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ORIGINAL ARTICLE

"The Bad Things that Happened Are Kind of Good Things": Exploring Gambling Among Residents of a Transitional Housing Service

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Abstract
A small body of research has shown that gambling problems are elevated among homeless populations and suggests the complexity of relationships between homelessness, gambling and a broad range of other social and addiction issues. This research explored patterns of gambling and coexisting issues at the level of the individuals' experiences. We describe the experiences of 17 residents of a transitional housing service who had experienced gambling harm as people who gamble and/or affected others, using a descriptive qualitative approach. Four themes, each with subthemes, were identified in the data. Participants described their histories, strong links between methamphetamine use and gambling and the importance of connectedness and family to recovery. Gambling was seldom an issue raised by professional services or divulged by the participants, nor was it described as a key factor in becoming homeless. General self-help strategies (such as distraction) were adapted by participants in attempts to modify or control their gambling. The present results stress the need to destigmatise gambling problems (even relative to methamphetamine use) and to provide gambling information and support through a broad range of social and health services in a way that resonates both with those affected those providing professional support.

Keywords Gambling · Homelessness · Social services · Methamphetamine · Stigma · Qualitative

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A growing body of research suggests that rates of problem gambling are elevated among homeless populations (Matheson et al., 2014; Nower et al., 2015; Shaffer et al., 2002; Sharman et al., 2015, 2016). For example, in the UK Sharman et al. (2015) used the Problem Gambling Severity Index (PGSI, (Ferris & Wynne, 2001) with 456 participants recruited from 16 homeless centres in London and found a problem gambling prevalence of 11.6% compared with the national prevalence of 0.7% (Wardle et al., 2010). Using different measures, in the USA Nower et al. (2015) and in Canada Matheson et al. (2014), both found lifetime measures of problem gambling to be higher in their samples. Furthermore, qualitative studies from several countries have suggested that gambling problems are among the issues contributing to homelessness and extreme poverty (Alhabshi & Abdul Manan, 2012; Crane et al., 2005; Crane & Warnes, 2010; Holdsworth & Tiyce, 2012, 2013; Holdsworth et al., 2012; Landon et al., 2018; Urale et al., 2015; van Laere et al., 2009). Collectively, these studies begin to describe complex relationships where excessive gambling is sometimes a factor in becoming homeless through its negative financial effects on individuals and families, and its impacts on relationships and social support. They also highlight that for some gambling can be a coping strategy via the potential for financial gain, provide a degree of social connectedness, psychological escape or simply be a pragmatic solution to the need for shelter.

New Zealand (NZ) was an early adopter of a public health approach to gambling-related harms. The New Zealand Gambling Act (2003) is a legislative framework with multiple goals, chief among them is to limit the growth of gambling, and prevent and minimise the harms associated with gambling, including problem gambling. Under this Act, the Ministry of Health is responsible for the prevention and minimisation of harm attributable to, or exacerbated by, gambling (Ministry of Health, 2019). While it is debatable whether these goals are being achieved (Adams & Rossen, 2012), an emphasis on understanding the context in which gambling and its associated harms occurs is a key component of the approach. Understanding the nature of harms to people experiencing vulnerability, and the role gambling plays in their lives is an important complement to population-level research.

While definitions vary from country-to-country, in NZ, homelessness is officially defined as a living situation without the option to acquire safe and secure housing (Parliamentary Library, 2014). Statistics New Zealand (2014) formally identify four categories of homelessness: living without shelter; living in temporary accommodation (such as supported accommodation, refuges, motor camps); sharing accommodation (temporarily living in someone else's private accommodation) and living in uninhabitable accommodation. Accurately estimating the prevalence of homelessness is difficult, given the transient nature of the population. Amore (2016) used NZ Census data and estimated that 1% of New Zealanders were homeless, and that the population had grown at an accelerating rate across three successive censuses (2001, 2006 and 2013). Māori (Indigenous New Zealanders), Pacific (Pasifika) and Asian groups were over-represented in these estimates. The Organisation for Economic Co-operation and Development (OECD, 2017) estimated that in 2015, 0.94% of the NZ population was homeless, the highest percentage of any OECD country. They did note that, like Australia and the Czech Republic, the comparatively high incidence of homelessness was to some extent due to the adoption of a broad definition of homelessness relative to the definitions used by other countries. Variations in definitions aside, homelessness is a growing, and serious, issue in NZ.

While there is growing evidence of elevated problem gambling rates among people experiencing homelessness (e.g. Matheson et al., 2014; Nower et al., 2015; Sharman et al., 2015), there is also evidence of elevated levels of substance or alcohol use disorders (e.g. Mallett et al., 2005; Nower et al., 2015; Sharman et al., 2016; Shelton et al., 2009), financial

and legal problems, domestic violence and unemployment (Baldry et al., 2006; Holdsworth & Tiyce, 2013; Taylor, 2008). Clearly, there are many inter-related factors that can contribute to homelessness including structural factors, life situations, health states and inequalities (Holdsworth & Tiyce, 2013). Factors such as relationship breakdown, financial difficulty, job loss and incarceration may be precursors. These factors are also commonly associated with harmful gambling (either one's own gambling or the gambling of a loved one) (Langham et al., 2016).

The relationships between gambling and homelessness clearly warrant further investigation in ways that engage with the contexts, social situation and range of issues and concerns faced by people experiencing homelessness (Holdsworth & Tiyce, 2013; Sharman, 2019). It is clear that the relationships between gambling and homelessness are likely linked to multiple additional, sometimes interrelated, factors. The research to date suggests multiple experiences among people experiencing homelessness that are highly contextual, and that person-centred approaches are required (Guilcher et al., 2016; Sharman, 2019). To support the development of these approaches, studies focused on individuals' experiences of gambling and homelessness in the context of the families, communities and environments in which they live their lives can help to contextualise population level patterns.

These notions informed the present research in which we explored the experiences of gambling among people legally considered homeless, current residents of a transitional housing service in NZ. Given the range of interrelated factors present, contextualising and/or delineating gambling harms in people who have experienced multiple traumas and present with a multitude of acute issues is not straightforward. Affected individuals and services providing support seldom assess gambling and the harms associated with it as a priority among the range of presenting issues (Guilcher et al., 2020; Roberts et al., 2019; Rogers, 2013). In NZ, the focus of policy, research and media tends to be on issues identified as more serious, for example illicit drug use (notably methamphetamine use), alcohol abuse, domestic violence and crime (e.g. Morgan & Mattson, 2018; Wilkins, et al., 2018b). While it is acknowledged that these issues are not independent, screening and research seldom extend beyond a few key indicators of interest. To that end, and in the context of the public health approach adopted in NZ, we undertook qualitative interviews with residents of Epsom Lodge (a transitional housing service operated by The Salvation Army in Auckland) who self-reported being affected by gambling, their own and/or someone else's. Interviews explored their experiences and perceptions of gambling in the context of their lives, including other challenges they face. The research question was: How does gambling and gambling harm affect the lives of people experiencing homelessness in New Zealand?

Method

Setting

Epsom Lodge is a 90-bed transitional housing service run by The Salvation Army in Auckland, New Zealand. Fifteen beds are in a dedicated wing for women (the remainder are for men). The Salvation Army's model of care emphasises structure and case management to "help clients overcome their difficulties and prepare them for an independent and constructive life out in the community" (The Salvation Army, 2014). Residents are required to commit to creating positive change in their lives and to working with a caseworker. In addition to

accommodation and meals, they are provided with or supported to access a range of assistance to support community reintegration (e.g. counselling, advocacy, medical care, financial supervision and budgeting and programmes ranging from parenting to anger management). Clients can be referred to other Salvation Army services such as Addiction Services or Education and Employment, as well as other social and health services, government agencies and services tailored for cultural needs.

Data collected routinely on intake to Epsom Lodge showed across a 2-year period that only 8.7% of residents indicated they gambled, and only 0.5% noted their gambling was a concern for them (note these data indicate substantially lower participation in gambling than evident in the general public, see Abbott et al., 2014).

Recruitment

The eligibility requirement for participation in the study was residents self-identifying as having been affected by gambling (their own, or someone else's). Flyers were posted around Epsom Lodge, and interviewers attended resident wing meetings to provide an overview of the research. Potential participants self-identified as being impacted by gambling (their own, or someone else's) and contacted the researchers via email (computers are provided at Epsom Lodge) or after the meeting, to arrange participation. An information sheet was provided and discussed with the participants. Consent to participate was obtained in writing prior to any data being collected. Recruitment and interviews were undertaken across two 2-week periods.

Participants

Seventeen participants (from a maximum of 90 residents) took part and are referred to by gender appropriate pseudonyms to protect their identities. Demographic information on the participants is summarised in Table 1. Thirteen of the participants were men reflecting the gender balance of Epsom Lodge. The average age of the participants was 40, with male participants (42) being on average older than female participants (33). Ten participants identified as European (one Australian, the remainder New Zealand), six as Māori (indigenous New Zealanders) and one as Pasifika/Pacific Islander. Sixteen participants identified as having experienced gambling harm related to their own and someone else's gambling, just one participant (Andrew) said he did not gamble and was only affected by someone else's gambling.

Procedure

Semi-structured interviews were conducted in a private room on-site at Epsom Lodge. The interviews focussed on the participants' experiences of gambling in the context of their lives. An interview topic guide was developed based on existing literature describing the relationships between homelessness and gambling (see Appendix 1). Demographic information was collected, and interviews commenced asking the participant about their lives and how they came to be residents at Epsom Lodge. The interview focused increasingly on gambling's place in the participants' lives in the context of the other challenges they faced. The guide was designed to enable the participants to tell their stories and provide context to their experiences that they deemed most relevant.

Table 1 Demographic characteristics of participants

Participant	Age	Gender	Ethnicity	Self-identified gambler affected by own gambling	Self-identified substance abuse
Andrew	40	Male	NZ Māori	No	Methamphetamine, alcohol
Bruce	44	Male	NZ European	Yes	Methamphetamine, marijuana, alcohol
Chris	47	Male	NZ European	Yes	Alcohol
Darryl	44	Male	NZ Māori	Yes	Methamphetamine
Edward	68	Male	NZ Māori	Yes	Alcohol
Fiona	37	Female	NZ Māori	Yes	Methamphetamine, alcohol
Georgia	27	Female	NZ European	Yes	Alcohol
Helen	31	Female	NZ European	Yes	Methamphetamine
Ian	51	Male	Australian European	Yes	Methamphetamine, heroin, alcohol
James	27	Male	NZ European	Yes	Alcohol
Keith	47	Male	NZ European	Yes	Methamphetamine, marijuana
Lance	32	Male	NZ European	Yes	Methamphetamine, GHB
Mike	30	Male	NZ European	Yes	Methamphetamine, alcohol
Ngaire	35	Female	NZ Māori	Yes	Methamphetamine, alcohol
Ollie	37	Male	NZ European	Yes	Methamphetamine, marijuana, alcohol
Pio	32	Male	Pasifika	Yes	Methamphetamine, marijuana, heroin, alcohol
Quentin	47	Male	NZ Māori	Yes	Methamphetamine, marijuana, alcohol

The interviews lasted 50–60 min and were recorded and then transcribed verbatim. The participants were thanked for their time with a department store voucher (NZ $40 value). This research was approved by the authors' institutional ethics committee (ref 17/208).

Analysis

A thematic analysis (Aronson, 1994) was undertaken on the data. Given the exploratory nature of the research, a descriptive (Sandelowski, 2010) and inductive (Gibbs, 2018; Saldaña, 2015) approach was used. This approach was used as the focus was on summarising and presenting the participants' experiences as they described them, in relation to the research question/s, rather than interpreting though any particular epistemological framework (Sandelowski, 2010).

The data were organised into themes using the standard analytic steps outlined by Braun and Clarke (2006). Briefly, we began by reading, re-reading and annotating the transcripts to develop familiarity with the data. We then developed initial codes and, through several iterations, modified them in the context of the entire dataset. Similar codes and patterns in the data were identified and developed into draft themes. Then, again through several iterations, these were refined to ensure they were representative of the entire data set.

Results

Four themes, each with subthemes, were identified in the data: (1) Early life (subthemes: trauma and addiction; highs and lows: mixed early gambling experiences); (2) Gambling and

methamphetamine 'go hand-in-hand' (subthemes: the cycle; ambiguity around the relationship between gambling and drug addictions); (3) Recognising problems and making changes (subthemes: environmental change; family) and (4) Engagement with support services (subthemes: gambling is not discussed; connectedness; self-management and distraction).

Early Life

The participants reflected on their early-life experiences in the context of their current situation and vulnerabilities. A range of experiences were described, capture in three sub-themes.

Trauma and Addiction

Early-life trauma and familial instability were common among participants with several describing unstable family environments, abuse and eventually incarceration.

Basically, I've been in institutions since the age of 5 and then from 20 to about 38–39 I've been in and out of jail. The whole abandonment stuff, my mum leaving me when I was 5 and the deep-seated mistrust issues and the abuse, the sexual abuse, all that stuff that is in the mix (Andrew–non-gambler).

Alcohol abuse and addiction were commonly reported (13 of 17 participants) and linked to coping with aversive early experiences and subsequent problems.

Alcohol, alcohol. And stuff from my childhood that I have not really dealt with. Anti-social behaviours and incarceration. Like, I'm 27 but I've … since school I've only spent probably two and a half years out of prison. I left school at 13 so I do not have much of an education (James).

Several reported using illicit substances from very young, often progressing to methamphetamine, with 13 of 17 participants reporting using methamphetamine.

Because I started using solvents when I was 7…it progressed to alcohol, marijuana…..you know standard LSD, mushrooms. Probably 1996 when I had methamphetamine, that was the one that I was searching for… (Bruce).

Given the participants were in transitional housing, and hence officially 'homeless', the prominence of these disruptions was expected. However, it was notable some participants with addiction issues reported less problematic family environments.

My family's not like, they are not gamblers or drinkers or drug-takers or anything. They're just like, good hard working Christian people, so it's really out of it (Fiona).

Highs and Lows: Mixed Early Gambling Experiences

There was a diversity evident in discussions of early gambling experiences. Some participants described positive family experiences at horse race meetings, particularly the older participants.

You know, winning some money ... to spend it with mum and dad and having to wear a tie to go into the member's stand and a jacket and a little pin (Edward).

Bonding with parents was common among these participants, although some activities became more focused on gambling and establishing gambling behaviours.

He'd (father) get me to go round and pick up every ticket I could find that had been thrown away. And I used to find hundreds of these things. And then we'd go home and we'd sit there and we'd go through them in case someone had thrown one away and there was an enquiry

and the horse that beat them had got put back and then their horse got promoted, that sort of thing. And every now and then there'd be one. And I started to think, this is fucking cool. And suddenly, I'm 10 years old reading the race book (Chris).

However, most of the early experiences were mixed, at best, reflecting the highs and lows associated with gambling and their impacts on families.

Gambling goes right back with three four generations within my family … My grandmother was obviously big into gambling, bingo, housie. And as little children, you know, running around having fun. Yeah the good things when they were good they were great you know? My father was a gambler, big time, so I think probably learnt that from his mother. So you know I've got memories of as a family sometimes lots of money, and majority of the time having no money (Bruce).

Gambling and Methamphetamine 'Go Hand-in-Hand'

Many participants described the interlinked nature of drug use, crime and gambling. Several drugs were mentioned, but the majority (13 participants noted methamphetamine use, and of them only, 'Andrew', a non-gambler, did not link it to gambling in some way) focused on methamphetamine (colloquially, "meth", "P" or "the/P pipe" in New Zealand).

For some reason gambling and meth go hand-in-hand. I do not know why. Every user I know has gambling issues. And all of a sudden I found myself with a gambling issue, it just popped out of nowhere (Pio).

The Cycle

Methamphetamine use and gambling were consistently described as interrelated. Participants offered varying degrees of insight into the potential connections, but commonly described increases in gambling behaviour associated with methamphetamine use.

When I first started playing I was only 18, I had not done drugs, well I had not smoked methamphetamine yet. I wasn't a hardcore gambler, I would put $10 here and there and then I could leave. Whereas when I was smoking methamphetamine, I would not leave. And if I lost I would be like flipping out you know? And then I would go find some money somewhere and go back and try to win it, you know? And even if I did win I would still sit there like, I want jackpots, and push it all back in trying to win more (Ngaire).

Similarly, Bruce described a cycle that was consistent with the experiences of others.

I was living with my parents. I was working and had a job at one time, before I'd go home to give Mum some rent money I'd call into the tavern to have a spin. But what I'd normally do is go see the drug dealer. Go have a shot and then hit the pokies (Bruce).

Darryl elaborated on the interrelationships, noting the extended opening hours and the speed and stimulation that gaming machines provide as being important in the relationship to methamphetamine use.

Because at night-time most people are sleeping and people on meth do not sleep. So they go out and that is one of the only things they can do, socialise. And if they play pool which is a really slow game and their brain's going 100 miles an hour, it's a bit boring. So, they play pokies because it's always moving and a big win to them is like ahhh (Darryl).

Using methamphetamine meant being unable to sleep and often gravitating to late night bars and clubs. Operating at too high a velocity to engage meaningfully in conversation with

others (socialisation) or other traditional bar activities (e.g. playing pool), in these situations, electronic gaming machines (pokies) were seen as a good fast game to engage with.

Ambiguity Around the Relationship Between Gambling and Drug Addictions

There was sometimes a lack of clarity around the primacy or either drug or gambling addiction. Some participants suggested that their gambling cravings continued even when drug issues were resolved.

I suppose for me I kind of used to blame it on the actual drug and I used to think that because I was stimulated and I needed it (gambling). It's not actually the wins, it's what you get from the almost wins. It's those that keep you going, you know it's like fuck! I identify as a drug addict who has a gambling problem. With drug use comes gambling, but it's a big but, it's not true. Ultimately the reward is about the money but I was more sort of passing time, but when I actually gave up for a little while the freaking games used to call me. I would walk past, knowing full well that I wasn't mean to go in and I would sneak in … I'm getting real agitated just thinking about it. I'd hate to think what would happen if I came into some money (Bruce).

Others described differences in the emotional consequences and subsequent behaviours associated with gambling and methamphetamine use. For example, Mike describes methamphetamine as having a greater, more active driving force in his life (motivating crime and jail time) and associates gambling with internalised negative emotions.

(gambling) was very antisocial. You sort of keep to yourself, you do not want to talk about it because one minute you are up, and the next minute you are down. It was very secretive. Usually it's a lot of negative feelings that come with it. I've done crime to pay for meth. I've gone and taken cars and motorbikes and done jail for it. Whereas gambling I would never go and steal to tap a button. So the feeling is definitely not the same feeling as I would have got from a rush of meth (Mike)

In our sample, both methamphetamine and gambling were frequently described as forms of escape from problems or boredom. Female participants were more open about emotional issues they perceived as underlying the behaviours.

I was with him for 11 years and there was a whole lot of drug abuse and mental abuse, physical abuse. Just getting over that too and being able to cope with my emotions. That's the hardest thing is being able to cope with things without drugs (be)cause usually if I get upset about something I'd just go and have a puff and then it would be all good. I'd forget about it, blank my mind … gambling too (Helen).

In contrast to methamphetamine use, some participants noted that beyond coping, gambling presented the notion of changing their life situation via winning.

Gambling is more, trying to better my situation. Whereas meth was a really powerful want. Like I really wanted to get that high, that hit. So I was almost prepared to do almost anything to get that hit. Whereas gambling was more of, I might be in a better situation if I do it (Mike).

When asked what the role of gambling was in their life now, another participant simply responded with one word, "hope" (Ollie).

Recognising Problems and Making Changes

Several participants noted the difficulty in identifying gambling (and other) problems as they occurred, especially in the context of multiple ongoing interlinked issues. But with hindsight, they were very recognisable.

You do not know you have a problem when you have a problem. But afterwards when you look back it's easy to see it (Darryl).

Environmental Change

A range of factors were discussed as key in terms of making, or being motivated to make, changes. Hitting 'rock bottom' was a common motivator, often via incarceration or residential rehabilitation. Environmental changes or constraints were important, notably for those that spent time in prison. Despite drugs and gambling being available in prison, concerns around violence and the inability to meet escalating debts were often discussed.

(gambling) is one thing I did not do because I never wanted to end up with a massive debt that I could not pay. There was a lot of drugs in the prison but I'd only use drugs if they were shared. No way, I could not gamble in there. Like why could not I think like that outside? Because there's a fear factor inside, it's a whole different level of rules so yeah I did not want to get it. I still wanted to keep my teeth (Bruce).

Family

Family impacts or interventions were important for many. One participant talked about a public confrontation with his partner as a key moment for him.

I've been with the same girl, and I dragged her through it. I've seen girls, partners, even boyfriends, come into the pokie spot and say please no more, come outside. And then they are having huge arguments and stuff. I would laugh at that and be like oh my God, that's so far. And then my girlfriend came and did it one time. And that's when it really hit me, you know, all of the bad things that happened are kind of good things (Pio).

Family, in particular children, was discussed by many as motivating change.

I've missed out on family gatherings. Once I did not go to a family Christmas, I was out committing crimes to get money to go gambling. I've missed my daughter's birthdays, my granddaughter's commitments. There's humongous pride to actually even getting to a birthday (Bruce).

The potential harm to children, and a strong sense of guilt and responsibility was clear, especially among women. With the benefit of hindsight, one participant talked about regretting involving her children in gambling.

Being a parent, like I'm there. I'm physically sitting there with my kids but I'm not there (be)cause I'm staring at my phone. And even like, I'll play it on my laptop and my son will come along and I'll be like oh can you just keep pushing this button I'm going outside to have a smoke. And I'll be watching him through the window. And then I'll sit with my baby on my knee, and I'll be pushing the buttons and he's watching, and I'm like, am I just making more problem gamblers? (Georgia).

She went on to describe significant feelings of guilt, worry and gratitude. Similar feelings and hopes for the future were expressed by others.

Like I feel so bad for all of that stuff now. Just putting gambling and drugs before my children, before their needs. The lies I've told to my family and stolen from them to support my habits. Like they do not deserve any of that, I've been a real bitch for the last 10 years and for them to still be backing me and supporting me, not understanding, but still supporting me through this is like amazing that they still want to help me. At the time I wasn't thinking about

anything. I'm just thinking about the pokies. But yeah, I do worry now. But he's (son) a really smart boy. That's why I've got to change and just be a better role model for him (Georgia).

Guilt was paralleled by secrecy and shame, which was largely specific to gambling habits and not evident in discussions of drug use.

I mean, I can only speak for myself and those that I know, and things that I've experienced with my own eyes and ears, it's a shameful thing, you know? You do not get a lot of people saying guys I just gambled my rent, I've got no money. I do not know what to say to my partner, my kids. People aren't as open as you want them to be, you know? So yeah, they are feeling disconnected, and they will disconnect themselves, because the less people that know, the less they are going to be judged, you know? Who wants to be judged these days? (Pio).

Engagement with Support Services

The participants had been in contact with a range of support services, although these had seldom been gambling specific. They were provided either in prison or in the community and focused on alcohol and drug issues, emotional regulation and most recently housing support and independent living.

Gambling Is Not Discussed

Despite common gambling problems and the consensus that methamphetamine use and gambling problems were related, participants reported that gambling issues were seldom raised by or with professional support services. Methamphetamine is recognised as the more serious issue, and thus the focus of support.

It's not really talked about (be)cause meth is more of an issue. Meth is the thing that they are like really anti. So you know, they know I've done a lot of crime and that to support my meth habit, but they do not know it was to support my gambling as well. They never really asked (Georgia).

I only divulge it on a need to know basis. It's not something that I like to say. I'm not going to go up to the staff and say hey I've got a gambling issue (Chris).

While alluding to secrecy and stigma along with harms, the participants also tended to view gambling as a secondary issue.

I'm sure if you told your case worker that you had a gambling problem then they'd lay it all out for you. But they know my issues are more with meth and marijuana … I do not think gambling should be at the top (Keith).

Connectedness

Nonetheless, while directly addressing gambling issues, or having specific support for gambling issues was not a priority, the participants cited various support services efforts that strengthened networks and resilience, as being generally helpful. These were sometimes centred on Māori cultural practices, or broader notions of inclusiveness.

Wednesday night is about traveling in the same waka (Māori watercraft) together and supporting each other in recovery. You know, living life, loving life and being really grateful for life. Cultural connectedness, all-inclusive and we do not leave nobody behind … I'm really proud of it because I could not talk in front of people or a crowd months ago, and through

singing and reclaiming my identity, finding out about who I am all of a sudden I'm not so fucking scared (Andrew – non-gambler).

Consistent with the ethos of The Salvation Army, spirituality, whether linked to religion, or more generally, was noted as key to finding meaning and connection.

I suppose you know they speak about a higher power. I'm more on a spiritual level not on a religious level. Focusing on something that's bigger than me, you know holding on to some goals holding on to some sort of key values that I want to hone in on (Bruce).

Intertwined with these activities were notions of structure, routine and feeling safe, supported, accepted and included.

I just love the structure, and the safety, and just because they are helping me actually figure myself out. Like I do not even know why I do drugs like, usually people have like terrible childhoods and all that kind of stuff. But my life has been all good. So I do not even know what I do drugs for. So they are helping me understand myself, I guess, and giving me the tools I need to have a better life, be a better mother, and be a better role model to my children (Fiona).

I only stay here, I go out all day. Yeah, it's okay, everyone's accepting. Yeah, it's a lot of alignment of what I'm persevering for. Which is a quality life and surviving and there's a lot of support around that. A lot of meetings and my experience is that I get more support here than at a typical lodge. (Be)cause they show more interest in me and become more involved and offer stuff, they encourage you to do courses and things. Like AA meetings (James).

There was a sense that connectedness, community inclusiveness and well-being were keys to supporting addictions recovery generally, regardless of the particular substance or behaviour in focus. Participants were drawn to services that seemed to offer this overarching approach.

Self-Management and Distraction

Many of the approaches to maintaining a behavioural change were self-initiated or adapted from professional or informal support in other areas. Budgeting or diversion of funds were common strategies. This started with living costs being automatically diverted to Epsom Lodge, but some participants used this approach more generally, for example opening bank accounts for family and using it when detecting an urge to gamble.

Now I've started doing a thing where I've opened up an account for her (daughter) and any time I get an inkling, I go down and just put it in her account. Things like that because that's who I am deep down inside. I'm not a gambling, drinking, degenerate (Chris).

Support and education around self-control strategies were also commonly discussed and general principles described.

Say if there's like a chocolate bar in front of you, but you have already eaten ten chocolate bars, but you know that chocolate bar is going to be so good … So it's all about thinking 'do I need that chocolate bar?' I guess it's just about pausing and processing what's actually going on instead of just impulse (Georgia).

Self-control strategies were extended to gambling, and incorporated a broad perspective on progress, using social support and an awareness of the potential impacts on families.

I still want to gamble, like I get triggered all of the time, but I know that I cannot gamble (be)cause if I do I'm just going backwards. I'll lose and then I'll be all disappointed about it and then one thing will lead to another and next thing I'll be back smoking meth again and be stuck in the same hole. I do not want to restart that again (be)cause I do not want to let my family down and all of that. I've decided I will not do it. But then if I'm really triggered, like

I'll talk to the people at [service] about it and I'll talk to the residents … (be)cause they have been through it before, you know? (Fiona).

Self-defined recovery supported this broader perspective on participants' behaviour and its impacts, but also allowed a focus on hope and future goals.

Like when I was in my using days of meth, that was sort of my priority. Getting high. I was probably very selfish. And it's not really a priority to meet someone. As for family, I was probably always thinking about my own well-being instead of how my family's doing. But since I've been out of recovery, and out of addiction, I'm more thoughtful with how other people are. I would like to maybe meet someone and settle down and get a house and a job. Just to pay the bills and get well away from drugs and alcohol and gambling (Mike).

Discussion

A large proportion of gambling harm is hidden (e.g. Abbott, 2020; Browne et al., 2017; Wardle et al., 2019) notably among people experiencing disadvantage (e.g. Abbott, 2020; Breen & Gainsbury, 2013; Dyall, 2007; Landon et al., 2018; Sharman et al., 2015; Urale et al., 2015; van der Maas, 2016). Stigma and shame around harmful gambling work to continue this and hinder support seeking (Baxter et al., 2016; Hing et al., 2014, 2016). The present research further supports these notions in participants officially classified as homeless as they are residents of a transitional housing service. Furthermore, the present results highlight potentially important links between methamphetamine use and harmful gambling, particularly in communities and individuals experiencing social and economic disadvantage. The importance of environmental constraints and social support in facilitating change was emphasised, but sadly, it remains that gambling issues are not often viewed as a priority by non-gambling specific social and health agencies (Guilcher et al., 2020; Roberts et al., 2019; Rogers, 2013) or indeed by those presenting with multiple and complex needs (Landon et al., 2018; Sharman et al., 2016). To that end, it was interesting that no participants drew any direct connections between gambling and their current housing instability, whereas clear links were drawn between early-life trauma, crime and drug addiction.

There were consistent and strong views from participants that a clear relationship between methamphetamine use and excessive gambling exists. These views were not evident in discussions of other substances. While there is little research in this area to date, some studies have shown links between methamphetamine use and harmful gambling (Bruner et al., 2010; Richard et al., 2019) and stimulants generally (Geisner et al., 2016; Richard et al., 2019). The lack of attention could be due to regional variations in the degree to which methamphetamine abuse is an issue, or perhaps because applied research seldom discriminates between various illicit stimulants in inferential analyses (Bruner et al., 2010; Richard et al., 2019). Methamphetamine availability and use in New Zealand is high (e.g. Puljević et al., 2020; Wilkins et al., 2018a), even when compared with cannabis (Wilkins et al., 2018b). Wastewater analyses suggest usage is similar to Australia, and substantially higher than many European cities (Wilkins et al., 2018a). For context, wastewater samples from two Auckland sites failed to detect cocaine, and MDMA was only detected on one day whereas methamphetamine was detected every day (Wilkins et al., 2018a).

Experimental research has shown that chronic methamphetamine use may lead to changes in reward function in the ventral striatum and caudate nucleus (Bischoff-Grethe et al., 2016). Specifically, they established a decreased response to loss anticipation, along with a greater

response to loss outcomes in a monetary task. Bischoff-Grethe et al. argued that these effects might underlie an increased likelihood of future risky behaviour. Decision making studies have shown that methamphetamine abusers tend to make poor choices despite negative outcomes (e.g. Gowin et al., 2013; 2014; Hoffman et al., 2006; Koester et al., 2013; Kohno et al., 2014). Thus, converging evidence is consistent with the present participants' accounts. In New Zealand, the ready availability of methamphetamine and electronic gaming machine venues could create an acute issue. Several participants specifically referred to the accessibility of gambling venues, and the ability to buy and sell methamphetamine in them, as this exemplar from Fiona illustrates:

I'd go there (pub) straight away in the morning when it opened at 9 o'clock and just go in there all day, leave like 3 o'clock in the morning. Everything I needed was there. There are cigarettes there, there was meth there, all of the dealers go in there. You know, and there's just pokies. So you just played all day until you ran out of money. Then you'd just sell a bag in there and just keep playing (laughs) (Fiona).

The access and availability issues are of interest and known to policy and enforcement services; however, the potential link is something they would be less aware of. Various government agencies and community organisations are engaged with these issues in New Zealand. However, while gambling harm is explicitly identified as a public health issue in New Zealand, there is ongoing debate as to whether that status has been embraced fully (Adams & Rossen, 2012). In terms of support services, it is becoming increasingly clear that gambling is often a component among a constellation of issues that people experiencing extreme socio-economic disadvantage experience (e.g. Breen & Gainsbury, 2013; Dyall, 2007; Landon et al., 2018; Sharman et al., 2015; Urale et al., 2015; van der Maas, 2016), but that barriers to disclosure and raising it as an issue remain. At the very least, social and health services engaged with clients experiencing such disadvantage, and particularly those dealing with substance use as an issue, should be aware of the potential for concurrent gambling issues (e.g. Guilcher et al., 2016, 2020; Landon et al., 2018; Sharman et al., 2016). Additionally, the documented issues around stigma and shame (Baxter et al., 2016; Hing et al., 2014, 2016; Horch & Hodgins, 2008) should be noted and integrated into approaches to supporting clients. Comments from the present participants and anecdotal ones from staff make it clear that establishing trust and multiple respectful discussions or enquiries are required (Guilcher et al., 2016). For some, the notion of gambling providing hope was evident, this has been documented before in individuals in NZ experiencing poverty (Landon et al., 2018; Urale et al., 2015) and elsewhere (see Hahmann et al., 2020 for a review).

The present results suggested the key ingredients and motivations for change for participants were environmental restrictions (either via incarceration or a rehabilitation centre) and direct intervention by, or support of, family. While these were often the result of drug abuse and/or crime, the participants included gambling as part of the picture. However, gambling issues were not disclosed to services, nor were they asked about. Non-disclosure was discussed in terms of shame and embarrassment, clearly more so than substance use and crime. These findings further reinforce the notion that stigma around harmful gambling remains a key barrier to obtaining appropriate support (Baxter et al., 2016; Hing et al., 2014, 2016; Horch & Hodgins, 2008). Importantly, participants were engaged with a range of social and community support services for issues generally regarded as more serious than harmful gambling. Despite this, there was a clear reluctance to seek support or advice on gambling issues. Rather, the participants addressed their gambling by extrapolating strategies from other areas and applied them to their gambling issues themselves. This often involved a clear focus on what was

important in their lives and setting modest goals and being aware of behaviours that were a threat to them.

The reluctance of participants to divulge issues with gambling was paralleled by services not formally screening for, or asking about, gambling issues. This remains an issue in many countries; people experiencing gambling harm present at a range of social and health services seeking support for other issues. Seldom are they asked about gambling. Whether that is because of a lack of awareness, a lack of resourcing, a lack of time or simply not viewing gambling issues as serious is not clear. Participants here presented with an array of complex needs, and they themselves did not view gambling as a priority. As noted, a very low proportion of residents acknowledged any gambling behaviour on admission to Epsom Lodge. It was possible this underreporting is linked to the stigma around gambling, especially in the context of being homeless and seeking residence in a transitional living service. This also points to the timing of raising gambling as being important—a trusting relationship with the social service and/or case worker might be a necessary condition prior to disclosure.

It remains that harmful gambling seldom is a focus for a range of social and health services. Services remain relatively poorly informed with respect to gambling issues, and aside from specific gambling services are not resourced appropriately to ask about them and either provide support or referrals. Gambling issues are usually viewed as less serious or acute, despite many accounts (including those here) of the significant and ongoing harms to gamblers and people in their lives, and strong links to other harmful activities. Various authors (e.g. Heiskanen & Egerer, 2019; Manning et al., 2020; Roberts et al., 2019; Rogers, 2013; Sullivan et al., 1998, 2007; Tolchard et al., 2007) have argued for the need to provide gambling education and support in a range of services. Despite this, and even in a country such as NZ which has adopted a public health approach to gambling harm, it remains that many people experiencing substantial gambling-related harm do not get adequate support unless they approach gambling services directly. The accounts here suggest that is unlikely, as the participants did not recognise their need for support until later, and even then gambling remained an issue they were reluctant to divulge unprompted. The present results support the notion that carefully adapted brief interventions focused on self-help could be useful adjuncts in social services (e.g. Oakes et al., 2020; Rodda et al., 2018).

As an exploratory qualitative study with a purposely recruited sample, the present results should be interpreted with caution. Given the vulnerabilities experienced by the population in question and the small potential sample pool, we believe the approach was the most appropriate. The sample was relatively large in the context of the number of residents of Epsom Lodge (17 participants from a maximum occupancy 90), and appropriately representative of gender and ethnicity when compared with Epsom Lodge intake data. However, the residents of Epsom Lodge are not representative of the broader population experiencing homelessness in NZ, it remains that relatively little is known about experiencing other forms of homelessness in NZ, notably those living without shelter. Given the stigma expressed, it is possible that participants under-reported the extent of their issues, or that some potential participants avoided participating. Nonetheless, clear patterns were evident from a diverse group of participants, and there is no reason to doubt their honesty.

In conclusion, this research describes the perceptions and experiences of gambling in residents of a transitional living service. Accounts such as these are important components of understanding the pervasive and hidden nature of gambling harms and developing appropriate and accessible services. Despite the NZ Government's adoption of a public health approach, there is little evidence that public health messages around gambling had reached or

resonated with the participants. While they are receiving high-quality support to reintegrate with the community, it remains that neither they, nor the services they engage with, have easy access to information or support specific to gambling-related harm. In New Zealand and globally, there is a need for further research to better understand the experiences of people experiencing housing instability so that more tailored support services can be provided. Broader awareness of gambling issues among the multitude of issues faced by people experiencing housing instability and extreme poverty is required (see Hahmann et al., 2020), aided by the provision of strategies, information and support to community and professional services.

Appendix 1. Indicative structure used to guide interviews with participants

For this research, we have an interest in exploring some of the issues that have impacted on residents of Epsom Lodge. We have a particular interest in gambling, but we understand that there are a range of issues that people are affected by, so we would like to discuss gambling in the context of other issues important to you. In volunteering for this research you have indicated that you or someone you know has been affected by gambling, and we would like to chat to you about your experiences.

We have a few questions we would like to ask, but we are interested in your experiences, so please do not hesitate to bring up anything you would like to add.

If you feel uncomfortable talking about any issues or you do not wish to answer a particular question, just let me know, and we will move on.

Before we begin, I would just like to let you know that while Epsom Lodge support this research, your participation or non-participation is confidential, and will not in any way affect the support you receive at Epsom Lodge, now or in the future.

For research purposes, I would like to record this interview on my digital voice recorder, and possibly make notes on occasions to assist me later, are you okay with this?

Indicative Structure

1. Can you please tell me a bit about yourself, how you got here to Epsom Lodge.
2. We understand that residents of Epsom Lodge have faced a range of difficulties, for you what are some of the key issues that have impacted on you?

a. Prompts if required–family problems, relationship problems, crime, alcohol, substance use, gambling, unemployment etc.
b. How have they affected you and contributed to your current situation?
c. What sort of things have been helpful in addressing these issues?

3. Can you tell me a bit about gambling, and the role it plays/has played in your/your family's life?
4. Gambling can have both positive and negative impacts on people. We'd like to know about both…

a. For you and your family, what are the positive aspects/impacts of gambling?
b. Similarly, what have been some of the negative impacts?

5. Where does gambling fit for you and your family now?
6. How do you view gambling compared to some of the other issues you deal with?

a. Have you or they ever sought support for gambling issues?
b. Are you/they aware of services available?

7. We're keen to understand your views and experiences of gambling, do you have any other stories or views of gambling that you'd like to share

a. Or any comment on related issues–we understand that gambling can often be linked to other behaviours that can cause problems.

Thank you for making the time to talk to me today and sharing your experiences with me, I am very grateful for this opportunity.

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Declarations

Ethics Approval All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5).

Informed Consent Informed consent was obtained from all patients for being included in the study

Conflict of Interest The authors declare no conflict of interest.

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