited in an evidence review by Luo and Ferguson (2017) mentioned that financial restrictions could act as a protective factor against gambling and migrant communities are more likely to have constrained financial circumstances. However, the evidence behind this statement was not clear.
- **Social connections / networks:** As social isolation following migration is perceived as a driver of gambling harm, it follows that social capital (such as social connection, support) can act as a protection against gambling harms. Qualitative research involving interviews with Pacific Islander women living in Australia found that community support allowed women to cover financial losses related to bingo and prevented financial harms without the support of external institutions.

6.6 Service and healthcare provision

As already highlighted, this chapter brings together evidence from a variety of countries and migrant groups who all have unique experiences and characteristics related to their personal circumstances. Despite the uniqueness of each migrant's experiences and needs, this review has identified multiple barriers to accessing services, as well as best-practices, that are relevant to the multiplicity of their experiences, such as the presence or absence of culturally relevant and sensitive resources, addressing the range of needs that migrants can experience, and migrants' concerns about the ramifications of seeking support (such as fear of deportation).

Barriers to accessing service and healthcare provision for gambling

Barriers to accessing services and health provision primarily related to accessibility and availability of culturally appropriate services. Specifically:

- **Awareness of support options:** Qualitative research with migrant communities and stakeholders supporting migrants in Australia and the UK identified that people with experience of migration are often unaware of support available for gambling harms, as well as how to access support, and if there are any costs associated (Wardle et al., 2019; Hum et al., 2018 *cited in* Bramley et al., 2020b; Bramley et al., 2020b; Brown et al., 2023). Moreover, evidence reviews indicated that migrants may be unaware of what gambling counselling and support might look like in their country of destination, and therefore might be reluctant to engage in case support does not meet their expectations (Mazbouh-Moussa and Ohtsuka, 2017; Wardle et al., 2019; Kim and Kim, 2012 *cited in* Bramley et al., 2020b; Bramley et al., 2020b). There was also qualitative evidence from English-speaking countries (including the UK) that some migrants might prefer to seek help from family members or friends instead of more formal services due to personal and cultural attitudes towards seeking professional help (Mazbouh-Moussa and Ohtsuka, 2017; Hing et al., 2015 *cited in* Bramley et al., 2020b; Bramley et al., 2020b; Cox et al., 2022).
- **Lack of accessible and culturally appropriate services and resources**: Stakeholders working with migrants in the UK who took part in focus groups, as well as some authors in the US, observed that the websites and services are often only available in English, making it difficult for migrants who might have limited English skills to access information and access those services (Bramley et al., 2020a/b; King et al., 2020; Okuda et al., 2020). Participants from minority ethnic backgrounds in the UK, who had been affected by gambling harms and crime, discussed in interviews how a lack of diversity in support services was also a

barrier to accessing treatment (Brown et al., 2023). Participants described how gambling harms services they had accessed in the UK did not work for them, as they felt 'different', which led them to not pursue treatment past one or two sessions. Conversely, having someone from their community or who they could relate to had the potential to increase their confidence to talk openly and express their feelings. Racism and discrimination were also felt to be key barriers to accessing support for gambling harms. Okuda et al. (2016) reported that racial and ethnic minority groups were more likely to have prior experience of discrimination by mental health providers, which might cause distrust in formalised mental health (and gambling) treatment. Mazbouh-Moussa and Ohtsuka (2017) also discussed how racism and anti-Arab sentiment in Australia following the 9 / 11 attacks (and prior) impacted the Australian Arab community's motivation to attend face-to-face counselling. Although this finding was not specific to gambling support, it was felt that similar challenges were likely to have impacted engagement with these services. Asian-American migrants who took part in in-depth interviews about gambling harms within the Boston region (USA) reported that they would prefer to receive help and services from organisations within their community that they already trusted and who could better understand their lived experience and culture (Colby et al., 2022).

- **Lack of consideration of migrant communities when planning services.** Furthermore, there is a lack of disaggregated data on different migrant communities and treating migrant communities as a homogeneous group in both research and practice can lead to assumptions being made on what the best services are, without involvement of the communities (Colby et al., 2022; Luo, 2022; Brown et al., 2023). Moreover, there is some qualitative evidence from interviews with migrants and stakeholders that the lack of existing data on migrants' gambling can result in migrant communities being left out of gambling policies and services, which therefore can lead them to feel that their perspectives are not listened to, and their needs overlooked (Cox et al., 2022; Brown et al., 2023). This could also be seen by using a vocabulary that did not reach migrant communities (for instance the use of the acronym 'BAME' (Black, Asian and Minority Ethnic) or talking of gambling instead of gaming (Tse et al., 2014; Keovisai and Kim, 2019; Brown et al., 2023).
- **Concerns about the ramifications of seeking support:** Migrants with experience of gambling harms and stakeholders working with 'vulnerable' migrants[29] have reported that some migrants in the UK with irregular migration status[30] fear that seeking help for gambling harms could impact their migration status (e.g., attendance being recorded and shared with other services and agencies, potentially leading to deportation) (Bramley et al., 2020a/b; Brown et al., 2023). Although not discussed by authors, there is a wealth of evidence linking irregular migration status to fear of detention, violence, or loss of employment (Brabant and Raynault, 2012) which may also impact help seeking related to gambling harms. Qualitative research with some migrant groups in Australia, the UK and the USA highlighted that fears of shame and stigma could also prevent people within these communities from seeking support (e.g., King et al., 2020; Cox et al., 2022; Brown et al., 2023). While this could be linked to cultural attitudes around gambling / seeking support (Dickins and Thomas, 2016; Mazbouh-Moussa and Ohtsuka, 2017; Hing et al., 2015 *cited in* Bramley et al., 2020b) which may be more common among some communities, these findings did not directly relate to experiences of migration.

Innovative or promising programmes and approaches

Authors have argued that services for gambling harms targeting migrant communities should be culturally competent. Authors have emphasised that cultural competency extends beyond just the translation of information and involves ensuring that information provided is accessible and available, and there is an understanding of cultural beliefs associated with gambling through the involvement of migrant communities in

[29]Migrants considered to be vulnerable to gambling harms due to the circumstances of their arrival in the UK and their low understanding of English (in Leeds and London).
[30] Irregular migration status includes migrants who lack legal status in their country of destination due to unauthorised entry in their country of destination, breach of a condition of entry, or because their visa has expired (IOM, 2011).

the development of programmes and services (Mazbouh-Moussa and Ohtsuka, 2017; Wardle et al., 2019; Fogarty et al., 2017 *cited in* Bramley et al., 2020b; Bramley et al., 2020b). There was limited evidence on culturally competent services co-developed with communities, and no evidence on their success to reach migrant communities (Dickins and Thomas, 2016; Mazbouh-Moussa and Ohtsuka, 2017).

Mazbouh-Moussa and Ohtsuka (2017) reported on campaigns developed with migrant communities by the Arab Council Australia that included information videos with an Arab GP and an Arab counsellor providing their thoughts on gambling within the 'Arabic culture', in Arabic with English subtitles, as well as culturally sensitive materials to educate and raise awareness of gambling harm. The objective was to gain the community's trust and support help-seeking behaviour. Qualitative studies have found some preference among migrant communities for engaging with community organisations or representatives that they trust, emphasising the importance of partnerships between community organisations and gambling services (Tse et al., 2014; Keovisai and Kim, 2019; Bramley et al., 2020b; King et al., 2020; Colby et al., 2022). Moreover, some authors suggested that involving wider family or community in treatment plans, which is rarely offered in Western services, might also have a positive outcome on access to services for migrants who may view harms and treatment as a more collective issue (Dickins and Thomas, 2016; Mazbouh-Moussa and Ohtsuka, 2017).

There was a lack of evidence identified about innovative or promising programmes which have aimed to support migrants experiencing gambling harm to reduce harm. The review identified one programme of work in New Zealand where the Asian Services division of the Problem Gambling Foundation of New Zealand launched a campaign promoting healthy entertainment and lifestyle choices among Chinese and South Korean migrants to encourage open discussion about gambling harms and raise awareness and knowledge of harms and existing services. The programme aimed to strengthen community action and develop personal skills through a variety of activities. Participants who took part in the activities reported increased general knowledge about gambling harms, the opportunity to discuss gambling and gambling harms with their friends and family, an increased awareness of culturally and linguistically responsive services and increased willingness to seek support from them if required in the future (Tse et al., 2014). Additionally, there was limited evidence that accessible and shorter treatment programmes or programmes that could be accessed remotely (i.e., online or through books), such as Cognitive Behavioural Therapy (CBT), were preferred by some people from migrant communities as it allowed them to maintain anonymity, which was an important concern where there was stigma and shame surrounding gambling and access to gambling services (Richard et al., 2017 *cited in* Bramley et al., 2020b; Schulte et al., 2020; Luo, 2022; Brown et al., 2023).

A cross-cutting issue also identified in the evidence was the importance of a public health approach that specifically targeted the root causes of gambling harm within migrant communities (e.g., racism, poverty, loneliness, boredom, isolation due to linguistic and cultural barriers, and stress due to acculturation) (Mazbouh-Moussa and Ohtsuka, 2017; Kang and Shin, 2019; Rogers et al., 2019; Kim and Kim, 2020; Colby et al., 2022; Luo, 2022; Brown et al., 2023). For instance, in-depth interviews with social workers providing services to older migrants who gamble in Canada, received positive feedback on a collaboration with a community centre to run a 'culturally sensitive' senior's theatre programme to raise awareness about gambling harm (Luo, 2022). Authors have also suggested addressing challenges related to stress, past trauma, and mental health challenges (including PTSD) as part of a holistic approach to gambling treatment (Mazbouh-Moussa and Ohtsuka, 2017; Kang and Shin, 2019).

6.7 Recommendations

Given the limited evidence on gambling harms among migrants in vulnerable circumstances and the absence of evidence on transient communities, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: There is some evidence, from the UK, Australia, New Zealand and Spain, that migrant communities experience higher levels of harm compared to non-migrant communities, despite having lower rates of gambling participation. There are also a number of studies which highlight drivers of gambling / gambling harms and barriers to support which are specific to, or particularly pertinent for, some migrant communities. However, there was little evidence exploring the specific experiences of migrants in vulnerable circumstances (such as refugees and asylum seekers as well as people with irregular migration status). Many of the drivers of gambling / gambling harms and barriers to support cited in this chapter (e.g., stresses relating to acculturation, accessibility of services, financial constraints) are likely to be particularly applicable for these groups.
Recommendations: • Further qualitative research (e.g., in-depth interviews and focus groups) should be undertaken which focuses on the experiences of these groups, including drivers of specific harms as well as wider motivations for gambling and views about available support. • Due to the stigmatisation and fears / uncertainties experienced by these groups, a co-production approach (involving people with lived experience and organisations already working with those communities) would be vital to facilitate the research, ensure accessibility / inclusivity and guide data collection and reporting of findings. • This research would also need to consider the diversity of experiences within these communities and take an intersectional approach, recognising the role of factors such as gender, ethnicity / culture, immigration status and length of stay in Great Britain.
Limitation of current research / justification: There was some evidence about the roles that policy / law, the healthcare system and regulation / actions of the gambling industry can play in the experiences of migrants specifically. However, much of the research cited took place outside the UK.
Recommendations: • Future research needs to consider the context in Great Britain specifically, including specific policy and societal drivers, the impacts of marketing / the gambling industry and accessibility of services.
Limitation of current research / justification: There is some evidence that current gambling service provision in Great Britain does not meet the needs of some migrant groups in terms of accessibility, treatment efficacy, and satisfaction of 'culturally competent' services. Qualitative studies have shown that some people from migrant communities refrain from seeking support due to fears about ramifications (e.g., impacts on migration status). Although some participants with lived experience have highlighted the need for specific changes (e.g., diversity among support staff), there was an overall lack of evidence on innovative or promising programmes to support these groups.
Recommendations: • More research is needed to understand how best to overcome these barriers and develop accessible and 'culturally competent' support services, with the involvement of migrant communities and organisations

already working to support these communities. These approaches should be evaluated and lessons learned communicated within the sector.

Limitation of current research / justification: This review found no evidence on gambling harms among transient communities (Gypsy, Roma and Traveller communities) in Great Britain. However, many of the challenges highlighted in this chapter (and elsewhere in the review), including impacts of marginalisation, financial resources, employment factors and accessibility of support services may apply to these groups.

Recommendations:

- A qualitative scoping study or consultation with organisations / groups embedded within these communities would help establish next steps for sensitively exploring experiences of gambling harms.

7. Gambling harms among people with disabilities, neurodiversity and / or mental health challenges

Key findings

- The review found evidence that rates of ‘problem gambling’ (measured using PGSI) or similar clinically-framed measures of gambling harm may be high among some groups of people with *specific* conditions, when compared to rates in the general population. Most evidence identified was from small, localised samples so can only be interpreted as an indication of potentially higher rates of gambling harm. The communities included in this review are broad and heterogeneous and these findings should not be generalised to this group as a whole.
- There was some evidence identified about drivers of gambling and gambling harm, although studies identified took a largely clinical view of gambling harm and focused on symptoms or psychological factors related to disability, neurodiversity or mental health which may make individuals with particular conditions more likely to gamble or experience harm. There was some evidence that gambling may provide a means of social connection or feeling included for discrete groups of people with disabilities or health conditions experiencing isolation or marginalisation. However, these factors were not linked specifically to gambling *harm* and there was little wider consideration of how societal barriers may impact people with health conditions or disabilities (e.g., attitudes to difference and ableism).
- The review found very limited evidence about barriers to support and innovative or promising programmes / services for these communities. Existing research has focused on the need for more integrated care approaches, particularly for people experiencing mental health challenges and gambling harm. However, no UK evidence was identified on this topic and international literature provided little detail on the rationale and benefits of different approaches.

7.1 Overview of evidence identified

Overall, this review included 44 papers with relevant evidence about gambling harms among people living with disabilities, neurodiversity or mental health challenges. We included evidence related to a broad range of conditions. Neurological conditions such as Parkinson’s disease and epilepsy were excluded from the review after pilot searches in PubMed identified a significant amount of literature exploring specific pathways between gambling, cognitive functioning associated with neurological conditions and medication commonly used in the treatment of Parkinson’s disease[31] (e.g., Cavanna et al., 2008; Djamshidian et al., 2011; Santangelo et al., 2013; Molina et al., 2000). While this is an important field of research, the clinical focus of these topics was not aligned

[31] Rates of ‘pathological gambling’ are higher in treated Parkinson’s disease patients compared to the general population. Amongst other factors, this has been linked to treatment with dopamine agonists and levodopa (l-dopa); neurofunctional studies suggest these medications might induce impulsive behaviour which subsequently contributes to ‘pathological gambling’ (Santangelo et al., 2023).

with the research aims and could not have been meaningfully summarised within the scope of this review. However, it is important to acknowledge that there are established links between gambling and certain neurological conditions, which should be considered when commissioning further research (see section 5.7).

Most included papers focused on a specific condition, particularly attention deficit hyperactivity disorder (ADHD), learning disabilities and post-traumatic stress disorder (PTSD). 15 papers related to mental health in general, five to PTSD, five to depression, three to schizophrenia, one to bipolar disorder, one to self-harm, six to ADHD, one to autism, six to people with learning disabilities and three to disability in general. The majority of evidence identified was quantitative (25 papers), with a smaller number of qualitative studies (nine papers), evidence reviews (six papers) and mixed methods studies (four papers). Of the 44 papers included, only eight focused solely on the UK. The remaining evidence focused on countries in the EU (11 papers), the USA (eight papers), Canada (seven papers) and Australia (five papers). Five papers were evidence reviews which included evidence from multiple countries.

7.2 Terminology used to describe gambling harms and the community of interest

Most papers framed gambling harms in clinical terms, focusing on measurements of 'problem gambling' using the Problem Gambling Severity Index (PGSI), 'pathological gambling' using the South Oaks Gambling Screen (SOGS) or clinical diagnosis of 'gambling disorder'. Some more recent papers referred to gambling harms (e.g., financial harm or social harm), but this approach was limited. No quantitative papers identified used specific gambling harms measurement tools, and instead used tools such as PGSI which measure 'problem gambling' status. Papers tended to use 'person-first language' to describe the communities of interest, for example 'people with ADHD', 'individuals with schizophrenia' or 'people with learning disabilities'. However, papers discussing people with mental health challenges often used clinical language and discussed the 'co-morbidity' of 'gambling disorder' with mental health conditions (e.g., Fotang et al., 2020). Most papers provided no critical discussion of the language used to describe gambling harm or their communities of interest, with many citing DSM[32] definitions with no further discussion. 'Co-morbidity' is a medical term describing the experience of having more than one disease or condition at the same time. There is a case for avoiding overly medical terminology to avoid pathologising and medicalising those experiencing gambling harms as well as those who are part of other stigmatised communities – notably those living with disabilities, those using drugs, and so forth, all of whom can be pathologised as living with 'morbidities' – and to ensure that research aligns with a public health approach to harm reduction. However, we recognise that in some cases such language is necessary to recognise clinical diagnosis. In these cases, researchers should use 'person-first' terminology (e.g., 'person diagnosed with a gambling disorder') (GambleAware, 2022).

Some papers were appropriately nuanced in their framing and acknowledged a range of experiences within these communities and did not make broader generalisations, but there were examples of the homogenisation of diverse groups (e.g., grouping and generalising people with different learning disabilities). This was particularly problematic when papers discussed factors which could promote stereotypes about people with disabilities, mental health conditions or neurodiversity (e.g., around vulnerability or reduced capacity).

7.3 Rates of gambling harm

There was some evidence about rates of 'problem gambling' (measured using PGSI) among groups of people with disabilities, mental health challenges and / or neurodiversity. The PGSI is intended to capture 'problem gambling' rather than harm. However, the measure is widely used and many of the items capture harm (Murray-Boyle et al., 2021) so PGSI data has been included as proxy of harm in the absence of other more relevant data.

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[32] DSM stands for The Diagnostic and Statistical Manual of Mental Disorders. This is a publication by the American Psychiatric Association which outlines the classification of mental disorders using standard criteria.

Papers included in this review tended to find that rates of 'problem gambling' among groups of people with disabilities, neurodiversity or mental health challenges were higher than in broader populations. Key recent findings were:

- In **the UK**, the latest national rate of 'problem gambling' using PGSI is 0.2% (Gambling Commission, 2023). A UK survey of 435 patients drawn from the Bipolar Disorder Research Network found that among people with **bipolar disorder**, 2.7% experienced 'problem gambling' according to the PGSI (Jones et al., 2015).
- In a cross-sectional survey of 2,185 **UK** veterans (who are known to have higher rates of **PTSD** than the general population) and those in the general population, veterans were found to be over six times more likely to be experiencing 'problem gambling' (measured using PGSI) than participants without experience of military service (43.1% compared to 6.5%).[33] Those experiencing PTSD and complex PTSD (C-PTSD) were at increased risk of experiencing 'problem gambling' (Dighton et al., 2022). However, in a small questionnaire study of 150 adults in **Canada**, there was no relationship found between individuals with lifetime **PTSD** and 'gambling disorder' severity (Ledgerwood and Molsevic, 2015).
- There was also a higher rate of gambling harm found among those attending mental health services due to **'psychotic disorders'** in two states in **Australia**. Analysis of survey data of 435 adults found that 5.8% of individuals diagnosed as having these conditions were experiencing 'problem gambling' and 6.4% were 'moderate-risk gamblers' (experienced a moderate level of problems with their gambling, measured using PGSI) (Haydock et al., 2015). The authors argued this is much higher than rates among general populations in western countries where usually 0.5-2% of the population are experiencing 'problem gambling'.
- In a survey of 4,888 **Swedish** students, students with **hearing loss** were significantly more likely than students without hearing loss to be identified as 'problem gamblers' using the Lie / Bet questionnaire (7.1% compared to 4.3%)[34] (Geidne et al., 2016). However, hearing loss was not a significant predictor for 'problem gambling' when adjusting for other predictors such as age, gender, and socio-economic factors such as living situation.
- Among a sample of 6,095 **people receiving treatment for mental health challenges** in **Sweden**, 1.83% were experiencing some level of problems with their gambling ('at risk' or 'problem gambling', measured using PGSI), which the authors stated was high in comparison with national figures (1.3%), particularly when considering that the numbers of people engaged in gambling were much lower (Forsström et al., 2022).
- In **Canada**, higher rates of experiences of 'disordered gambling' have been found among **those receiving disability benefits** compared to the general population in a study of 769 participants (Cortina et al., 2015). Among those receiving disability benefits, 15.3% met the study's criteria for 'disordered gambling',[35] which was significantly higher than rates reported in the general population (3.8%).

Papers also referenced much older national surveys which identified higher rates of 'problem gambling' among groups of people with 'affective disorders' (e.g., depression, anxiety and bipolar disorder) (Cowlishaw et al., 2016; data from the 2001 US National Epidemiologic Survey on Alcohol and Related Conditions) and with ADHD (Jacob et al., 2018; data from the 2007 Adult Psychiatric Morbidity Survey).

Altogether, these figures should be interpreted with caution given that findings have generally been produced on the basis of small, localised samples (e.g., members of a bipolar disorder research network, or patients in a specific clinic) and used varied measurement approaches. This makes it challenging to compare the findings with statistics presenting rates of 'problem gambling' in the general population, which take into account factors

[33] This finding was statistically significant (Pearson's Chi-squared test, $p<0.01$).
[34] This finding was statistically significant (Pearson's Chi-squared test, $p<0.05$).
[35] The study defined 'disordered gambling' as a score of 4 or more on the Canadian Problem Gambling Index (CPGI).

such as age, gender and region and to try and ensure that figures are nationally representative. While the above findings give indications of potentially higher rates of gambling harm among people with certain conditions, it should not be assumed that the figures are representative of the population experiencing those conditions. There could be a number of factors (e.g., demographics and severity / type of health challenges) which have not been taken into account and may influence experiences of gambling harms.

This review aimed to assess what is known about rates of gambling harm among people with disabilities, mental health challenges and / or neurodiversity to allow comparisons to rates of gambling harm among the general population. However, it should be noted that there is also further research reporting on the prevalence of certain conditions among those seeking support or treatment related to gambling harm, for example ADHD (Karaca et al., 2017 *cited in* Cairncross et al., 2019; Brunault et al., 2020) as well as autism, depression, affective disorder and anxiety (Lee et al., 2011; Rogers et al., 2019; Wullinger et al., 2023).

7.4 Drivers of gambling and gambling harms

Mental health and cognitive functioning

Evidence identified in the review took a largely clinical view of gambling harm, focusing on symptoms or psychological factors related to disability, neurodiversity or mental health which may make individuals more likely to gamble or experience harm from gambling.

There was a significant focus on gambling as a ‘coping mechanism’ or ‘escape’ from negative emotions or experiences for those experiencing mental health challenges (O’Brien, 2011; Haydock et al., 2015; Wardle, 2015; Jauregui et al., 2016; Edgerton et al., 2018; Grubbs et al., 2018, Keough et al., 2018; Grubbs and Chapman, 2019; Wullinger et al., 2023). Some professionals working in the field of mental health have also highlighted that this ‘coping mechanism’ may be used more when there are wider societal factors which worsen mental health (e.g., cuts to healthcare services and the cost-of-living crisis) (Wardle, 2015). This review identified one quantitative study which supported this association. A questionnaire study of 332 USA veterans seeking treatment for ‘gambling disorder’ found that those with PTSD were more likely to be gambling in response to negative emotions compared to those without[36] (Grubbs et al., 2018, Grubbs and Chapman, 2019).[37] While the association between mental health and gambling was posited by authors in wider studies, researchers have also highlighted that the fluctuating nature of some mental health conditions (e.g., depression) can present challenges for quantitatively exploring this relationship (Edgerton et al., 2018). Evidence reviews have also highlighted a lack of clarity around the sequencing of gambling and mental health challenges (Yakovenko and Hodgins, 2018, Rogers et al., 2019) while healthcare professionals have stressed that the specific relationship between mental health and gambling harms (including the sequencing of these experiences) will be unique for each individual (Holdsworth et al., 2012b, Wardle, 2015). This review found no further evidence (and, crucially, no qualitative research with people with lived experience) which would enable a fuller exploration of this relationship.

Another area of focus revolved around how certain disabilities or health conditions can influence decision-making around gambling, thereby impacting the likelihood of gambling harms. For example, qualitative studies involving professionals working with people with learning disabilities and wider healthcare professionals identified a view that certain (unspecified) conditions may impact understandings of the risks associated with gambling (Wardle, 2015; Bramley et al., 2019a, Scheidemantel et al., 2019; see also Taylor et al., 2015). A

[36] This finding was statistically significant (Holm’s method, $p<0.005$).
[37] This study also found wider associations with PTSD and gambling in response to negative associations in a bigger cross-sectional sample of USA adults (743 participants), although these were primarily people gambling ‘recreationally’ rather than those experiencing harm.

survey of 287 men who regularly gambled in France also found that measures of "impulsivity"[38] were associated with 'problem gambling' amongst men with ADHD compared to men without ADHD (Brunault et al., 2020; see also Szerman et al., 2020), while a study of 98 people being treated for 'gambling disorder' found links between emotional regulation and ADHD symptoms (Mestre-Bach et al., 2021). In a study with 170 individuals diagnosed with schizophrenia or schizoaffective disorder in the USA, authors found relationships between the severity of different symptoms of schizophrenia and gambling motivations, for example between higher psychosis symptom severity and financial motivations for gambling (Fortgang et al., 2020). The authors concluded that "delusional beliefs in psychosis may lend themselves to increased motivation to gamble for financial gain" (p.1). In a qualitative study in Canada, people with schizophrenia described how psychosis could influence their perception of gambling; one participant described feeling like they could 'control' gambling machines (Yakovenko et al., 2016). Similarly worded views were found in wider literature, for example that high levels of 'problem gambling' among people with psychosis may be related to 'poor impulse control' and 'cognitive deficits' which may increase risk taking (Haydock et al., 2015). As highlighted in section 1.6, there is also wider literature (outside the scope of this review) which makes links between cognitive functioning related to neurological conditions such as Parkinson's disease and gambling activity.

While these findings are valid and important, there are some considerations which should be taken into account when viewing this individualised and often biological / psychological research. Firstly, the language used often has the potential to lead to blame being attributed primarily to individuals (or their health condition) for their experience of harm. While we appreciate that the focus of the above cited research is on individual or biological factors, to fully understand the pathways which lead to gambling related harms it is also necessary to consider wider societal factors that may also influence risk-taking and decision-making among these groups. Secondly, some of the language used in this research tended towards generalised statements (such as assumptions about the 'traits' of people living with mental health challenges) and there was little qualitative research which explored the range of experiences and perspectives of those with lived experience. Among groups of people with any health condition, there will be a range of needs and attitudes towards gambling harms risk, and care should be taken to avoid making assumptions about vulnerability or agency.

Societal factors

In contrast to the studies discussed above, a small number of papers focused on the wider social factors which may drive gambling participation or gambling harms among people with disabilities, mental health challenges or neurodiversity. Most of the evidence focused on drivers of gambling rather than specific gambling *harms* (e.g., financial, or social hams). Across the review, the following factors emerged:

- **Accessibility**: Gambling can be an accessible and inclusive activity for some disabled people who feel marginalised and excluded from society (Bramley et al., 2017; Pitt et al., 2020b). A qualitative study in the UK which involved interviews with social workers and others working closely with people with a range of learning disabilities noted the particular appeal of mobile and online gambling for those who find other activities less accessible due to mobility considerations (Bramley et al., 2019a). Survey data analysis of 769 people in Canada receiving disability benefits also found that 'physical limitation'[39] was significantly associated with increased likelihood of 'problem gambling' (measured using the Canadian Problem Gambling Index (CPGI)) (Cortina et al., 2015). However, these studies only considered the impact of the person's physical health

[38] Impulsivity was measured using the UPPS-P Impulsive Behaviour Scale. The UPPS-P assesses five impulsivity facets: negative urgency, positive urgency, lack of premeditation, lack of perseverance, and sensation seeking.
[39] Measured using the Short Form-8 (SF-8) instrument for assessing health related quality of life.

rather than wider societal influences (e.g., inaccessibility of alternative activities and the ways people are marginalised within society).

- **Financial exclusion**: Some people with learning disabilities will have limited financial income due to challenges securing employment and therefore the possibility of making money through gambling may be more appealing (Pitt et al., 2020a). There was limited data to substantiate this relationship. However, this would merit further exploration, including consideration of barriers to employment (e.g., ableism).
- **Social connection**: Gambling can also offer social benefits for those in the community who are isolated (Bramley et al., 2017; Pitt et al., 2020a; Forsström et al., 2022). An evidence review found that, for some disabled people, these social benefits included intellectual stimulation and being in a warm place with food and drinks on offer (Bramley et al., 2017). Focus groups with people supporting those with learning disabilities in Australia also highlighted that interactions with gambling venue staff can provide social connection (Pitt et al., 2020a). Qualitative research with people with schizophrenia / schizoaffective disorder also found that gambling could be a way to build social connection and routine for those who had experienced isolation which they related to their condition (Yakovenko et al., 2016).
- **Social inclusion:** In qualitative research, those supporting people with learning disabilities in Australia reported that gambling could enable people with learning disabilities to feel they were doing something 'everyone was doing' and have their own independence (Pitt et al., 2020a). Although this sentiment was not explored further within this study, it may be that such views are grounded in experiences of feeling left out due to broader marginalisation and exclusion within society and the subsequent inaccessibility of other leisure activities. They also emphasised that gambling advertising reinforced the idea that gambling was a 'normal' activity to take part in. This was the only evidence identified in this review which was related to the gambling industry, however there are wider factors which could be explored in relation to these communities (i.e., the role of marketing on perceptions of risk from gambling). Focus groups with people with a 'dual diagnosis of schizophrenia and gambling disorder' also identified gambling as a fulfilling a need for activity in life. Some participants associated having schizophrenia with 'not mattering to the world' and highlighted gambling as a way to counteract that (Yakovenko et al., 2016).

Other social factors such as poverty, socio-economic status and employment are likely to interrelate with mental health, disability and gambling harm and should be acknowledged when considering drivers of harm. In a national survey of 848 people in Sweden, psychiatric disorders and self-harm were more common among people with a 'gambling disorder' who received social welfare payments (Karlsson et al., 2021). Surveys with adults attending mental health services in two Australian states also found that certain socio-demographic factors (including low levels of education and long-term use of government financial support) positively correlated with 'moderate-risk gambling' (moderate problems with gambling) and experiences of 'problem gambling' (measured using PGSI) (Haydock et al., 2015).

7.5 Protective factors

There was very limited evidence identified on protective factors which can reduce or prevent gambling harm among people with disabilities, neurodiversity and / or mental health challenges. The only evidence identified related to young people (with depression and hearing loss), with one quantitative paper arguing that monitoring and support from parents was a protective factor for gambling harm (Geidne et al., 2016).

7.6 Service and healthcare provision

Barriers to accessing service and healthcare provision for gambling

- **Shame and stigma**: One author reporting on qualitative research with people accessing support for mental health challenges and 'problem gambling' in Australia suggested that people with mental health challenges may be less likely to seek support due to shame, stigma, or pessimism about the potential for improvement

(McCartney et al., 2019; Bramley et al., 2019b). Other authors have highlighted that similar feelings of shame and stigma are likely to impact people whether they are seeking support for mental health conditions or gambling harms, and may be influenced by wider factors (e.g., gender norms) (Larsson and Håkansson, 2022).

- **Limited awareness of support services among those supporting people with learning disabilities:** Qualitative studies in the UK and Australia found limited awareness about gambling harm support services among people with learning disabilities and those involved in their care and support (Bramley et al., 2019a; Bramley et al., 2019b; Pitt et al., 2020b). Interviews with social workers and those working with adults with social care needs in the UK highlighted that many professionals lacked knowledge about gambling harms and did not feel confident managing incidences of gambling harm in their work. Knowledge gaps included identifying if clients were experiencing gambling harm and available sources of support (Bramley et al., 2019a). Participants with learning disabilities who took part in qualitative interviews in Australia also highlighted a need for more accessible information about gambling, in particular videos / visuals and a need for more signs within gambling venues explaining how gambling products work and are designed (Pitt et al., 2020a).
- **Lack of integration between services:** Papers identified several barriers related to the nature of existing services and healthcare provision for gambling harms. Qualitative research with those accessing a 'problem gambling' and mental health programme in Australia highlighted challenges related to a lack of integration between mental health and gambling harm services, due to separate funding and management mechanisms (McCartney et al., 2019). Authors found that routine screening for 'problem gambling' by mental health clinicians was rare and those working in gambling services had varied experience supporting people with mental health challenges. They argued that integrated care approaches for gambling harm and mental health could improve outcomes and reduce the number of appointments for patients. In the USA and Germany, authors researching ADHD and 'problem gambling' have proposed that a failure to detect ADHD at the start of treatment for 'problem gambling' could be detrimental as it would not allow a tailored treatment plan (Peter et al., 2016, Retz et al., 2016). Although these studies were conducted outside of Great Britain (and will be specific to the context of local healthcare systems), there is the potential for similar challenges in Great Britain, particularly in relation to the separate commissioning and delivery of mental health and gambling harms support services.
- **Location of services:** Services also need to consider barriers to support arising from the intersection of mental health and wider factors (e.g., employment type). For example, following a review of existing evidence, Hitch et al. (2023) argued that for veterans with PTSD, gambling harm services need to be able to reach people who spend limited time at a single location (e.g., a military base).

Innovative or promising programmes and approaches

Qualitative research has shown that integrated care approaches for those with mental health challenges experiencing gambling harm can improve outcomes and benefit patients through fewer appointments and better care planning (McCartney et al., 2019). However, these authors have noted that very few programmes exist globally. While more integrated approaches are being taken in the UK[40] (Woodall et al., 2020), there was no evidence identified in our review about the effectiveness of such models in the UK context. Instead, the review identified some (limited) positive evidence about a treatment programme in Ohio (USA) which combined gambling harm support with mental health and substance use support (Kruse-Diehr et al., 2022) and an

[40] Services such as the NHS Northern Gambling Clinic have set up models which provide care and treatment for both gambling problems and other conditions (including mental and physical health conditions). The Northern Gambling Clinic has set up a model of care which utilises multi-disciplinary teams during assessment and triage, as well as the use of a range of therapeutic interventions and aftercare (Woodall et al., 2020).

Australian integrated ‘problem gambling’ and mental health programme which included a broad delivery team with varied expertise (McCartney et al., 2019). Findings of the evaluations are summarised below.

The Ohio Problem Gambling Treatment Model for Adults with Co-occurring Disorders (OhPGTM)

The OhPGTM is a 12-week group-based treatment model that aims to address gambling harms, mental health and substance-use in a holistic way. It was developed because most existing group-based therapy approaches did not account for these co-occurring challenges. Implementation of the OhPGTM is instead guided by a treatment manual that was developed using multi-therapeutic approaches, drawing on approaches such as Cognitive Behavioural Therapy (CBT), Motivational Interviewing, Stages of Change and Life Skills Theory-applied. An evaluation of the programme which (involving a pre / post survey of those who took part) produced mixed findings. Those who completed the programme reported a reduction in self-reported ‘gambling disorder symptom severity’, but not an improvement in self-esteem or reduction in ‘gambling urges’ (Kruse-Diegr et al., 2022).

The Problem Gambling and Mental Health Programme (PGMHP)

The PGMHP is an integrated programme for people experiencing ‘problem gambling’ and mental health challenges which started in 2010 in Australia. It brings together a broad clinical team with expertise across gambling harm and mental health. Service users are given a brief intervention (usually less than one month) such as psychoeducation, advice on medication, family intervention or motivational interviewing to enhance readiness for treatment. Clinicians in specialist problem gambling or mental health services were given education to enhance cross-sectional collaboration. An evaluation which involved questionnaire-assisted interviews with service users and those who had referred them to the service (e.g., primary care clinicians) found that the programme allowed service users to access specialist care related to both gambling and mental health, which improved continuity of care. Service users reported feeling more hopeful following their treatment and reported that the support was easy to access and timely (McCartney et al., 2019).

Many authors recommended tailoring gambling services and healthcare provision for those with specific disabilities or mental health challenges, although this was often framed through the lens of co-morbidity and ‘dual diagnoses’ and focused on medical intervention rather than the need for holistic support (Echeburúa et al., 2011; Yakovenko et al., 2016; Linnet et al., 2017; Edgerton et al., 2018; Grubbs et al., 2018; Pitt et al., 2020b). For example, a Canadian qualitative study with people with schizophrenia concluded that this group may require unique clinical considerations due to the interaction of ‘gambling disorder’ and schizophrenia symptoms (Yakovenko et al., 2016). However, it is notable that participants in this study also discussed the impacts of societal responses to their condition (e.g., isolation) which will not be unique to schizophrenia. A USA study involving veterans seeking treatment for ‘gambling disorder’ also argued that treatment should be tailored for those with PTSD to address motivations which they found to be more common among this group (e.g., gambling due to negative emotions) (Grubbs et al., 2018). A mixed method study of 123 patients from outpatient clinics in Germany found that individuals with ‘gambling disorder and psychiatric co-morbidity’ benefitted less from outpatient gambling care (measured by reduction in ‘gambling disorder severity’) than those only experiencing ‘gambling disorder’ (Wullinger et al., 2023). The authors suggested that this is because this group requires more ‘comprehensive’ treatment including psychotherapy and pharmacotherapy than outpatient care alone can provide. Based on views collected during qualitative research with people with learning disabilities and their families / carers in Australia, it has also been argued that harm prevention messages should be delivered in a more accessible variety of formats including using audio and visuals (Pitt et al., 2020).

7.7 Recommendations

Despite evidence gaps, there is a strong indication that some people with disabilities, neurodiversity and / or mental health challenges experience higher levels of gambling harms and unique drivers for gambling. Some groups also have specific support needs and inequalities with regards to access to support. There is a need for further research to build on this existing evidence, and (in particular) explore experiences in Great Britain. Given the limited evidence on gambling harms among people with disabilities, neurodiversity and / or mental health challenges, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: Most evidence about rates of gambling harm among people with disabilities, neurodiversity and / or mental health challenges is from small, localised samples rather than nationally representative samples, with a focus on 'problem gambling' rates or gambling participation, rather than gambling harms. Previous research has also focused mainly on links between gambling harms and ADHD, PTSD, learning disabilities and depression, with some authors flagging a lack of evidence around some conditions such as autism (Chamberlain et al., 2023).

Recommendations:

- Future quantitative research should be conducted to assess rates of gambling harm among people living with different disabilities, neurodiversity and mental health challenges to enable a fuller understanding of which groups are at particular risk of gambling harm.
- Surveys should use harms measurement tools such as the Short Gambling Harms Screen which would allow an assessment of whether people with different conditions are more likely to experience *specific* harms (e.g., financial vs relationship harm).
- Survey data analysis could also be conducted using the forthcoming Adult Psychiatric Morbidity Survey (APMS) although publication will likely not be until early 2025 and the survey uses PGSI as a proxy for gambling harm. Despite this, the APMS will be an important data source as it includes a wide range of variables relating to mental health, neurodiversity and disability.

Limitation of current research / justification: The majority of evidence identified about people with disabilities, neurodiversity and mental health challenges is quantitative in nature, examining the associations between these specific conditions and gambling harms (or as in the case with the majority of research, 'gambling disorder' or 'pathological gambling') and often does not incorporate the views of those with lived experience.

Recommendations:

- Further qualitative research (such as depth-interviews or diary studies) with a public health approach to gambling harm should be conducted to understand the lived experience of these communities.
- There is emerging evidence that social factors such as marginalisation and exclusion from broader society may be a driver for gambling activity and harm (Bramley et al., 2017; Pitt et al., 2020a; Pitt et al., 2020b). Research must take an intersectional approach, appreciating that wider factors such as age, gender, ethnicity, and socioeconomic status are likely to impact people's lived experience. Research should also take into account that many people experience multiple challenges relating to their physical or mental health concurrently and may be subject to overlapping stigma and discrimination related to both their health condition(s) and gambling harms.
- Drawing on the social model of disability, research should consider societal barriers which impact all those with health conditions (e.g., attitudes to difference and ableism) rather than solely focusing on specific conditions. Given that existing research has largely focused on pathways to gambling for these

communities, qualitative research should focus on pathways to gambling harm and explore the relationship between participation and harm for different groups.

Limitation of current research / justification: Previous research has often not involved those with lived experience. There is an urgent need to engage those with disabilities, neurodiversity and lived experience of mental health challenges to inform next steps with commissioning research, as well as inform research priorities.

Recommendations:

- A stakeholder consultation involving people with disabilities and mental / physical health conditions could assess research priorities and advise how (if at all) communities should be grouped or considered within future research. Such consultation could also assess the most effective mode of data collection for different groups and the use of language to ensure that research is inclusive and captures experiences from across communities.

Limitation of current research / justification: There is evidence that integrated mental health and gambling harm support may benefit those with experiencing mental health challenges by reducing appointments and allowing more holistic care planning. While some more integrated approaches are being taken in the UK (Woodall et al., 2020), there was no evidence identified in our review of the effectiveness of such UK models.

Recommendations:

- There is a need to develop the evidence base for integrated support options in Great Britain. This may include case study research or evaluations of existing services in Great Britain, to highlight the benefits and challenges of various support approaches for those with different mental health challenges, as well as assess the comparative effectiveness of different approaches for reducing gambling harm.

8. Gambling harms among people with experience of unemployment, peripheral employment, or insecure employment

Key findings

- This review identified very few relevant papers which looked at the relationships between unemployment, peripheral employment, insecure employment and gambling harms.
- There is research from the UK and abroad which highlights a possible link between employment status and 'problem gambling'. However, the UK data stems from a 2010 survey and all quantitative analysis focuses on 'problem gambling' or similar measures rather than exploring specific gambling harms.
- There was some evidence of employment-related gambling motivations, including consideration of gambling as a way to generate additional income, opportunities to gamble in connection with work and gambling as a response to challenges relating to job insecurity, working conditions or job satisfaction. There was also some suggestion that unemployment or insecure employment could increase the risk of financial harms due to pre-existing financial vulnerability or cash-in-hand forms of payment.
- The evidence did not look at specific support programmes for gambling harms that might be relevant to this population, other than to suggest that taking a public health approach to gambling harm is important, and there may be value in offering integrated services to support people experiencing gambling harm alongside unemployment, insecure employment, or poverty.

8.1 Overview of evidence identified

This review included ten papers with relevant evidence on gambling harms among people with experience of unemployment, peripheral employment,[41] or insecure employment.[42] As the literature on the topic was very limited (only one paper looked solely at unemployment and gambling), interlinked findings on poverty, low income, and local area deprivation were also included from within papers already identified.[43] Four of the papers examined communities experiencing multiple elements of deprivation or disadvantage (including, but not limited to, unemployment). There was no specific evidence identified about peripheral or insecure employment,

[41] Types of employment which are normatively atypical or irregular.

[42] Types of employment where employment status or financial security is uncertain. This type of employment may result in unusual working hours (for example, shift work), or that are illegal (for example, people who are employed by the black market or another informal labour market).

[43] We included evidence on poverty and low income based on the evidence found in included literature review papers looking at multiple 'vulnerable' communities who joined those different factors under a 'constrained economic circumstances' or 'economic disadvantaged' umbrella. Additionally, the authors also mentioned lower income and lower employment in local areas of deprivation (Wardle, 2015; Rogers et al., 2019).

although five papers considered factors which may be relevant to these types of employment (e.g., part-time employment, working conditions and low income).

Most evidence (six papers) was quantitative, with some qualitative studies (one paper), evidence reviews (two papers), and mixed-method papers included (one paper). Of the ten papers, only three provided evidence solely from the UK. The remaining evidence was from Sweden (two papers), as well as one each for Australia, Finland, and the USA. Two additional papers provided evidence from multiple countries (including the UK).

8.2 Terminology used to describe gambling harms and the community of interest

Most papers framed gambling harms in clinical terms and used measures of 'problem gambling' or 'gambling disorder' as a proxy measure of gambling harm (using the Problem Gambling Severity Index (PGSI), diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the Problem and Pathological Gambling Measure (PPGM)). No quantitative papers identified used specific gambling harms measurement tools.

There was some discussion of the language used to describe gambling harms in two evidence reviews which applied the language used in the original papers but were also explicit in their aim to look at gambling harms (Wardle, 2015; Rogers et al., 2019). Both papers argued that research and policies should avoid pathologising people who gamble (e.g., through terms like 'problem gambler') and individualising harm, and should instead look at wider social, economic, and cultural determinants of harms.

When discussing people's employment experiences, most papers used 'person-first' language (e.g., 'people with low income', 'employees experiencing stress') or 'identity-first' language (e.g., 'unemployed people'). We have used 'person-first' language in this review to reflect that people should not be defined by employment status and these experiences are likely to fluctuate over time.

8.3 Rates of gambling harms

This review found some evidence on rates of gambling harm among people experiencing unemployment or related measures. However, it should be noted that all the evidence included in this section used rates of 'problem gambling' (measured using PGSI, DSM, or PPGM) as a proxy for gambling harms prevalence. Available data does not therefore necessarily encompass the range of gambling harms that can be experienced among people with experience of unemployment, peripheral employment or insecure employment, as well as affected others and the wider community. There was also no consideration of different experiences / types of unemployment and it was not always clear if figures included those who were 'economically inactive' (i.e., not actively seeking work).[44]

Unemployment

Analysis of survey data from 7,756 participants from the final wave of the British Gambling Prevalence Survey (BGPS, 2010), found that 14.6% of people with current experience of unemployment had experienced low or moderate levels of problems with their gambling and 3.3% were experiencing 'problem gambling' (measured using PGSI), compared to 7.5% and 0.9% respectively of the general population (Wardle et al., 2011 *cited in* Wardle, 2015 *and* Rogers et al., 2019). Unfortunately, these figures are now quite dated; however wider international studies have also found an association between employment status and gambling status or harms. Analysis of survey data in Australia (Hing et al., 2016; 15,000 participants) and Finland (Latvala et al., 2020;

[44] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/january2024.

7,186 participants) has shown that people in full-time employment were less likely to experience a moderate level of problems with their gambling or 'problem gambling' (measured using PGSI) compared to people in part-time employment or who are unemployed.[45] A comparative analysis of survey data related to alcohol use, drug use, and gambling participation in 81,229 16 year-olds across 30 countries (including the UK) showed that a one percent increase in youth unemployment was associated with a two percent increase in the probability of gambling[46] (Spångberg and Svensson, 2020). The paper did not look at 'problem gambling' rates but argued that underage gambling could be a proxy for 'at-risk gambling behaviour'.

There also appeared to be a reinforcing loop; a Scottish cohort study investigating changes in gambling behaviour over time (by monitoring changes in NODS scores over time) found that 'stable' or 'reduced' gambling behaviour was associated with more stable employment (remaining in the same job for longer) (Reith et al., 2013 *cited in* Wardle, 2015).

In a scoping review examining 'problem gambling' in the context of poverty, Hahmann et al. (2021) found that in all but one of the studies included in the review, unemployment was associated with gambling harm. However, many of the included studies involved very specific, discrete populations. For instance, one study reported that in a sample of 100 patients with human immunodeficiency virus (HIV) in the USA, those experiencing 'gambling disorder' (measured using DSM-5) were more likely to be unemployed compared to the rest of the sample (Langan et al., 2019 *cited in* Hahmann et al., 2021). Another study looking at gambling among 1,114 Indigenous people in the Prairie provinces of Canada found that employment status significantly predicted 'problem or pathological gambling' status in adjusted multivariate analysis (Williams et al., 2016 *cited in* Hahmann et al., 2021).

There was no evidence regarding factors that might protect against gambling harms in people experiencing unemployment, peripheral or insecure employment.

Occupation type

Rogers et al. (2019) reported data from the Welsh Omnibus Survey (2015) (4,048 participants) which showed that individuals with skilled and unskilled manual occupations were more likely to gamble and more likely to experience 'problem gambling' than people working in supervisory, managerial, administrative, or professional occupations. Data from GambleAware's Annual GB Treatment & Support Survey (2021) (18,038 participants) has also indicated some statistically significant differences[47] in PGSI score between different occupations. 'Foreman or Supervisor of Other Workers' (20%) as well as skilled (15%) and semi-skilled (17%) workers were more likely to experience any level of problems with their gambling than 'Professional or higher technical work / higher managerial' (10%) and 'Clerical / junior managerial / professional / administrator' (11%)' (GambleAware, 2021). Analysis of survey data from 7,284 working-age participants in Sweden has also shown evidence, though limited, that occupations requiring a higher level of education had lower rates of gambling participation and 'problem gambling' (measured using PGSI) compared to workers performing manual labour or skilled trades[48] (Binde and Romild, 2020). However, further research is needed to assess whether these differences exist after adjusting for known influencing factors for gambling harm (e.g., age, gender, and ethnicity) (Hahmann et al., 2021).

[45] The findings in both papers were statistically significant (Pearson's Chi-squared test, $p<0.001$).
[46] This finding was statistically significant (OR 1.024 (95% CI 1.013-1.034 $p<0.001$).
[47] At an alpha level of 0.05 (test not specified).
[48] This finding was statistically significant (Pearson's Chi-squared test, $p<0.001$).

Income and neighbourhood disadvantage

Hahmann et al. (2021) reported that gambling problems were associated with several other measures of poverty which can relate to employment status such as low income and neighbourhood disadvantage. A USA cohort study of 596 former students from inner city Baltimore schools (Martins et al., 2013 *cited in* Hahmann et al., 2021) found that people experiencing 'problem gambling' (measured using SOGS) were more likely to live in disadvantaged neighbourhoods (measured using the self-reported Neighbourhood Environment Scale (NES)), and that the association remained even when controlling for other variables (such as perceived racism, sex, ethnicity). Data from the 2016 Scottish Health Survey (5000 adult participants) (*cited in* Rogers et al., 2019) showed that people from the most deprived areas[49] were more likely to experience 'problem gambling' (measured using PGSI) (2.1%) compared to people from the least deprived areas (0.8%).[50] The same survey also showed that people from the lowest income households were more likely to experience 'problem gambling' (1.1%) compared to the highest household income (0.5%). In contrast, Edens et al. (2012) *cited in* Hahmann et al., (2021) found that a higher income was considered a risk factor for 'problem gambling' (measured using clinical diagnosis) among a sample of 1,120,424 USA veterans accessing mental health services. However, this is a specific group and patterns may be different at the population level. There is also some evidence from a nationally representative survey in Finland that people receiving social security benefits were more likely to be considered within the 'at-risk' (experiencing low or moderate problems with gambling) or 'problem gambling' PGSI categories, but when adjusting for household structure and education there was no difference in gambling status for people on a low income (Latvala et al., 2021).

8.4 Drivers of gambling and gambling harm

While there was little clear evidence, papers included some discussion of the drivers of gambling among those experiencing unemployment or as a result of wider employment-related factors:

- **Need for additional income and stimulation as a result of unemployment:** Some authors have suggested that people experiencing unemployment or receiving social benefits may use gambling as a mean to further limited incomes (e.g., Spångberg and Svensson, 2020; Latvala et al., 2021). It has been highlighted that this may be especially likely among people experiencing unemployment who cannot access public funds or services (e.g., people with irregular migration status)[51] and people unable to work for very long periods of time (e.g., due to health conditions) (Latvala et al., 2021; Brown et al., 2023). Similarly, it was suggested that people experiencing unemployment (especially for longer periods) may engage in gambling to pass the time (Latvala et al., 2021). However, there was no clear evidence supporting these views or linking these motivations to specific gambling harms (e.g., financial or social harms).
- **Response to wider challenges relating to job insecurity and conditions:** As has been established throughout these reviews, coping in response to difficult circumstances again emerged as a clear theme. There was some qualitative evidence that insecure employment types, poorer work conditions and low job satisfaction could be associated with specific motivations to gamble and increased likelihood of gambling harms. Focus groups with migrants and frontline staff working with migrants in London and Leeds highlighted that those with recent experiences of migration were more likely to have insecure employment, low wage jobs, and work unsociable hours (Bramley et al., 2020). Gambling venues are often open extended hours and therefore offer people a place to socialise and have hot food and drinks after work. Frontline staff also highlighted that these types of jobs were also more likely to be paid in cash, which was argued to enable

[49] Deprivation was measured using the Carstairs index, which consists of four indicators: low social class, lack of car ownership, overcrowding, and male unemployment (Carstairs et al., 1991 *cited in* Rogers et al., 2019).
[50] This finding was statistically significant (95% CI) (test not specified).
[51] Irregular migration status includes migrants who lack legal status in their country of destination due to unauthorised entry in their country of destination, breach of a condition of entry, or because their visa has expired (IOM, 2011).

'binge gambling' and increase the risk of financial harms because people could not access banking services to keep their money safe (e.g., through daily withdrawal limits). In a USA based web survey about work stress, employees across a range of sectors who reported that they had high stress at work or were experiencing burnout perceived gambling as a way to provide mood modification, excitement, and a sense of control (Tang et al., 2019).

- **Opportunities to gamble at, or in connection to work:** There was some evidence that opportunities to gamble at, or in connection to, work might impact 'problem gambling' status. This included gambling as part of workplace cultures (e.g., sports betting while socialising at work) and exposure to gambling at or in connection to work (e.g., exposure to gambling in cafés and diners during breaks) (Binde and Romild, 2020).
- **Interaction between employment-related and wider factors**: More deprived neighbourhoods[52] have a higher concentration of gambling venues in Australia and Great Britain, leading to increased accessibility of gambling, as well as increased targeted advertisement for gambling (Wardle, 2015; Rogers et al., 2019; Bramley et al., 2020). Researchers have highlighted that people living in these areas often have financial difficulties (e.g., related to low income, unemployment, or debt) and are experiencing stresses relating to these challenges – this creates a situation whereby gambling losses may lead to greater financial harms and stress than in a more affluent population (Wardle, 2015; Rogers et al., 2019; Larsson and Håkansson, 2022). This is thought to result in a 'harms paradox', where although unemployed people are less likely to gamble than employed people (59% vs 71% reported gambling in the past year in the 2010 British Gambling Prevalence Survey, 7,756 participants), those who gamble do so more frequently and engage in activities that are associated with an increased risk of gambling harms (e.g., electronic gambling machines (EGM)) (Wardle et al., 2011 *cited in* Wardle, 2015; Abbott et al., 2014b *cited in* Bramley et al., 2020; Cox et al., 2022).

8.5 Service and healthcare provision

There was very little evidence on barriers to accessing services and healthcare provision, or actions that could be taken to meet treatment and support needs of people with experience of unemployment, peripheral employment, or insecure employment who experience gambling harms. There was a brief mention in papers identified in this review that stigma surrounding gambling and poverty might inhibit people from seeking care, and that low awareness of services might make them fear costs associated with treatment, but these barriers were not specific to people with certain employment experiences and focused on the impact of living in less affluent neighbourhoods in England and Canada (Bramley et al., 2020; Hahmann et al., 2021).

There was also some limited discussion on the need to integrate services supporting people experiencing gambling harms and wider challenges (e.g., housing and financial precarity) and raise awareness about gambling harms across professionals working with already marginalised communities (e.g., social workers, welfare benefits advisors) to ensure person-centred care (Bramley et al., 2020; Hahmann et al., 2021; Latvala et al., 2021; Deutscher et al., 2023). While these factors would merit consideration in the context of unemployment, there was no evidence on existing programmes or services specifically targeting people experiencing unemployment, insecure or peripheral employment and gambling harms.

8.6 Recommendations

Although there is limited evidence, findings highlighted in this review suggest that there are some links between unemployment, wider employment-related factors (e.g., income and working conditions) and gambling harms which merit further exploration. There is a need for additional research to build on this existing evidence and explore experiences in Great Britain. Given the limited evidence on gambling harms among people with

[52] Deprivation was measured using the Indices of Multiple Deprivation (IMD) and other measures (e.g., areas with Spearhead PCT status).

experience of unemployment, peripheral employment, or insecure employment, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: UK survey data has been used to highlight a link between employment status (and associated factors) and gambling harms. However, all evidence on rates of gambling harms use 'problem gambling' as a proxy measure.
Recommendations: • Future quantitative research should look at the prevalence of specific gambling harms through data collection using harms measurement tools. For example, the upcoming Gambling Commission survey which includes variables on gambling harms will additionally include a question on employment status in the previous seven days. • Qualitative research would be needed to support interpretation of this data by exploring how and why different gambling harms are related to employment status.
Limitation of current research / justification: There is some limited evidence that wider factors related to employment (e.g., occupation type, working conditions and job satisfaction) might be associated with gambling and gambling harms, although there is a lack of data on peripheral and undeclared employment in Great Britain.
Recommendations: • Future quantitative research should look at gambling harms associated with different occupations in Great Britain (including insecure and peripheral employment types), as well as potential mechanisms that explain associations. GambleAware's Annual GB Treatment & Support Survey includes data on gambling status, specific gambling harms, service and treatment access, as well as employment status and occupation, that could be used for analysis. • Qualitative research should be used to support quantitative research, exploring specific drivers of gambling (e.g., unsociable hours, high stress, opportunities to gamble at work or with co-workers) and the conditions which might interrelate with gambling harms (e.g., being paid in cash). • This research should take an intersectional approach, considering the interplay between employment experiences and wider factors such as socio-economic status, age, and ethnicity / migration experiences.
Limitation of current research / justification: There is limited evidence on the directionality / bidirectionality of the relationship between employment status (including unemployment, peripheral and insecure employment) and 'problem gambling' / gambling harms, and therefore conclusions cannot be drawn as to whether employment status influences gambling harms (and / or vice versa). Existing data collection also does not explore wider factors such as whether the duration of unemployment results in differences in gambling status and gambling harms.
Recommendations: • Longitudinal research could explore how changes in employment impact gambling harms, and vice versa.

- Furthermore, a longitudinal study would allow an exploration of if (and how) gambling status and harms might change during prolonged periods of unemployment or following changes to employment type or conditions.

9. Gambling harms among people who experience or are at risk of homelessness

Key findings

- This review found evidence that experiences of 'problem gambling' (measured using PGSI) are high among some homeless communities; however there was not sufficient evidence to make conclusions about overall rates of gambling harms among people experiencing homelessness in Great Britain.
- Papers identified a number of motivations for gambling, linked to some of the key challenges faced by these communities (e.g., financial constraints, lack of accessible and safe spaces and experiences of loneliness). However, there was little consideration of drivers of specific gambling *harms* (e.g., financial losses, relationship challenges, mental health impacts).
- There was limited evidence about barriers to support and healthcare, or innovative programmes or services for people experiencing homelessness and gambling harm. However, available evidence suggests that compounding stigma and discrimination related to experiences of homelessness and gambling will form an important barrier to accessing support in this community. Papers suggested that there may be a need to improve understanding of gambling harms among support providers supporting people experiencing homelessness and ensure provision of holistic support which tackles intersecting challenges.

9.1 Overview of evidence identified

This review included 17 papers with relevant evidence about gambling harms among people who experience or are at risk of homelessness. Under the umbrella term of 'homelessness' there are several different experiences; rough sleeping,[53] being in temporary accommodation or insecure housing,[54] hidden-homeless,[55] and statutory homelessness.[56] Most of the papers identified focused on people living in insecure housing with only a few papers exploring the drivers of gambling harms among those who are rough sleeping. However, a couple of the papers explored how the drivers of gambling harm differ between those with different experiences of homelessness. Out of the 17 studies included, 11 used qualitative methods (e.g., depth interviews and focus groups). Evidence reviews made up a further four papers and two papers analysed quantitative data. Six papers were focused on the UK (two of these based in England only) with one of those focusing on the UK and Europe. Six focused on North America and Canada, four focused on Australia and New Zealand and a final paper used data collected from the US, Canada, and Australia.

[53] Rough sleeping means sleeping without adequate shelter, typically on the streets of a town or city.
[54] Insecure housing refers to when a person or family's living situation is tentative, or their home situation is unliveable.
[55] People who come under the term 'hidden homeless' are people who may be considered homeless but are hidden from statistics and services as they are dealing with their situation informally. This can mean staying with family and friends, sofa surfing, or living in unsuitable housing.
[56] Statutory homelessness refers to being legally defined as homeless due to lacking a secure place to live. Local authorities have a statutory duty to provide secure housing for homeless households (Crisis, 2023).

9.2 Terminology used to describe gambling harms and the community of interest

In many cases, gambling harm was framed in clinical terms, focusing on measurements of 'problem gambling' using the Problem Gambling Severity Index (PGSI), 'pathological gambling' using the South Oaks Gambling Screen (SOGS), the Massachusetts Gambling Screen (MAGS), the National Opinion Research Centre Diagnostic Screen for Disorders (NODS) or the clinical diagnosis of 'disordered gambling'. No quantitative papers identified used specific gambling harms measurement tools (such as the Short Gambling Harm Screen (SGHS)).

The terminology used to describe community members was varied, including 'person-first language' ('people who are homeless' / 'people experiencing homelessness') and language that is less inclusive (e.g., 'the homeless', 'homeless people'). Throughout this chapter we have used 'person-first' language to emphasise that people as individuals are separate from their challenges related to housing, while also understanding the impact of having insecure housing. This approach can help avoid harmful stereotypes (Shelter, 2024) in not reducing people's personhood to this one facet of their lived experience. Papers provided no critical discussion of the language used to describe gambling harm or people experiencing homelessness.

9.3 Rates of gambling harm

There was some evidence identified on the prevalence of gambling harms among homeless communities. UK studies have reported high rates of gambling harm, when compared to rates of 'problem gambling' (measured using PGSI) among the general population (0.2%) (Gambling Commission, 2023). One study of 72 participants currently 'rough sleeping' (recruited from homeless shelters, day centres and hostels throughout Westminster) found that 23.6% of the sample experienced 'problem gambling' (measured using the PGSI screening tool) (Sharman et al., 2016). Another study by the same authors involved interviews with 456 individuals who were homeless and sleeping rough or hotel residents in Westminster (Sharman et al., 2014). This study found that 11.6% experienced 'problem gambling', while 3.3% were classified as being 'moderate-risk' (experiencing a moderate level of problems with their gambling) and 8.3% 'low risk' (experiencing a low level of problems with their gambling). The variation between these two studies examining the same area may be due to the different types of homelessness that these individuals were currently facing, with the earlier paper focusing on various experiences of homelessness while the later paper only including individuals currently sleeping rough. Studies involving 690 participants in Poland and 87 participants in Canada have also reported rates of 'problem gambling' (11.3% and 12.6%; measured using PGSI and SOGS) which would be considered high (Lepage et al., 2000 *cited in* Sharman, 2019; Wieczorek et al., 2019 *cited in* Vandenberg et al., 2022b).

When considering these findings, it should be stressed that the samples in question were non-representative and tended to involve discrete groups of people with particular experiences of homelessness (e.g., rough sleeping), making comparisons to general population figures challenging. This would be expected for research with these communities and while findings should not be assumed to be representative of all people with (diverse) experiences of homelessness, these figures do give indications of potentially higher rates of gambling harm among people experiencing homelessness.

9.4 Drivers of gambling and gambling harms

This review identified a number of factors which may influence gambling activity among people experiencing homelessness but there was limited evidence identified about factors influencing gambling harms.

- **Financial motivations:** Previous research has identified financial motivations as a driver for gambling among those who are experiencing homelessness. Authors of qualitative studies involving people experiencing homelessness in the UK (Sharman and d'Ardenne, 2018) and service providers working in the fields of

gambling harm and / or homelessness in Australia (Vandenberg et al., 2022a) have identified similar financial motivations. These two papers found that people experiencing, or at risk of homelessness are often experiencing financial hardship and can see gambling as a way to earn income and potentially escape poverty due to the chance of a 'life-changing win'.[57] In a Canadian qualitative study, participants with experience of homelessness stated they had continued to gamble due to an early win which may have given them unrealistic expectations of the long-term financial impacts of gambling (Hamilton-Wright et al., 2016). However, other authors have also argued that people who find themselves in serious financial hardship (including those experiencing homelessness) may be more likely to make 'risky behaviour choices' to overcome their situation, and therefore are at greater risk of gambling harm (Guilcher et al., 2016; Sharman and d'Ardenne, 2018). This review did not identify any further literature which discussed wider financial drivers of gambling *harms*. Given the relationship between financial hardship and experiences of homelessness, it may be that gambling losses are more impactful within this community. However, this type of relationship was not explored in papers identified in this review.

- **Accessibility / availability of gambling:** Gambling participation is often influenced by practical and environmental factors, such as the accessibility and availability of gambling (Sharman, 2019). Authors have argued that high street gambling venues are easily accessible to the homeless community and often within walking distance. They can be open late or even open 24 / 7 which can provide a space of safety and shelter away from the streets. Service providers who took part in qualitative interviews in Australia and the UK emphasised that gambling venues can be one of the only places for people without adequate accommodation to turn for safety and security, especially at night (Sharman et al., 2016; Wardle et al., 2014 *cited in* Bramley et al., 2018; Landon et al., 2022; Vandenberg et al., 2022a). Qualitative research with people from 16 homeless shelters in Westminster found that gambling venues are perceived as beneficial for those who are sleeping rough, by providing shelter or even free hot drinks and food. Participants also described how high-street venues often offer low stake gambling which allows them to place small bets and be away from the streets for a short time (Sharman et al., 2014). Qualitative research involving interviews and focus groups with people who were currently experiencing homelessness in the UK and Australia identified other benefits of gambling venues for those experiencing homelessness, particularly those rough sleeping. These benefits included heating, toilets, free tea and coffee and even low-priced meals which made them attractive to people living on the streets or in insecure housing where these amenities may be harder to access (Sharman and d'Ardenne, 2018; Vandenberg et al., 2022a).
- **Emotional response to difficult circumstances:** Authors have argued that gambling has been used by people within the homeless communities as a 'coping mechanism', to provide escape and temporary relief from challenges in life including mental and physical health issues, social isolation, exhaustion, trauma, poverty, harm related to drug use or loneliness. With fewer mechanisms to mitigate such challenges (such as access to support networks or services), gambling can emerge as a form of self-medication to provide soothing and relief (Nower et al., 2015; Hamilton-Wright et al., 2016; Sharman and d'Ardenne, 2018; Matheson et al., 2021; Vandenberg, 2022a; Deuthsher et al., 2023). These arguments draw on qualitative research with people experiencing homelessness. In interviews with participants recruited from homeless shelters and day centres across the UK (many of whom had previously experienced rough sleeping), some described using gambling machines and games as an escape (Sharman, and d'Ardenne, 2018). Another study, which involved people who were experiencing homelessness and at risk for 'problematic gambling' (measured using the NODS) in Toronto, Canada found that gambling participation could help to manage stress, emotions and mental health issues and bring about temporary relief from other problems in life such as

[57] Although out of scope for this review, there is a wealth of evidence linking the potential of escape from poverty and deprivation to gambling participation (for example see Casey, 2008).

drug-related harm (Matheson et al., 2021). Similar examples of coping in response to difficult circumstances or events have emerged across these reviews, often tied to multiple challenges faced by communities as a result of marginalisation or stigmatisation.

- **Loneliness and social isolation:** Mixed-method research in the UK, New Zealand and Australia has identified that gambling can provide social interaction for those experiencing homelessness, for example through sharing tips with others who gamble (Bramley et al., 2018; Sharman and d'Ardenne, 2018; Vandenberg et al., 2021a; Landon et al., 2022). Qualitative research with service providers in Victoria, Australia working with people experiencing homelessness highlighted that this was particularly relevant in older adults experiencing homelessness; grief and loneliness can become a 'trigger' for increased and more harmful gambling participation (Vandenberg et al., 2021a). In an England based study which involved interviews with people with varying experiences of homelessness (including rough sleeping or staying in hostels), some participants could pinpoint a specific event they believed acted as a 'trigger' for difficulties experienced with homelessness and gambling, which was often the death of a close family relative (Sharman and d'Ardenne, 2018).

While these findings provide important evidence about motivations for gambling, there was little consideration of drivers of specific gambling *harms* (e.g., financial losses, relationship challenges, mental health impacts) within this community.

9.5 Protective factors

There was limited evidence identified on factors which protect against gambling harms amongst homeless communities. Qualitative research (including a qualitative study with participants working in service provision in Victoria, Australia) did highlight that improved housing security or being near a homeless shelter can provide stability and support for someone who is experiencing homelessness alongside gambling harm (Bramley et al., 2018; Vandenberg et al., 2022a). Qualitative research with service users has also found that having these safe spaces to receive housing support and being able to feel included and gain strong social bonds, can all add to an individual's feelings of self-worth, and has been argued to be important protective factor for gambling harm (Hamilton-Wright et al., 2016). Additionally, having close familiar relations who can provide support has been identified as a protective factor for those experiencing homelessness, but this was also noted to have a negative impact in some cases as it could stop them facing up to their 'problem gambling' (Holdsworth et al., 2012b).

9.6 Service and healthcare provision

Barriers to accessing service and healthcare provision for gambling

There was some, limited evidence on barriers to healthcare provision and services among people at risk of, or experiencing, homelessness.

Research has highlighted that there may be limited support available for those experiencing gambling harms within services supporting people who are homeless. During qualitative research with people experiencing housing challenges in the UK, participants expressed concerns that gambling harms would not be taken seriously by service providers in comparison to other issues such as drug-related harm which were felt to be prioritised by services (Sharman and d'Ardenne 2018). In the context of Toronto, Canada, authors have argued that there is a need for greater awareness of gambling harms among service providers supporting those experiencing homelessness, coordinated screening between gambling and homelessness services and funding for innovative models of care that integrate services and address the needs of specific communities (Matheson et al., 2022). One UK study identified that for individuals experiencing homelessness most gambling support services are not always a viable option, making options extremely limited for this vulnerable population

(Sharman and d'Ardenne, 2018). There was no further evidence identified in this review about the availability or accessibility of gambling services for people experiencing homelessness within the context of the UK.

Individuals experiencing homelessness are already highly stigmatised, reducing the likelihood that they will feel able, or comfortable, to share challenges such as gambling harms which may result in further stigmatisation, shame and embarrassment (Holdsworth and Triyce, 2012a; Guilcher et al., 2016; Wright et al., 2019; Vandenberg et al., 2022a). In qualitative research with people experiencing homelessness and challenges with gambling in Australia, service users described how they felt a need to keep their problems hidden so they would not be labelled or viewed negatively (Holdsworth and Triyce, 2012a). Authors have highlighted that there is a social stigma attached to being both a 'homeless person' or a 'problem gambler' that focuses on the "perceived deficiencies and flaws in the individual" (e.g., being seen as untrustworthy) that may be being carried into the support setting (Holdsworth and Triyce, 2012a, p.476; Guilcher et al., 2016). As would be expected, research has also identified that those with previous negative experiences of support services will be particularly unlikely to access healthcare and support for gambling harms. Participants accessing housing support from a housing organisation in Canada described in interviews how previous negative experiences with treatment or support across the health and social care sector made them subsequently less likely to reach out for further support (Guilcher et al., 2016). People experiencing homelessness who took part in qualitative research in the UK and Australia, have also expressed concern that (due to the financial nature of gambling) discussing their challenges with gambling harm could impact hostel placements, access to housing, benefits, and overall levels of assistance (Holdsworth and Triyce, 2012a; Manthorpe et al., 2015 *cited in* Bramley et al., 2018; Sharman and d'Ardenne, 2018; Sharman, 2019; Vandenberg et al., 2022a).

Innovative or promising programmes and approaches

Very few papers discussed innovative programmes or services that have had promising results for people at risk of or experiencing homelessness. Holistic approaches to healthcare and service delivery have been suggested as a way to address the complex needs that these service users may be facing, by tailoring support to address multifactorial issues such as mental and physical health, interpersonal relationships, financial management, and unemployment (Guilcher et al., 2016). As individuals experiencing homelessness can be dealing with a complex combination of issues, there is a necessity for services to deal with issues simultaneously. While holistic methods of treatment were recommended by a number of authors (Hamilton-Wright et al., 2016; Bramley et al., 2018; Wright et al., 2019; Matheson et al., 2021), there was a lack of quantitative or qualitative data on effectiveness or outcomes of these types of approaches. The review identified one Canadian-based treatment program that has integrated gambling treatment with other services called the Gambling Addiction Programme (GAP).

The Gambling Addiction Programme (GAP)

The GAP was designed and implemented in 2017 in Canada. This was the first treatment programme to address experiences of gambling harms within the context of poverty and homelessness, with the aim of providing a more integrated and person-centred approach to gambling support (Matheson et al., 2022). The programme included group work with clients in the treatment centre as well as case management for individualised support. Authors argue that GAP has become an important resource for people who are confronting and managing the issues that arise from 'problem gambling' in the context of poverty and homelessness. There were some positive reflections from clients, who reported the regular meetings involved in the programme allowed them to stay 'on track' and helped them to stay focused and motivated through accountability and individualised goal setting (Matheson et al., 2022). However, this review did not identify any evidence about the success (or otherwise) of the holistic nature of the approach.

Two papers discussed the merits of peer support groups being part of treatment provision for people experiencing homelessness (Sharman and d'Ardenne, 2018; Sharman, 2019; Matheson et al., 2021; Matheson et al., 2022). One paper involved qualitative research with clients at a shelter service in Toronto that employs group sessions as part of Cognitive Behavioural Therapy (CBT), as well as group life skills sessions (Matheson et al., 2022). Clients felt that group sessions gave them a platform to share and learn from others, which was helpful for reflecting on their own experiences. Group meetings could be beneficial as they could be a platform to share and learn from others, helping people to reflect on their own issues as well as meeting social needs - this was thought to be particularly important in a community which experiences high levels of social exclusion (Matheson et al., 2022).

Although there is limited evidence about specific programmes which have aimed to support people experiencing homelessness and gambling harm, papers identified in this review suggested improvements that can be made to current healthcare and support provision to improve its effectiveness. Stakeholders (including people working within the housing and shelter sectors, social services, medicine, and gambling support services) and those with lived experiences of gambling harm and precarious housing in Toronto, Canada highlighted the importance of better training for homelessness service providers (Wright et al., 2019). This included education around how to screen, treat, and refer those experiencing gambling harms through their services. Authors have also suggested that improvements in staff training could help ensure positive experiences for those seeking help by reducing the stigma and judgement they face while accessing services (Guilcher et al., 2016) as well as building knowledge among service providers of the interplay between gambling harm, homelessness and other challenges such as drug-related harm (Guilcher et al., 2016; George and Boden-Jones, 2014 *cited in* Bramley et al., 2018; Landon et al., 2021; Matheson et al., 2021). This was viewed as essential to high quality provision of care for clients that are facing poverty, homelessness, and gambling concerns (Wright et al., 2019).

9.7 Recommendations

Despite the lack of evidence currently available for the community of people who are experiencing gambling harms and homelessness there is a clear indication that they are experiencing higher rates of gambling harms and unique challenges in comparison to the general population. Given the limited evidence on gambling harm among people experiencing or at risk of homelessness, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: Research on the prevalence of gambling harms among people at risk of, or are experiencing homelessness has focused on local populations, with small sample sizes and there is a lack of data on national prevalence (both in the Great Britain and comparable contexts). However, existing evidence strongly suggests that this group experience higher rates of gambling harm and a nationally representative survey would likely be challenging and costly.

Recommendations:

- Future research should focus on gathering qualitative data to understand existing quantitative and qualitative findings in greater depth. Existing research (highlighted above) suggests that this community faces specific, complex drivers of harms and barriers to support which require further detailed and sensitive exploration through one-to-one interviews or similar approaches.
- This research will need to take an inclusive approach, ideally involving people with lived experience at all stages of the research (e.g., through lived experience panels) to help tailor data collection approaches and presentation of findings.

- For this community, consideration should also be given to research which draws on ethnographic approaches. For example, research in gambling venues to better understand how these spaces are perceived and used by people experiencing homelessness.

Limitation of current research / justification: Currently research does not provide an in-depth exploration of the issues of stigma, discrimination, and marginalisation in relation to communities experiencing homelessness and gambling harm. However, through existing research around homelessness we can establish this is likely to be an issue which urgently needs investigating further in relation to both drivers of gambling harms and barriers to treatment and support.

Recommendations:

- Further qualitative research should explore the experiences of those experiencing homelessness and gambling harms in the context of marginalisation, stigmatisation, and discrimination.
- Research should take an intersectional approach to fully understand experiences among these communities, taking into account broader factors such as structural racism and discrimination (e.g., related to gender or sexuality) as well as exploring experiences of gambling harms among people with different experiences of homelessness (e.g., rough sleeping, insecure housing). Understanding how these factors relate to each other for those experiencing homelessness and gambling harms will help to improve how services support those individuals.

Limitation of current research/ justification: While papers identified a number of motivations for gambling (e.g., financial constraints, lack of accessible and safe spaces and experiences of loneliness), there was little consideration of drivers of specific gambling harms (e.g., financial losses, relationship challenges, mental health impacts) within this community.

Recommendations:

- Through qualitative interviews participants should be supported to explore their journeys with gambling, including motivations, different experiences of gambling activity (which could include periods where gambling led to harms and periods when it did not) and drivers of these experiences.
- These interviews should also provide a platform for participants to discuss the temporal relationships between gambling, homelessness and other adverse life events or challenges.

Limitation of current research/ justification: Research has highlighted challenges that people experiencing homelessness can face when seeking support and treatment (e.g., stigma, lack of integration of services and holistic support for needs). However, there was very little evidence exploring these challenges (or the potential for more holistic care) in the context of the UK.

Recommendations:

- Further research needs to take place in Great Britain to understand what support is on offer for people experiencing homelessness and gambling harms. This will help to identify key gaps and recommendations for practice and should involve qualitative fieldwork with service providers and people with experience of seeking and receiving treatment and support.
- Specific issues for further investigation include the provision of integrated / holistic support for individuals facing multiple challenges (including gambling harms and homelessness), recognition of gambling harms among homelessness service providers and the impacts of stigma and marginalisation on help seeking and what can (or is) being done to overcome these issues.

10. Gambling harms among older people

Key findings

- While overall rates of 'problem gambling' (measured using PGSI) may be lower among older people (see section 9.3), there is evidence of relationships between older age and specific drivers of gambling / gambling harm.
- As would be expected across all age groups, loneliness and the need for social connection and entertainment / leisure can drive gambling activity (and, in some cases, harm) among older people. In some cases, these motivations are influenced by age-related factors (e.g., retirement or changes in day-to-day responsibilities). However, the intersection between these motivations and societal factors such as accessibility of leisure / entertainment options, marketing of gambling activities and stigma also appears to have a particularly important role to play in driving gambling among older age groups. Further research should look to build on this evidence, exploring how different factors can specifically link to gambling harm in the context of Great Britain. This research must take an intersectional approach and take care to avoid making generalisations relating to older age (e.g., vulnerability, risk-awareness, loneliness and boredom).
- Given the lower rates of 'problem gambling' among older people in Britain and knowledge gaps among professionals supporting this group (e.g., social workers), there is a risk that those experiencing gambling harm in older age may be less likely to be identified and supported. However, there is currently a lack of clear evidence about barriers to treatment and support for older people, or about innovative or promising programmes targeted to this group.

10.1 Overview of evidence identified

This review included 38 papers with relevant evidence around gambling harms among older people. Papers defined this group with varying parameters. 13 papers focused on people aged 55 and over. Six papers each focused on those aged 60 and over and 65 and over, and a further two focused on people over 50. There were an additional eight papers which focused on a more specific age range, however these appeared to be defined by the sample, rather than a prespecified definition of 'older people'. The lowest age included was 46[58] and the highest was 94.

Methods of included papers varied; ten evidence reviews were included, in addition to quantitative (primary and secondary analysis) (ten papers), qualitative (interviews and focus groups) (12 papers), and mixed method studies (six papers). The ten cited evidence reviews contained evidence from multiple countries (including the UK). Five studies (qualitative and quantitative) were conducted in the UK. The remaining 23 papers focused on Australia (five), the USA (six), Canada (three), Poland (three), Spain (three), Finland (one), Italy (one) and Israel (one).

[58] This represented the upper third of ages within an entire population sampled.

10.2 Terminology used to describe gambling harms and the community of interest

Language associated with gambling in the papers was frequently clinical, referring to, 'pathological gambling', and 'gambling disorder'. Papers tended to use standardised tools to quantity gambling severity such as the Problem Gambling Severity Index (PGSI) and the Canadian Problem Gambling Index (CPGI); however, some qualitative studies used wider measures to identify participants with experience of gambling related harms (e.g., self-identified negative impacts of gambling (e.g., McCarthy et al., 2021) and experience of treatment or support (e.g., Levinson and Ayalon, 2019). Some papers referred to specific gambling harms such as financial and relationship harm (e.g., Wardle, 2015; Public Health England, 2023). However, no papers provided measurements of specific harms.

The vast majority of papers described the community of interest as 'older adults' or 'older people', with some using language such as 'elderly people', 'elders', or 'seniors'. Two papers described the population of interest as 'retired people' or 'retirees'. Within this review, we will apply the NHS guidance which involves specifying ages where possible and otherwise using the term 'older people' rather than words such as 'elderly' which can perpetuate stereotypes about this group (Age UK, 2019; National Ageing Research Institute, 2024; NHS, 2024). The ages of the populations included in the evidence were broad and it should be stressed that such groups encompass people with varying experiences which are unlikely to be homogenous (Elton-Marshall et al., 2018). Some papers sought to understand different experiences within age groups by exploring the impacts of gender, generation, marital status or explicitly using an intersectional approach. However, there were also examples of language throughout the included papers which risks further stigmatising older age groups and generalising experiences. In particular, this included broad statements being made about the lifestyles and abilities of older people such as assumptions around free time / boredom and frailty / vulnerability. There were also assumptions made about 'generational traits' (e.g., suggesting that older people are less likely to share their feelings or seek support than younger people).

10.3 Rates of gambling harm

Nationally representative surveys commissioned by the Gambling Commission have measured rates of 'problem gambling' (using the PGSI) among different age groups in Britain. The PGSI is intended to capture 'problem gambling' rather than harm. However, the measure is widely used and many of the items capture harm (Murray-Boyle et al., 2021) so PGSI data has been included as proxy of harm in the absence of other more relevant data. In a report of quarterly telephone survey trends between 2015 and 2023 (involving a nationally representative sample of 4,001 adults), it was highlighted that over this eight-year period older people were less likely to experience 'problem gambling' than younger people. Specifically, on average over this period, 0.9% of 16–24-year-olds had been identified as experiencing 'problem gambling' in comparison to 0.1% of those aged 65 and over (Gambling Commission, 2023). This pattern was consistent with earlier findings reported in the British Gambling Prevalence Survey 2010, a nationally representative survey of 7,756 people (Wardle et al., 2011 *cited in* Wardle, 2015 and Pattinson and Parke, 2016).[59]

It has been suggested in the international literature that while overall rates of 'problem gambling' may often be lower among older people, age may influence the types of harms experienced (Turner et al., 2018; Pitt et al., 2022) and the drivers of gambling related harms (Tira et al., 2013 *cited in* Matheson et al., 2018). Our review found no quantitative evidence on rates of specific harms; however, drivers are discussed in more detail below.

[59] Papers included in this review also captured rates of 'problem gambling' in other countries (e.g., Tse et al., 2013; Subramaniam et al., 2015). These figures have not been included as there is comprehensive data about how these rates vary across the life course in Britain.

10.4 Drivers of gambling and gambling harm

There is evidence that a range of drivers can influence gambling activity among groups of older people. However, in many cases papers did not specifically link the drivers to age or demonstrate that these factors were more common among older people. This section focuses on key age-related drivers of gambling and gambling related harms that emerged from the papers. It also considers broader societal structures and dynamics (such as ageism and age discrimination) which may drive experiences of harm. As highlighted above, it should also be stressed that 'older people' are not a homogenous group and individual experiences will be influenced by a range of factors other than age, including those discussed in this report (i.e., migration experiences, culture, and disability / health) (Granero et al., 2020a; Granero, 2022). These types of wider factors will only be discussed in this chapter where the findings specifically address the intersection with age.

Financial

Studies conducted in the USA, Australia, Canada, and Italy (including qualitative and quantitative methods) have found that financial reasons were key motivators for gambling among some groups of older adults (Martin et al., 2011; Phillips et al., 2012; Van der Maas et al., 2017; Keovisai and Kim, 2019; Pitt et al., 2020; Venuleo et al., 2021; McCarthy et al., 2022). Polish qualitative studies, involving interviews with women aged 55 and over (Lelonek-Kuleta, 2022) and retired men aged 55 and over (Lelonek-Kuleta, 2023) linked financial motivations for gambling to age-related factors. Among both samples, there were examples of participants who viewed their finances as insufficient and disadvantaged, relating to the low value of their pensions. It was further reported that gambling was an opportunity for both financial stability and to provide money to loved ones, particularly adult children, and grandchildren. While these studies took place in Poland, similar experiences are likely to be present among British older people.

There was some evidence linking financial motives to gambling *harm*. A Canadian survey of 2,103 people aged 55 and over (with experience of gambling) identified that odds of 'problem gambling' (measured using PGSI) were higher among those who gambled for financial motivations than those who did not (van der Mass et al., 2017). In Polish and Australian qualitative studies with people aged 55 and over, participants discussed how motivations such as financial stability may initially drive gambling; however, winnings may then motivate further gambling, indicating a more regular pattern of behaviour which can contribute to financial harms (Lelonek-Kuleta, 2022; McCarthy et al., 2022).

Authors of an evidence review exploring experiences of "culturally diverse older adults"[60] have suggested that intersection of older age and wider factors such as ethnicity / migration experience may enhance the need to gamble for financial gain (Luo and Ferguson, 2017, p.296). This statement was not clearly evidenced, however the impacts of intersecting challenges affecting older people from minority ethnic communities would merit further exploration.

The intersection of loneliness, social connection and entertainment with accessibility and stigma considerations

As would be expected across all age groups, loneliness and the need for social connection and entertainment / leisure can drive gambling activity among older people. However, the intersection between these factors and accessibility, stigma and marginalisation may have a particularly important role to play for older people. This

[60] Defined as being 'members of non-Caucasian cultural groups'.

section will first outline the relationships between these factors and gambling or gambling related harms, before discussing how accessibility and stigma can influence the ways in which these drivers operate for older people.

Social connection and loneliness

Some older people engage in gambling to facilitate social connection (Beynon et al., 2019). During interviews and focus groups with groups of older people in the USA and Australia, some participants discussed how gambling provided an opportunity to socialise with friends and family and make new connections with staff and other attendees (Tira and Jackson, 2015; Keovisai and Kim, 2019; Pitt et al., 2020). Social motivations to gamble among older people may be linked to a number of factors, including existing personal relationships. In a Canadian survey of 2,103 people aged 55 and over respondents were asked whether they gambled with family / friends and their motivations for gambling (with options including "socialising" and "loneliness or isolation") (van der Mass et al., 2017; Elton-Marshall et al., 2018). In this survey, respondents who were married were more likely than those were single, divorced or widowed to be gambling with family and friends,[61] however respondents who were widowed were more likely to indicate that they gambled to socialise[62] (Elton-Marshall et al., 2018). Wider factors, such as marginalisation and exclusion from other elements of society or leisure activities, will be relevant to understanding why certain groups choose to participate in gambling activities but have not been considered in the included papers.

While loneliness is experienced across all age groups, interviews, and focus groups with older people in Britain, Australia and Israel identified some factors which had particularly influenced experiences of loneliness in older age (Pattinson and Parke, 2016; Pitt et al., 2020; Levinson and Ayalon, 2021; McCarthy et al., 2022; see also Bramley et al., 2017). These included living alone and feeling isolated from communities, retirement, losing or separating from a spouse and children moving away from home. In these qualitative studies and a survey of 247 people over the age of 60 in Detroit (Martin et al., 2011), participants indicated that gambling could provide social connection and distraction from negative feelings for those experiencing loneliness. As with broader social motivations, experiences of loneliness will vary hugely among older people who gamble. Among a sample of 183 people over the age of 60 in Australia, men without a partner were more likely to experience loneliness[63] (Botterill et al., 2016) while in a Canadian survey of 2,103 people aged 55 and over, respondents who were divorced or widowed were significantly more likely to indicate that they gambled due to feelings of loneliness or isolation than those who were married[64] (Elton-Marshall et al., 2018). Neither survey was nationally representative and (as with regards to social connection) wider factors will also be relevant to whether loneliness acts as a motivator for gambling.

While social motivations and loneliness can drive participation in gambling activities, these motivations are not always linked to gambling *harm* among older people. In qualitative interviews with British people aged 65 and over, some participants who gambled expressed that the activity could be a positive way for older people to facilitate social connection and reduce loneliness (Pattinson and Parke, 2016). In a Canadian survey of 2,103 people aged 55 and over, gambling with friends or family and gambling to socialise were associated with lower average PGSI scores and reduced odds of experiencing 'problem gambling' (van der Mass et al., 2017; Elton-Marshall et al., 2018). Elton-Marshall et al. (2018) suggested that there was a distinction between those who gambled due to social reasons and loneliness, in terms of their experience of harm. This paper found that average PGSI scores were significantly higher for older adults who indicated that loneliness motivated their

[61] This finding was statistically significant (Pearson's Chi-squared test, $p<0.001$).
[62] This finding was statistically significant (Pearson's Chi-squared test, $p<0.001$).
[63] This finding was statistically significant (Hayes mediated moderation, $p<0.01$).
[64] This finding was statistically significant (Pearson's Chi-squared test, $p<0.001$).

gambling than those who did not; however, van der Mass et al. (2017) did not find an association between the odds of experiencing 'problem gambling' and loneliness as a motivation when adjusting for demographic factors in the same survey. Wider surveys have found associations between experience of loneliness and PGSI score among samples of people who gamble, but do not provide evidence on causality (i.e., whether loneliness was a motivation for gambling). Among a sample of 595 adults aged 65 and over in Britain, loneliness (measured using the De Jong Gierveld Loneliness Scale)[65] was positively associated with PGSI score (Parke et al., 2018). Loneliness (measured using the UCLA Loneliness Scale)[66] was also associated with an increased risk of 'problem gambling' among a sample of 183 people aged 60 and over in Australia (Botterill et al., 2016). Parke et al. (2018) have suggested that gambling to socialise may be less likely to result in harms (e.g., risk-taking which leads to higher financial loss) than gambling to escape negative emotions such as loneliness. However, this view was not substantiated by clear evidence and both motives could potentially lead to a situation of gambling related harms. This is demonstrated by an Australian qualitative study, within which some women (aged 55 and over) who self-identified as being negatively impacted by gambling described how the interlinked benefits of socialising and overcoming loneliness had led them to continue gambling to a point where they were suffering financial harms (McCarthy et al., 2021). Gambling participation to cope with difficult circumstances or events has emerged as a theme throughout these reviews. In the case of older people, isolation and loneliness (likely related to broader societal structures, such as ageism which can result in social exclusion), are linked both to gambling participation and experiences of harm.

Ageist stigma, discrimination, and marginalisation

A few papers briefly mentioned that stigma related to age and wider facets of identity may drive experiences of gambling for some older people. Ageism, which is discrimination based on a person's age, can result in wide-ranging inequalities, including in relation to social connection, healthcare, finances and employment (Age UK, n.d.; Luanaigh and Lawlor, 2008). In a qualitative study with Australian women aged 55 and over who had been negatively impacted by gambling, participants expressed that electronic gambling machine venues were one of the few spaces where older, single women could go to meet people and feel safe (due to the security presence) and not stigmatised (McCarthy et al., 2021). Participants described gambling venues as 'welcoming' and 'inviting' and described feeling safe and included because other people of a similar demographic also attended. Venues were similarly described by participants in a British qualitative study involving people aged 65 and over (Pattinson and Parke, 2016). In these interviews, another view was that attending gambling venues was an opportunity to demonstrate independence. While British participants did not link these factors to stigma and marginalisation, comments could be a reaction to feeling unwelcome, unsafe or 'frail' / 'elderly' in other social or entertainment settings.

One evidence review also cited literature which posited that the impacts of stigma and discrimination experienced by people from minority ethnic communities could accumulate over the life course and culminate in more frequent and harmful gambling in older age (Lee et al., 2007 and Tse et al., 2012 *cited in* Luo and Ferguson, 2017). The same evidence review also cited a source which suggested that ageism may increase negative emotions which could lead to gambling as a distraction or coping mechanism (Zaranek and Lichtenberg, 2008 *cited in* Luo and Ferguson, 2017). However, there was no further discission of these points or the underlying evidence.

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[65] The scale can be found in De Jong Gierveld, J., and Van Tilburg, T. (2006). A 6-Item Scale for Overall, Emotional, and Social Loneliness: Confirmatory Tests on Survey Data. *Research on Aging, 28*(5), 582–598.

[66] The scale can be found in Russell, D., Peplau, L.A., and Ferguson, M. L. (1978). Developing a measure of loneliness. *Journal of Personality Assessment*, 42, 290-294.

Desire for further entertainment and stimulation due to changes in life circumstances

Entertainment commonly emerged as a driver of gambling in interviews, focus groups and surveys with older people (e.g., Martin et al., 2011; Pattinson and Parke, 2016; Keovisai and Kim, 2019; Kim and Kim, 2020; Pitt et al., 2020; Lelonek-Kuleta, 2022). While this would be expected across all age groups, there is some evidence that changes in day-to-day routines during older age can lead to gambling for entertainment purposes. British and Polish qualitative studies involving interviews with older people, found that retirement and other changes in responsibilities (e.g., children moving away from home) can lead to a need for stimulating leisure activities (Pattinson and Parke, 2016; Lelonek-Kuleta, 2021; Lelonek-Kuleta 2022; Lelonek-Kuleta 2023). During interviews with older people in Great Britain and the USA, participants expressed that gambling could be an enjoyable activity for their age group, which was felt to provide excitement, stimulation and beneficial 'exercise' for the mind (Pattinson and Parke, 2016; Keovisai and Kim, 2019). Generally, no links were made between gambling for entertainment purposes and gambling *harm* or 'problem gambling', One evidence review highlighted that while some older adults may experience negative feelings such as boredom due to retirement or reduction in day-to-day responsibilities (which encouraged gambling), there were also examples of older women who had been full-time caregivers for whom "free time…meant freedom" to enjoy leisure activities such as gambling (Luo and Ferguson, 2017, p.305). This paper did not comment on whether these differing motivations had an impact on the likelihood of experiencing gambling harm. However, a Canadian survey of 2,103 people aged 55 and over found that gambling due to boredom was associated with higher average PGSI score while gambling due to entertainment was associated with lower average PGSI score (van der Mass, 2017).

Accessibility / Environmental factors

While social and entertainment-focused motivations and loneliness are not specific to older people, papers suggested that the following factors may cause some older people to choose gambling over alternative leisure activities:

- **Accessibility of gambling activities:** During interviews with British people aged 65 and over and social work practitioners, some participants highlighted that gambling was sometimes the most accessible option for entertainment or socialising for those whose ability to take part in leisure activities was limited due to mobility or geographical factors (Pattinson and Parke, 2016; Bramley et al., 2019). Participants cited physical limitations due to declining mobility and lack of local, accessible opportunities as common barriers to other leisure activities that they had previously enjoyed (e.g., sports). Older people interviewed in Great Britain and Finland have specifically noted being able to access gambling through the television, internet, local shops and community venues (Pattinson and Parke, 2016; Heikanen et al., 2020). Similar findings emerged from focus groups of people aged 55 and over in Australia, who identified that some gambling venues were more accessible (e.g., through accessible car parking) for people with physical mobility constraints when compared to other locally run activities (Pitt et al., 2020).
- **Organised activities focused around gambling / targeted at older people:** In focus groups in Australia with people aged 55 and over, participants discussed attending activities for their age group hosted at gambling venues (Pitt et al., 2020; Pitt et al., 2022). As well as gambling-focused activities, this included wider entertainment such as music and sports like bowls (Pitt et al., 2022). Courtesy transport provided by gambling venues was cited as easy to use in comparison to public or council provided transport and was therefore reported to be a factor which motivated participants to attend gambling venues (Pitt et al., 2020). Within these studies there were some examples of people who attended gambling venues for wider activities and subsequently engaged in gambling. In the same focus groups, participants noted that some marketing initiatives (which appeared to be tailored towards older people) were drivers for attending gambling venues. Examples were cheap meals, discounted entertainment such as music and sports, and "age-specific live entertainment" (Pitt et al., 2020, p.29) (although further details of this were not specified). Participants

reported that these activities incurred lower costs which encouraged attendance to gambling settings over alternatives within the community (Pitt et al., 2020). Similar findings were reported from other countries such as the USA / Canada in evidence reviews (e.g., Luo and Ferguson, 2017). However, authors highlighted a need for further evidence to more fully understand how the actions of the gambling industry impact gambling behaviours and harms among older adults (Johnson et al., 2023). It should be noted that accessibility of gambling and marketing restrictions will be locally / nationally determined and further research would be needed to understand how these factors specifically apply in the British context.

Health

In focus groups and interviews with older people in Britain and Australia, some participants mentioned that gambling could act as a distraction from age-related physical pain (e.g., arthritis) (Pattinson and Parke, 2016; Pitt et al., 2022). However, physical health has not been linked with gambling *harm* or 'problem gambling'. Qualitative studies and evidence reviews have also highlighted that negative emotions resulting from loneliness and changes to day-to-day routines (see above for further detail), age-related pain or other stresses related to age can provide a motivator for gambling, although specific mental health conditions (e.g., depression) were not discussed by participants (Pattinson and Parke, 2016; Luo and Ferguson, 2017; Pitt et al., 2022). Surveys conducted in Great Britain and Canada have examined the association between mental health conditions and 'problem gambling' among groups of older people. In a sample of 595 adults aged 65 and over in Great Britain who had gambled at least once within the past 12 months, anxiety was found to predict 'problem gambling' (measured using PGSI) (Parke et al., 2018). Gambling to cope with anxiety or depression was also associated with higher odds of 'problem gambling' (measured using PGSI) in a Canadian survey of 2,103 people aged 55 and over, although this relationship did not persist when the statistical model was adjusted to account for all other variables (e.g., wider motivations for gambling) (Van der Maas et al., 2017).

Links have also been made between gambling and changes in cognitive functioning in older age, both generally and in respect of specific conditions which particularly impact older people (e.g., Parkinson's disease) and may influence attitudes towards gambling (Guillou Landreat et al., 2019; Granero et al., 2020b). In a USA survey of 88 social service professionals working with older people, some respondents felt that conditions impacting memory or cognitive functioning (e.g., dementia) may influence how some of their clients viewed the risks of gambling participation (Stansbury et al., 2015). However, this view was not explored in detail, views of those with lived experience were not sought and almost half (42%) of respondents felt their clients were largely aware of the risks associated with gambling. As highlighted in Chapter 7, the impact of neurological conditions was not considered in detail in these reviews.

Attitudinal factors

Two evidence reviews (Alberghetti and Collins, 2015; Thompson et al., 2016) suggested that attitudes towards gambling and help-seeking may vary across different age groups due to different life experiences or common 'generational traits'. Focus groups in Finland with people aged 61-71 demonstrated how views towards gambling could be impacted by societal attitudes and cultures experienced across the lifetime (Heiskanen and Matilainen, 2020). This demonstrates the potential for attitudes to change across generations. However, no robust evidence, such as attitudinal surveys, was provided to evidence these claims.

10.5 Protective factors

There was some, limited, evidence on protective factors which aligns with some of the drivers of gambling / gambling related harms described above:

- **Social or entertainment-focused motives for gambling:** During interviews and focus groups with people aged 55 and over in Australia and Poland, some participants expressed that they had not experienced gambling related harm due to their motives for gambling – this included primarily attending gambling venues for other purposes (e.g., social activities) and gambling for entertainment (Pitt et al., 2020; Lelonek-Kuleta, 2021). A Canadian survey of 2,103 people aged 55 and over found that respondents who gambled with family and friends had lower PGSI scores (on average) than those who did not (Elton-Marshall et al., 2018). In this sample, married respondents were more likely to gamble with friends or family (and have lower PGSI scores) than those who were single, divorced or widowed. However, (as discussed in section 9.4) there will be many wider factors which impact the social context within which older people gamble.
- **Factors which reduce experiences of loneliness or provide alternative means for socialising:** Given the potential links between loneliness and experiences of 'problem gambling' (see section 9.4), it has been suggested that factors which reduce experiences of loneliness may act as protective factors against gambling related harm (e.g., Botterill et al., 2016). One evidence review suggested that availability of other social activities may be a protective factor (Luo and Ferguson, 2017), however the evidence for this statement was unclear.
- **Financial restrictions:** One evidence review suggested that financial restrictions can act as a barrier to more frequent or harmful gambling, which could impact older people living on lower incomes (e.g., small pensions) (Luo and Ferguson, 2017). In interviews with women over the age of 55 in Poland, some participants expressed that despite gambling regularly, they only spent small sums of money due to their limited financial resources (along with an understanding that they were unlikely to win) (Lelonek-Kuleta, 2021). However, this evidence was limited and should be interpreted with caution. As highlighted above, financial restrictions can also motivate gambling activity among older people and gambling for financial motives has been linked to higher PGSI scores (van der Mass, 2017). It has also been suggested that financial harms (e.g., incurring debts or being unable to meet basic needs) could be more likely for older people on lower incomes who do engage in gambling (Stansbury et al., 2015).

10.6 Service and healthcare provision

Barriers to accessing services and healthcare provision for gambling

There is a lack of evidence on barriers to accessing services and healthcare provision for older people, and research which does exist presents overly generalised statements on the basis of age. In an Australian qualitative study with women aged 55 and over, some participants felt that stigma around gambling made it more difficult to seek help (McCarthy et al., 2021). However, participants did not link this barrier to age. Martin et al. (2011) suggested that some older people may be particularly likely to experience stigma because gambling is less common among their age group. However, this opinion was based on a small study exploring casino gambling among people in Detroit and did not align with other findings (see section 9.4) which highlighted that gambling is a popular leisure activity for some groups of older people. While some further barriers (particularly 'generational attitudes' and lower awareness of support options) were suggested in wider papers (e.g., Martin et al., 2011; Alberghetti and Collins., 2013; Stansbury et al., 2015; Subramaniam et al., 2015; Thompson and McNeilly, 2016), no clear evidence was provided to support these opinions.

Consideration of the needs of older people in support / treatment provision

It has been suggested that social workers in Great Britain would be well-placed to identify and support those experiencing gambling related harms, including older people (Bramley et al., 2017; Bramley et al., 2019). However, during interviews with social work practitioners in the UK, concerns were voiced about knowledge gaps in this area (Bramley et al., 2019). Participants generally had little experience of supporting clients experiencing gambling harms and felt that more training and guidance was needed on identifying risks / harms and providing / signposting to support. GambleAware and GamCare now offer resources for healthcare

professionals (including social care workers) to support identification, understanding and support of people experiencing gambling related harms.[67] However, this review found no wider evidence about consideration of the needs of older people among social workers or other professional groups.

Innovative or promising programmes and approaches

No papers considered any existing programmes in any detail. While one paper highlighted that some organisations based in Great Britain are seeking to provide accessible social events to older people "as a replacement for gambling" (Parke et al., 2018, p.142), no further detail was provided.

10.7 Recommendations

Given the limited evidence on gambling harms among older people, these recommendations focus on the need for further research to inform policy and practice.

Limitation of current research / justification: While there is evidence about drivers of / motivations for gambling among older people, it is not always clear how specific factors link to gambling *harm.* As discussed above, in some cases gambling activities currently provide important opportunities for entertainment and social connection for older people. Therefore, it is important to understand what factors specifically drive, and distinguish, experiences of gambling harms among this age group.

Recommendations:

- Further quantitative research should specifically explore drivers of gambling related harms among older people. *The Gambling Survey of Great Britain* will be an important data source for this research, as it will enable exploration of whether / how older age is associated with *specific* harms (e.g., financial, social).
- Further qualitative research with older people with experience of gambling related harms (who could be identified via the aforementioned survey) should then be undertaken to better understand drivers of specific harms, including how age intersects with wider factors (e.g., accessibility of leisure activities and ageism) to influence these drivers.

Limitation of current research / justification: Given the lower rates of 'problem gambling' among older people in Great Britain and gaps in knowledge identified by social care professionals, there is a risk that those experiencing gambling related harms in older age may be less likely to be identified and supported. However, there is currently no clear evidence about barriers to treatment and support for older people, or about innovative or promising programmes targeted to this group.

Recommendations:

- Further qualitative research needs to explore the support needs of older people experiencing gambling harms, any barriers to treatment and support, and whether effective targeted programmes exist / are required. As well as engagement with older people with lived experience, it would be helpful to seek views from social care professionals and organisations who commonly support older people.

Limitation of current research / justification: Within the literature, there were examples of stereotypes / perceptions of older people leading to assumptions about drivers of gambling related harms (e.g., vulnerability, risk-awareness, loneliness and boredom). However, there was some evidence of the impact of wider societal factors on gambling activity among older people, particularly the accessibility of social spaces.

[67] https://www.begambleaware.org/for-professionals/health-and-social-care; https://www.kcl.ac.uk/research/identifying-gambling-harms.

Recommendations:

- While researchers should be open to capturing evidence on a range of drivers, it will be important to recognise and draw out societal factors (e.g., accessibility, stigma) which drive gambling related harms to better understand how these can be reduced.

11. Overall reflections and recommendations

11.1 Key findings across the scoping reviews

This report has set out findings from six scoping reviews which synthesised the latest available evidence (both academic and grey literature) on gambling harms among specific communities experiencing marginalisation, isolation and / or criminalisation. The six communities of interest were (1) people living with disabilities, neurodiversity and / or mental health challenges; (2) people who experience or are at risk of homelessness; (3) people with experience of unemployment, peripheral employment, or insecure employment; (4) migrants in vulnerable circumstances (e.g., asylum seekers) and transient communities; (5) older people; and (6) criminalised and / or moralised communities (including people who use illicit / illegal drugs). The reviews prioritised the inclusion of evidence related to the societal drivers of gambling harm and because of this some literature (for example, related to cognitive functioning in neurological conditions) was excluded.

Rates of gambling harm

Overall, there was limited evidence identified about rates of gambling harm among the six communities of interest. With the exception of data routinely collected through national gambling-focused surveys (e.g., age), available evidence tended to be from small, local / discrete samples (often from outside Great Britain). While this would be expected given the nature of the six communities,[68] it makes it challenging to conclude on rates across the communities as a whole and make comparisons with general population figures on gambling harms. Previous research has also focused on rates of 'problem gambling', 'pathological gambling' or 'gambling disorder' (with the most common measure used being the Problem Gambling Severity Index (PGSI)) rather than explicitly focusing on harms from gambling (e.g., financial harms, social harms). When exploring findings based on these 'proxy' measures of harm, there was some evidence of high rates for some specific groups - in particular, communities of people experiencing homelessness and poverty (including those on low incomes and those living in deprived areas),[69] people with experience of migration, some people with experience of drug use, people living with certain mental health challenges and people with attention deficit hyperactivity disorder (ADHD). However, the findings from these reviews have emphasised quantitative data provides only one part of the picture of gambling harms for these communities. For example, nationally representative surveys have demonstrated lower rates of 'problem gambling' among older people yet there are unique challenges within this community which can drive engagement with gambling and gambling harms.

Drivers of gambling and gambling harm

Evidence most commonly focused on drivers of gambling participation rather than pathways to *harm* or did not distinguish between the two. Although the reviews identified a wide variety of drivers, there were a number of experiences which impacted people across multiple communities such as:

- **Use of gambling as a mechanism to cope with difficult emotions or experiences**, including mental health challenges, or stress related to the process of migration / acculturation, unemployment / challenges relating to job security and conditions, homelessness, discrimination, or poverty. While experiences differed across and

[68] Communities were often small and underrepresented in traditional / large-scale quantitative research.
[69] Authors used various measures of area deprivation including Indices of Multiple Deprivation (IMD) and the Carstairs index.

within communities, each review identified examples of gambling harms driven by intersecting life challenges, often grounded in the marginalisation, isolation, stigmatisation or criminalisation of certain groups.

- **Factors influencing the need for entertainment / social connection** (e.g., loneliness / isolation, changes to day-to-day routines / responsibilities). This includes isolation and loneliness related to experiences of migration, racial discrimination, homelessness or mental health challenges, as well as changes to day-to-day routines due to retirement or leaving prison.
- **Gambling / gambling venues being perceived as accessible and inclusive when compared to other options for social connection or entertainment / stimulation which excluded people from these communities** (due to physical mobility / health, language barriers etc.). For some people (e.g., those experiencing homelessness) these venues could also provide a safe, warm space. There was some evidence of these drivers being exacerbated by the actions of the gambling industry (e.g., marketing techniques), however this was not considered in Great Britain specifically.
- **Financial motivations**, linked to low incomes / pensions and financial responsibilities (e.g., caring for dependants in another country). However, the relationships between financial resources and gambling are complex, with (limited) evidence suggesting that lower income can exacerbate and mitigate the risks of gambling harm.

Although experiences vary across and within communities, key underlying drivers are affecting multiple groups and leading to higher levels of gambling participation and gambling harm. Many of these factors are linked to wider societal issues including structural inequality, accessibility of public / social spaces, financial exclusion and poverty, social exclusion and discrimination or criminalisation. This relationship also has a geographic and spatial element, with more deprived neighbourhoods in Great Britain having a higher concentration of gambling venues (Rogers et al., 2019; Bramley et al., 2020) and marginalised, isolated or criminalised communities being more likely to live in deprived areas in Great Britain due to socioeconomic disenfranchisement (for example, people who use drugs (Scottish Government, 2023), people living with mental health challenges (Marmot et al., 2010), people experiencing social exclusion (Boardman et al., 2022) and disabled people (ONS, 2023)). Stigma was also identified as contributing to experiences of gambling / gambling harm and access to support and treatment. Many people in the included communities will be experiencing compounding stigma (for example, related to drug use, homelessness, or mental health challenges). Despite their varied experiences, what the groups brought together in this review have in common is the inequitable context in which they live in postcolonial Great Britain (and similar contexts). This is a context in which power and privilege is maintained through the process of constructing certain communities as ‘other’ (Said, 1978) – be that due to race, age, disability, social class, activity, and/ or employment. Such disproportionate burdens of gambling harm are not because of anything inherent and immutable about these communities, but rather these shared contexts.

All communities considered in this review are broad and heterogenous and many findings come from small, discrete qualitative studies. These findings on drivers of gambling and gambling harm should therefore be taken as indications of the types of challenges faced, rather than an exhaustive list.

Service and healthcare provision

Overall, there was limited evidence about specific service and healthcare needs for communities experiencing marginalisation, isolation or criminalisation. Although a small number of named programmes or services were identified that aimed to reduce gambling harm within specific groups, very little (if any) detail was given as to why and how the innovative nature of the services appeared to have led to positive outcomes for the community in question. There was also a lack of evidence about the outstanding needs of these communities in Great Britain in relation to existing provision. Many authors highlighted the potential benefits of integrated and joined up service delivery as part of a public health approach to tackling gambling harm. This ranged from improving

knowledge of and awareness of gambling harms in healthcare, social care services and the charity sector, signposting or screening for gambling harm in other services or institutions (e.g., within prisons or mental health services) or integrated services which aim to tackle often closely linked issues simultaneously (e.g., gambling harm alongside poverty, housing insecurity, drug-related harm or mental health challenges). Research also highlighted barriers to accessing gambling support related to shame and stigma, which was often exacerbated by intersecting stigmas related to wider factors (e.g., drug use, homelessness, sexuality) and fears driven by previous negative experiences accessing wider healthcare / support services.

Authors have noted that policies and interventions related to gambling harm tend to focus on individual responsibility, and often do not address the wider and social economic factors (such as access to support or stigma and discrimination) that are involved in gambling harm (Rogers et al., 2019). This is the case with some evidence identified in these reviews, with suggestions for service and healthcare provision tending to focus on individual treatment plans, often in clinical settings, without recognition of broader influencing factors. It is also important to recognise that the communities included in these reviews are not homogenous and service and healthcare needs will not be the same within groups. Services must instead be accessible, inclusive, and adaptable to various needs. This may require services to adapt or change current provision, and subsequently may require additional resources (e.g. for staff training or expansion of current provision).

11.2 Strengths and weaknesses of included research

Research included in these reviews has given insight into potentially higher levels of gambling harm for some communities experiencing marginalisation, isolation or criminalisation. Despite clear evidence gaps there is nationally representative data available for some groups (mainly using PGSI which is intended to capture rates of ‘problem gambling’ rather than harm) – in particular for older people, people who are unemployed, those born outside the UK, people living in deprived areas and people with certain mental health conditions. As mentioned above, it would be rare for these types of national studies to capture data on the experiences of some communities due to factors such as sample sizes, so some gaps in evidence were unsurprising. There is also a wide range of qualitative studies exploring drivers of gambling harm and barriers to healthcare and support among various communities. Although these studies are small scale and have often looked at specific local groups, research has pointed to many similar drivers of harm both within and between communities and the in-depth nature of the evidence allows a fuller understanding of pathways to gambling / gambling harm.

There were several key limitations of existing evidence which have limited the conclusions of these scoping reviews:

- **For some communities there was no or very limited evidence about experiences of gambling harm, either from Great Britain or comparable contexts** – in particular there are substantial gaps about people with experience of peripheral or insecure employment, sex workers, asylum seekers and refugees, and Gypsy, Roma and Traveller communities. Given that these communities are subject to marginalisation, stigmatisation and in some cases moralisation, it is reasonable to suggest that they may be at higher risk of gambling harms (in line with the findings from these reviews linking marginalisation to gambling participation and harm) and further scoping work is needed to explore experiences of gambling harms within these communities.
- **There is a lack of evidence about the experiences of communities experiencing marginalisation, isolation or criminalisation specifically in Great Britain, with the evidence base for many reviews drawing heavily on evidence from Australia, the USA and Canada as well as other countries** – although data from comparable contexts gives indications of potential higher and lower levels of gambling harm for some groups, rates of harm may be different in Great Britain. Similarly, drivers of gambling and gambling

harm may vary in Great Britain, particularly when experience of harm interrelates to national laws and policy (e.g., related to criminalisation) or specificities of the healthcare sector (such as referral pathways).

- **Despite a growing focus on a public health model for gambling (emphasising the importance of harm reduction at the population level), research identified in this review has largely focused on individual behaviours and personal risk factors for harm and viewed from an 'addiction-based framework' (Hancock and Smith, 2017)** – in line with this, quantitative research has largely relied on measures of 'problem gambling' or 'pathological gambling' (using screening tools such as the PGSI or the South Oaks Gambling Screen (SOGS)) or clinical diagnosis of 'gambling disorder' using Diagnostic and Statistical Manual (DSM) criteria, rather than gambling harms measurement tools. This approach risks the production of research solely focused on the attributes which make marginalised communities 'vulnerable' to gambling harm which may lead to increased stigma or blame placed on communities for the harms they are experiencing. The lack of detail on specific harms (e.g., impacts on resources or health) also limits understanding about *how* gambling may be negatively impacting these communities.
- **There was a lack of discussion in papers about the role of wider factors in the production of harm, including the role of national policies (e.g., related to crime, immigration or welfare) as well as the role of the gambling industry and other organisations** – these factors will likely affect communities in various ways and impact both their experiences of gambling harm and access to support services. Research should recognise (and explore) the role of the government, healthcare providers, the gambling industry and wider providers of leisure activities in both exacerbating and reducing gambling harm. For example, research has found that people with a minority ethnic background have a higher chance of experiencing gambling harm as well as being over-represented in the criminal justice system. Authors have stressed that there is a need for a clearer understanding of the racialised aspect of criminalisation and a need to understand how certain groups are criminalised for gambling related crime (Brown et al., 2023).

11.3 Cross cutting recommendations for future research, service provision and policy

Overall, these reviews have shown that there is an urgent need for further research in Great Britain to explore gambling harms among communities experiencing marginalisation, isolation or criminalisation. There are stark gaps in evidence about people with experience of peripheral or insecure employment including sex workers, asylum seekers and refugees, and Gypsy, Roma and Traveller communities. There is also a need for further research across all communities included in these reviews to understand drivers and experiences of harm, and needs related to healthcare and service provision in Great Britain. Given the limited evidence (specifically with regard to treatment and support) the recommendations focus on the need for further research to inform policy and practice rather than direct recommendations for practitioners or policy. Overall, future research exploring gambling harms among marginalised, isolated and criminalised communities should:

- **Use gambling harms measurement tools to explore the full range of potential gambling harms including financial, social and health harm** – existing research has largely relied on measures of 'problem gambling' or 'pathological gambling' (using screening tools such as the PGSI or SOGS) or clinical diagnosis of 'gambling disorder' using DSM criteria, rather than harms measurement tools. Developed several decades ago, these tools are not based on robust theoretical frameworks of harm and newer measurement tools should be used such as the Short Gambling Harms Screen (SGHS) or the gambling harms questions which are being deployed in the upcoming Gambling Survey for Great Britain (Close et al., 2023). This would allow more robust measurement of gambling harm and allow researchers to explore patterns related to types of harm (e.g., financial vs social harm). Researchers should explore options for adding variables (either related to gambling harm or the communities themselves) to existing gambling surveys run by GambleAware and the Gambling Commission. However, there would likely be challenges with sample sizes for some communities

and the accessibility of surveys (e.g., for people without a registered address / phone number / internet access) should be considered. For some communities, qualitative methods would likely be more suitable.

- **Take an intersectional approach to develop a more in-depth understanding of drivers of gambling harm** – there is an urgent need for research which explores the drivers of harm through an intersectional lens, considering how social factors such as structural discrimination, stigmatisation, inequality, isolation, and poverty relate to different facets of people's lived experience (e.g., age, migration status, living circumstances) and interact to drive / exacerbate gambling harm. These reviews have shown clear links between these factors and experiences of harm but existing research about communities experiencing marginalisation, isolation and criminalisation has often focused on individual risk factors (e.g., personality characteristics) for gambling harm. There is a need for research which aims to explore harm at the population level and understand the societal inequalities and structures which contribute to the marginalisation of various communities and the relationship between these broader factors and gambling harm.
- **Explore joined up working practices in Great Britain and signposting between services as well as potential areas of service integration** – across the reviews authors highlighted a need for improving knowledge about gambling harms within healthcare and other services and joined up working practices, including better screening for gambling harm (e.g., screening within prisons) and signposting (e.g., signposting to gambling support services within homelessness services), or integrated support (e.g., support which combines mental health and gambling harm intervention). There is emerging evidence that integrated support could in some cases reduce appointments and allow for more holistic care but there is a need to develop the evidence base for integrated support options in Great Britain. Case study evaluations of existing services would be particularly helpful to highlight the benefits and challenges of various approaches and future opportunities.
- **Involve people from within marginalised, isolated and criminalised communities in the design and interpretation of research** – research should be co-produced by those with experience of gambling harm and marginalisation, isolation and criminalisation. This will ensure that research explores the right questions, is insightful, does not stigmatise or make assumptions and benefits the communities in question. Researchers should work collaboratively with trusted organisations who have existing relationships with communities. This approach may take longer and require more resources and research timelines and funding should be considered accordingly.

12. Included papers

People living with disabilities, neurodiversity and / or mental health challenges

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People who experience or are at risk of homelessness

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Appendix 1: Search Strings

The final search strings used in electronic academic databases *Scopus, PsychInfo, PubMed and Sociological Abstracts* for academic literature[70] are shown in Tables 1-24 below.

Table 1 Disabilities and Mental Health search strings in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**
2	Disabled persons[mesh] OR disabilit*[tiab] OR disabled[tiab] OR differently abled[tiab] OR handicap*[tiab] OR visual impair*[tiab] OR visually impair*[tiab] OR hearing impair*[tiab] OR biopsychosocial[tiab] OR social model*[tiab]	351,272
3	depressive disorder[mesh:noexp] OR depression[mesh] OR anxiety[mesh:noexp] OR anxiety disorders[mesh:noexp] OR Attention Deficit Disorder with Hyperactivity[mesh] OR Stress Disorders, Post Traumatic[mesh:noexp] OR suicide[mesh:noexp] OR mental disorders[mesh:noexp] OR Personality Disorders[mesh] OR autism spectrum disorder[mesh]	663,802
4	neurodivers*[tiab] OR depressi*[tiab] OR anxiety[tiab] OR somatic symptom disorder[tiab] OR ADHD[tiab] OR PTSD[tiab] OR post-traumatic stress disorder[tiab] OR attention deficit disorder[tiab] OR suicid*[tiab] OR mental disorder*[tiab] OR borderline personality disorder*[tiab] OR antisocial personality disorder*[tiab] OR histrionic personality disorder*[tiab] OR narcissistic personality disorder*[tiab] OR autism[tiab] OR autistic[tiab] OR asperger*[tiab]	831,086
5	#2 OR #3 OR #4	1,365,794
6	#1 AND #5	2458
7	Date limit: 2010 to present	1734

Table 2 Disabilities and Mental Health search strings in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,406**
2	TITLE-ABS(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*")	502,193

[70] The final search for all databases was conducted on 21st June 2023.

3	TITLE-ABS(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*" OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*)	1,160,976
4	#2 OR #3	1,613,280
5	#1 AND #4	2684
6	Date limit: 2010 to present	1950

Table 3 Disabilities and Mental Health search strings in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**14,990**
2	TI(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*") OR AB(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*") OR SU(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*") OR KW(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*")	222,612
3	TI(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*" OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*) OR AB(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*" OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*) OR SU(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*" OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*) OR KW(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*"	822,624

	OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*)	
4	S2 OR S3	996,499
5	S1 AND S5	2,884
6	Date limit: 2010 to present	1803

Table 4 Disabilities and Mental Health search strings in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**2422**
2	TITLE,ABSTRACT,IF(disabilit* OR disabled OR "differently abled" OR handicap* OR "visual impair*" OR "visually impair*" OR "hearing impair*" OR biopsychosocial OR "social model*")	23,794
3	TITLE,ABSTRACT,IF(neurodivers* OR depressi* OR anxiety OR "somatic symptom disorder" OR ADHD OR PTSD OR "post-traumatic stress disorder" OR "attention deficit disorder" OR suicid* OR "mental disorder*" OR "borderline personality disorder*" OR "antisocial personality disorder*" OR "histrionic personality disorder*" OR "narcissistic personality disorder*" OR autism OR autistic OR asperger*)	52,280
4	S2 OR S3	74,293
5	S1 AND S4	150
6	Date limit: 2010 to present	71

Table 5 Sex workers, people who use drugs, and other moralised or criminalised communities search strings in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,379**
2	TITLE-ABS ("sex work*" OR prostitut*)	20,197
3	TITLE-ABS ("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) W/3 (drug* OR substance)))	247,948

4	TITLE-ABS (parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*")	9448
5	TITLE-ABS ((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*))	36,027
6	#2 OR #3 OR #4 OR #5	307,821
7	#1 AND #6	2257
8	Limit 2010-present	1665

Table 6 Sex workers, people who use drugs, and other moralised or criminalised communities search strings in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**
2	Sex Work[mesh] OR Sex Workers[mesh] OR "sex work*"[tiab] OR prostitut*[tiab]	13,365
3	Substance-Related Disorders[mesh] OR "drug use*"[tiab] OR "drug addiction"[tiab] OR "substance use*"[tiab] OR "substance misuse"[tiab] OR "drug misuse"[tiab] OR "substance abuse*"[tiab] OR "drug abuse*"[tiab] OR "drug depend*"[tiab] OR ((person[tiab] OR people[tiab) AND (drug*[tiab] OR substance[tiab]))	440,101
4	parolee*[tiab] OR probation*[tiab] OR "released prisoner*"[tiab] OR "prison leaver*"[tiab] OR "forensic population*"[tiab]	2397
5	(criminalis*[tiab] OR criminaliz*[tiab] OR moralis*[tiab] OR moraliz*[tiab] OR prohibit*[tiab]) AND (population*[tiab] OR communit*[tiab] OR person*[tiab] OR people[tiab] OR group*[tiab] OR individual*[tiab])	12,163
6	#2 OR #3 OR #4 OR #5	462,263
7	#1 AND #6	2289
8	Limit 2010-present	1645

Table 7 Sex workers, people who use drugs, and other moralised or criminalised communities search strings in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,379**
2	TI("sex work*" OR prostitut*) OR AB("sex work*" OR prostitut*) OR KW("sex work*" OR prostitut*) OR SU("sex work*" OR prostitut*)	7485
3	TI("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) N3 (drug* OR substance))) OR AB("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) N3 (drug* OR substance))) OR SU("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) N3 (drug* OR substance))) OR KW("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) N3 (drug* OR substance)))	162,712
4	TI(parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*") OR AB(parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*") OR KW(parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*") OR SU(parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*")	6516
5	TI((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*)) OR AB((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*)) OR SU((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*)) OR KW((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*))	6646
6	S2 OR S3 OR S4 OR S5	179,950
7	S1 AND S6	2278
8	Limit 2010-present	1560

Table 8 Sex workers, people who use drugs, and other moralised or criminalised communities search strings in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**2422**
2	TITLE,ABSTRACT,IF("sex work*" OR prostitut*)	7289
3	TITLE,ABSTRACT,IF("drug use*" OR "drug addiction" OR "substance use*" OR "substance misuse" OR "drug misuse" OR "substance abuse*" OR "drug abuse*" OR "drug depend*" OR ((person OR people) NEAR/3 (drug* OR substance)))	21,798
4	TITLE,ABSTRACT,IF(parolee* OR probation* OR "released prisoner*" OR "prison leaver*" OR "forensic population*")	3772
5	TITLE,ABSTRACT,IF((criminalis* OR criminaliz* OR moralis* OR moraliz* OR prohibit*) AND (population* OR communit* OR person* OR people OR group* OR individual*))	5646
6	#2 OR #3 OR #4 OR #5	37,018
7	#1 AND #6	230
8	Limit 2010-present	95

Table 9 People who experience or are at risk of homelessness search strings in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE-ABS (homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) W/3 (accommodat*)) OR ((temporary OR unstable) W/3 (accommodat* OR housing)))	27,016
3	#1 AND #2	79
4	Limit 2010-present	62

Table 10 People who experience or are at risk of homelessness search strings in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**

2	Ill-Housed Persons[mesh] OR homeless*[tiab] OR unhoused[tiab] OR "ill-housed"[tiab] OR "rough sleep*"[tiab] OR houseless*[tiab] OR "sofa surf*"[tiab] OR ((shelter*[tiab]) AND (accommodat*[tiab])) OR ((temporary[tiab] OR unstable[tiab]) AND (accommodat*[tiab] OR housing[tiab]))	17,988
3	#1 AND #2	55
4	Limit 2010-present	44

Table 11 People who experience or are at risk of homelessness search strings in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TI(homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) N3 (accommodat*)) OR ((temporary OR unstable) N3 (accommodat* OR housing))) OR AB(homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) N3 (accommodat*)) OR ((temporary OR unstable) N3 (accommodat* OR housing))) OR SU(homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) N3 (accommodat*)) OR ((temporary OR unstable) N3 (accommodat* OR housing))) OR KW(homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) N3 (accommodat*)) OR ((temporary OR unstable) N3 (accommodat* OR housing)))	26,973
3	S1 AND S2	44
4	Limit 2010-present	44

Table 12 People who experience or are at risk of homelessness search strings in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE,ABSTRACT,IF (homeless* OR unhoused OR "rough sleep*" OR houseless* OR "sofa surf*" OR ((shelter*) NEAR/3 (accommodat*)) OR ((temporary OR unstable) NEAR/3 (accommodat* OR housing)))	3430
3	#1 AND #2	4
4	Limit 2010-present	3

Table 13 People with experience of unemployment, peripheral employment, or insecure employment in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE-ABS(unemploy* OR ((peripheral*) W/3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) W/3 (employ* OR work* OR job*)))	84,873
3	#1 AND #2	161
4	Limit 2010-present	118

Table 14 People with experience of unemployment, peripheral employment, or insecure employment in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**
2	(unemploy*[tiab] OR ((peripheral*[tiab]) AND (employ*[tiab])) OR "economic inactivity"[tiab] OR "out of work"[tiab] OR "economically inactive"[tiab] OR jobless*[tiab] OR ((insecure[tiab] OR unstable[tiab] OR precari*[tiab]) AND (employ*[tiab] OR work*[tiab] OR job[tiab] OR jobs[tiab])))	45,759
3	#1 AND #2	98
4	Limit 2010-present	76

Table 15 People with experience of unemployment, peripheral employment, or insecure employment in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TI(unemploy* OR ((peripheral*) N3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) N3 (employ* OR work* OR job*))) OR AB(unemploy* OR ((peripheral*) N3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) N3 (employ* OR work* OR job*))) OR SU(unemploy* OR ((peripheral*) N3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) N3 (employ* OR work* OR job*))) OR KW(unemploy* OR ((peripheral*) N3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) N3 (employ* OR work* OR job*)))	11,390

3	S1 AND S2	76
4	Limit 2010-present	76

Table 16 People with experience of unemployment, peripheral employment, or insecure employment in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE,ABSTRACT,IF(unemploy* OR ((peripheral*) NEAR/3 (employ*)) OR "economic inactivity" OR "out of work" OR "economically inactive" OR jobless* OR ((insecure OR unstable OR precari*) NEAR/3 (employ* OR work* OR job*)))	24,328
3	#1 AND #2	39
4	Limit 2010-present	14

Table 17 Older people search strings in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE-ABS(aged OR aging OR ageing OR elder* OR ((old OR retired) W/2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*)	2,904,006
3	#1 AND #2	1637
4	Limit 2010-present	1223

Table 18 Older people search strings in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**
2	(aged[mesh] OR aged[tiab] OR aging[tiab] OR ageing[tiab] OR elder*[tiab] OR ((old[tiab] OR retired[tiab]) AND (people*[tiab] OR person*[tiab] OR individual*[tiab] OR woman[tiab] OR women[tiab] OR man[tiab] OR men[tiab] OR age[tiab])) OR older*[tiab] OR geriatr*[tiab] OR gerontolog*[tiab] OR senior*[tiab] OR senescen*[tiab] OR retiree*[tiab] OR sexagenarian*[tiab] OR	4,908,602

	septuagenarian*[tiab] OR octagenarian*[tiab] OR nonagenarian*[tiab] OR centenarian*[tiab] OR supercentenarian*[tiab] OR veteran*[tiab])	
3	#1 AND #2	2384
4	Limit 2010-present	1599

Table 19 Older people search strings in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TI(aged OR aging OR ageing OR elder* OR ((old OR retired) N2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*) OR AB(aged OR aging OR ageing OR elder* OR ((old OR retired) N2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*) OR KW(aged OR aging OR ageing OR elder* OR ((old OR retired) N2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*) OR SU(aged OR aging OR ageing OR elder* OR ((old OR retired) N2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*)	411,573
3	S1 AND S2	1825
4	Limit 2010-present	1825

Table 20 Older people search strings in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE,ABSTRACT,IF (aged OR aging OR ageing OR elder* OR ((old OR retired) NEAR/2 (people* OR person* OR individual* OR woman OR women OR man OR men OR age)) OR older* OR geriatr* OR gerontolog* OR senior* OR	21,805

	senescen* OR retiree* OR sexagenarian* OR septuagenarian* OR octagenarian* OR nonagenarian* OR centenarian* OR supercentenarian* OR veteran*)	
3	#1 AND #2	29
4	Limit 2010-present	22

Table 21 Vulnerable migrant or transient communities in Scopus

1	**TITLE-ABS(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE-ABS(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) W/3 (seek*)) OR ((nomadic OR traveller*) W/2 (population* OR communit*)) OR traveller* OR roma OR gypsy)	2,150,541
3	#1 AND #2	583
4	Limit 2010-present	419

Table 22 Vulnerable migrant or transient communities in PubMed

1	**Gambling[Mesh] OR gambling[tiab] OR gamble*[tiab] OR betting[tiab] OR bettor*[tiab] OR "loot box*"[tiab]**	**12,735**
2	(Transients and Migrants[mesh] OR Emigrants and Immigrants[mesh] OR Roma[mesh] OR transient*[tiab] OR migrant*[tiab] OR immigrant*[tiab] OR refugee*[tiab] OR migrat*[tiab] OR ethnic*[tiab] OR racis*[tiab] OR ((asylum[tiab]) AND (seek*[tiab])) OR ((nomadic[tiab] OR traveller*[tiab]) AND (population*[tiab] OR communit*[tiab])) OR traveller*[tiab] OR roma[tiab] OR gypsy[tiab])	1,006,704
3	#1 AND #2	280
4	Limit 2010-present	216

Table 23 Vulnerable migrant or transient communities in PsycInfo

1	**TI(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR AB(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR KW(gambling OR gamble* OR betting OR bettor* OR "loot box*") OR SU(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**

2	TI(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) N3 (seek*)) OR ((nomadic OR traveller*) N2 (population* OR communit*)) OR traveller* OR roma OR gypsy) OR AB(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) N3 (seek*)) OR ((nomadic OR traveller*) N2 (population* OR communit*)) OR traveller* OR roma OR gypsy) OR SU(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) N3 (seek*)) OR ((nomadic OR traveller*) N2 (population* OR communit*)) OR traveller* OR roma OR gypsy) OR KW(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) N3 (seek*)) OR ((nomadic OR traveller*) N2 (population* OR communit*)) OR traveller* OR roma OR gypsy)	248,490
3	S1 AND S2	397
4	Limit 2010-present	261

Table 24 Vulnerable migrant or transient communities in Sociological Abstracts

1	**TITLE,ABSTRACT,IF(gambling OR gamble* OR betting OR bettor* OR "loot box*")**	**27,351**
2	TITLE,ABSTRACT,IF(transient* OR migrant* OR immigrant* OR refugee* OR migrat* OR ethnic* OR racis* OR ((asylum) NEAR/3 (seek*)) OR ((nomadic OR traveller*) NEAR/2 (population* OR communit*)) OR traveller* OR roma OR gypsy)	215,541
3	#1 AND #2	135
4	Limit 2010-present	57

Appendix 2: Inclusion and exclusion criteria

Inclusion and exclusion criteria

Criterion	Inclusion criteria	Exclusion criteria
Topic	• Paper must consider at least one of the following: – Rates of gambling harms; – Drivers of gambling / gambling harms; – Protective factors which reduce or prevent gambling harms; – Barriers to accessing service and healthcare provision; – Provision and support for people experiencing gambling harms, including an exploration of innovative or promising programmes or services.	• Literature which is not relevant to these topics
Population	• Findings relevant to the above topics must relate to at least one of the following groups: – Sex workers, people who use illegal drugs, people who have left prison and other moralised or criminalised communities which emerge during the searches and screening; – People who experience or are at risk of homelessness;[71] – People with experience of unemployment, peripheral employment, or insecure employment; [72] – Older people; – Vulnerable migrant or transient communities, specifically including refugee/asylum seeker/gypsy/Roma/traveller communities; and / or – People with disability, neurodiversity and / or mental health challenges (interpreted broadly).	• Papers which do not contain any findings specific to individuals from these communities.

[71] We used Crisis guidance to identify populations experiencing homelessness (https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/types-of-homelessness/). Communities of risk of homelessness either fell within the Crisis definitions or were identified as 'at risk' within the research in question.
[72] For the purpose of this study, the term 'peripheral employment' was taken to refer to types of employment that are normatively atypical or irregular. The term 'insecure employment' includes employment where employment status or financial security is uncertain. Searches for peripheral and insecure employment were made broadly. When deciding whether an employment was included or excluded, we focused on whether this group experiences burdens of health and wellbeing challenges as a result of marginalisation or stigmatisation. For example, we considered factors such as lack of employee benefits, low pay, volatile working hours, poor working conditions and uncertain working arrangements.

Evidence type/methods	We will include all types of research (i.e., quantitative, qualitative, mixed methods).	Protocols, opinion pieces, popular media (e.g., blogs, social media feeds and / or newspaper articles).
Date of publication	January 2010 onwards.[73] We will prioritise the most recent evidence, given the potential for experiences within these communities to change over time.	Literature which pre-dates January 2010
Geography	We will prioritise papers which present evidence from Great Britain, including international or comparative evidence which also covers Great Britain, but will also draw on evidence from comparable policy contexts (OECD countries) if relevant to research questions.	Papers which present evidence from non-OECD countries only.
Language	English	Papers / grey literature not in English.

[73] We used this date as public health research on gambling harms expanded from 2010. See: Price, A., Hilbrecht, M., and Billi, R. (2021). Charting a path towards a public health approach for gambling harm prevention. *Journal of Public Health*, *29*(1), 37-53.

Appendix 3: List of grey literature websites

The following websites were searched as part of the grey literature search. The searches conducted depending on the capacities of website functions, but key words included 'gambling' and key terms to represent communities of interest (drawn from the search strings outlined in Appendix 2).

Sex workers, people who use drugs and other criminalised and moralised communities:

- Adfam
- Action on Addiction
- International Network of People who Use Drugs
- European Network of People who Use Drugs
- Tranform Drug Policy Foundation
- The Howard League
- English Collective of Prostitutes
- Beyond the Streets
- NUM (National Ugly Mugs)
- SWARM
- Streetlight

People who experience or are at risk of homelessness:

- Ruff Institute of Global Homelessness
- St Mungo's
- Salvation Army
- CentrePoint
- Shelter
- Crisis
- The Big Issue Foundation
- Albert Kennedy Trust (AKT)

People who experience unemployment, peripheral employment or insecure employment:

- Fast Forward
- Forward Trust

Older people:

- Age UK
- Alliance Scotland

Vulnerable migrant or transient communities:

- Migration Partnership
- Settlement Services International
- The Traveller Movement
- ROMA support group
- Refugee Council
- Refugee Action
- Joint Council for the Welfare of Immigrants (JCWI)
- NACCOM

Disabled and neurodiverse people and those living with mental health challenges:

- Mental Health Foundation
- Children and Adults with Attention-Deficit/ Hyperactivity Disorder (CHADD)
- Alliance Scotland
- Disabled World
- Edge Foundation
- AADD-UK
- Centre for Addiction and Mental Health
- ADHD Foundation

Gambling sector/ miscellaneous:

- Gambling Commission
- GambleAware
- GOV.UK
- GamCare
- GREO
- SCIE online database
- Tackling Gambling Stigma
- Public Health Wales
- VAGO
- Geofutures

Appendix 4: Full text screening tool

The full-text screening tool captured the following in open text boxes:

- Type of document (academic or grey literature)
- Author(s)
- Title
- Citation
- Date of publication
- Publishing organisation (grey literature)
- Study design

The full-text screening tool further scored papers against the following:

- Date (2010-2023 =1; before 2010 = 0)
- Country (UK, International / comparative paper which includes UK = 2; OECD country, International / comparative paper which includes an OECD country = 1; countries out of scope = 0)
- Methodology: (Quant / Qual / Mixed methods =1; Opinion piece or no evidence = 0)
- Whether the paper reports rates/prevalence of gambling harm among the community of interest (Reports on rates of specific harms = 2; Uses PSGI/similar or 'problem gambling' as a proxy for gambling harm = 1; No = 0)
- Whether the paper reports the prevalence of gambling harms, compared to the general population (Yes = 1; 0 = No)
- Whether the paper presents findings about drivers of/causes of/reasons/motivations for gambling and / or gambling harms among a community of interest (In detail = 1; In brief = 0.5; No = 0)
- Whether the paper presents findings to suggest these drivers differ to drivers in the general population (In detail = 1; In brief = 0.5; No = 0)
- Whether the paper presents findings about the role stigma and discrimination play in gambling harms in a community of interest (In depth = 1; In brief = 0.5; No = 0)
- Whether the paper presents findings on protective factors that reduce or prevent gambling harms among a community of interest (In detail = 3; In brief = 1.5 No = 0)
- Whether the paper presents findings on barriers to accessing services and healthcare for gambling for the community of interest (In detail = 3; In brief = 1.5; No = 0)
- Whether the paper presents findings on the needs of these communities have been considered in existing provision and support for gambling harms; and / or how the needs of these communities have not been considered in existing provision and support for gambling harms (In detail = 3; In brief = 1.5, No = 0)
- Whether the paper presents findings on innovative or promising programmes or services which can support people from the community of interest at risk of gambling harms (e.g., any new or specific services) (In detail = 3; In brief = 1.5; No = 0)
- Whether the sampling/data collection strategy is clearly described and appropriate for the research questions/aims (Yes = 1; No = 0)

- Whether there are any concerns regarding accuracy (e.g., discrepancies within the report)? (Yes = 0; No = 1)
- Whether the researchers identify ethical issues involved in the study design and explain steps to address these and / or specifically cite an ethics approval process (Yes = 1; No = 0)
- Whether the paper is explicit about sources of funding for or conflicts of interest for authors of the project/study (Yes = 1; No = 0)
- Whether there is critical discussion of the findings which makes caveats / limitations clear (Yes = 1; No = 0)

The full-text screening tool captured the following in open text boxes:

- Terminology the paper used to describe people who gamble and the communities of interest
- Whether there is critical discussion of the language / discourse around people who experience gambling harms, or people from these communities
- Whether the paper makes generalisations about the community of interest/treats this group as homogenous
- Whether the paper interrogates the relationship between factors discussed
- The involvement of the community of interest in the research

Appendix 5: Data extraction tool

The data extraction tool captured the following in open text boxes:

- Overview of paper (title, authors, publisher, type of literature, community/ies of interest, sample used to represent this population, date of publication, country in which the study is conducted, study design – if not already captured at full text screening stage)
- Which community/ies of interest are covered by the paper
- Sample used to represent the population
- Rates/prevalence of gambling harm among a community of interest
- Findings about drivers of/causes of/reasons/motivations for gambling and / or gambling harms among the community/ies of interest.
- Findings on protective factors that reduce or prevent gambling harms among the community/ies of interest
- Barriers on accessing services and healthcare for gambling for the community/ies of interest
- Findings on how the needs of these communities have or have not been considered in existing provision and support for gambling harms
- Findings on innovative or promising programmes or services which can support people from these communities who are at risk of gambling harms
- Any recommendations for future research
- Terminology the paper uses to describe people who gamble and the community/ies of interest
- Details of any critical discussion from the papers about the language / discourse around people who experience gambling harms, or people from these communities
- Details about the involvement of the community of research in the research
- Any key caveats that would need to be included when using the findings

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