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Self-Management Strategies for Problem Gambling in the Context of Poverty and Homelessness

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Abstract

Problem gambling and gambling disorder are serious public health issues that disproportionately affect persons experiencing poverty, homelessness, and multimorbidity. Several barriers to service access contribute to low rates of formal treatment-seeking for problem gambling compared with treatments for other addictions. Given these challenges to treatment and care, self-management may be a viable alternative or complement to formal problem gambling interventions. In this study, we described problem gambling self-management strategies among persons experiencing poverty and homelessness. We conducted semi-structured interviews with 19 adults experiencing problem gambling and poverty/homelessness, and employed qualitative content analysis to code and analyze the data thematically. We identified five types of self-management strategies: (1) seeking information on problem gambling, (2) talking about gambling problems, (3) limiting money spent on gambling, (4) avoiding gambling providers, and (5) engaging in alternative activities. Although these strategies are consistent with previous research, the social, financial, housing, and health challenges of persons experiencing poverty and homelessness shaped their self-management experiences and approaches in distinct ways. Approaches to problem gambling treatment should attend to the broader context in which persons experience and attempt to self-manage problem gambling.

Keywords: self-management, problem gambling, poverty, homelessness, qualitative

Introduction

Problem gambling and gambling disorder (PG) are serious public health issues affecting between 0.12–5.8% of the general population depending on the country of study (Calado & Griffiths, 2016). Harms of PG can include loss in personal finances, food security, housing, and relationships (Holdsworth et al., 2012; Neal et al., 2005). PG often co-occurs with additional social and health concerns, including other behavioural addictions, mental illnesses, substance use disorders, chronic physical illnesses, disabilities, and criminalized statuses (Cowlishaw et al., 2014; Ferentzy et al., 2013; Matheson et al., 2014; Roberts et al., 2017; Shi, Boak et al., 2019; Turner et al., 2013). PG also affects certain groups more than others. Rates of PG among persons experiencing poverty, homelessness, or both, are as high as 58% (Matheson et al., 2014; Nower et al., 2015; Sharman et al., 2015).

The complex set of harms, co-occurring issues, and population-specific challenges underscores the need for effective PG prevention and treatment services, but PG treatment-seeking rates remain low compared with treatments for other addictions, such as alcohol misuse (Cunningham & Breslin, 2004; Suurvali et al., 2008). Barriers to service access contribute to low rates of PG treatment-seeking and care, especially among persons experiencing PG, poverty, and homelessness (Guilcher et al., 2016). These barriers include prohibitive commutes to services, long service wait times, and unaffordable service costs (Goslar et al., 2017; Guilcher et al., 2016; Hodgins & El-Guebaly, 2000; Pulford et al., 2009; Rockloff & Schofield, 2004; Suurvali et al., 2009; Tavares et al., 2002). Embarrassment, shame, stigma, and other self-identity issues also deter persons who are experiencing homelessness from disclosing and seeking help for gambling problems (Holdsworth & Tiyce, 2012). Further, while the complex relationships among PG, housing instability and other co-occurring challenges require holistic, person-centered approaches to service delivery and care (Guilcher et al., 2016), most PG services focus on PG-related harms in isolation from the broader spectrum of health and social concerns (Waddell et al., 2018).

Given these service barriers and gaps, self-management may be an effective alternative or complement to formal PG treatment and care options (Matheson et al., 2018; Matheson et al., 2019). In health research and practice, self-management refers to "an individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition. Efficacious self-management encompasses the ability to monitor one's condition and to affect the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life" (Barlow et al., 2002, p. 178). Self-management approaches can be informal efforts (e.g., an individual's exercise regimen), formal interventions (e.g., evidence-based programs for self-managing chronic conditions), or certain combination thereof (e.g., ad hoc adjustments to formal interventions, tailoring them to individual circumstances) (Audulv et al., 2019). Likewise, both individual and group treatment modalities can include self-management components. Mobile technologies may also facilitate self-management interventions (Cafazzo et al., 2012; Solomon, 2008).

Over the past two decades, self-management for chronic health conditions has gained momentum as an important complement to clinical care (Barlow et al., 2002; Barrio et al., 2017; Gainsbury & Blaszczynski, 2011; Hulton et al., 2017; Lorig & Holman, 2003). Several studies evaluated the efficacy of self-management interventions for a variety of chronic conditions, focusing on specific components, supports, or programs (Chaplin et al., 2012; Jonkman, Schuurmans et al., 2016; Jonkman, Westland et al., 2016; Vernooij et al., 2015). Others have detailed the everyday self-management processes for specific conditions, such as regimen adherence, symptom perception, and symptom management in the case of heart failure (Riegel et al., 2016). Still others have identified the basic socio-cognitive skills, resources, and processes underlying adherence to self-management regimens, such as problem-solving skill, problem-solving orientation, disease-specific knowledge, and transfer of past experience in cases of chronic disease (Hill-Briggs, 2003). Emerging evidence suggests self-management interventions may also be effective interventions for drug and alcohol addictions (Barrio et al., 2017; Sakakibara et al., 2017) as well as behavioural addictions, such as excessive internet use (Akın et al., 2015).

Although there has been only limited research on self-management, self-help, and remote care strategies for problem gambling (Gainsbury & Blaszczynski, 2011; Matheson et al., 2019; Moore et al., 2012; van der Maas et al., 2019), recent research nevertheless suggests these self-management approaches align with participants' treatment needs and preferences. For example, studies have found that persons who experience PG need access to treatment resources in high-risk situations, such as at night, on weekends, and during the holidays (Sanchez et al., 2019; van der Maas et al., 2019). Qualitative research suggests that men experiencing PG prefer to be active participants in their own care plans through self-management strategies (Guilcher et al., 2016).

Self-management supports optimal care when tailored to person-specific cultures, beliefs, chronic health conditions, and disease trajectories (Huang & Garcia, 2020; Pinnock et al., 2017). More work is needed to address the variety of self-management strategies and challenges among those populations that are at greater risk of experiencing PG and PG-related harms, including particular ethnic minority populations, youth, older men and women and those living in poverty (Caler et al., 2017; Kryszajtys et al., 2018; Matheson et al., 2018; Matheson et al., 2019; Raylu & Oei, 2004). Therefore, this study explores participants' experiences of poverty and homelessness and their use of PG self-management strategies.

Method

Design

This qualitative study is part of a larger project, within a large multiethnic city in Canada, designed to examine optimization of service delivery via mHealth technologies for persons experiencing PG, poverty and/or homelessness, and other social and health needs. We followed a community-based participatory approach, defined as a "systematic inquiry, with the collaboration of those affected by the issue

being studied, for the purposes of education and taking action or effecting social change" (Green & Mercer, 2001, p. 1927). We engaged a community advisory committee (CAC) that included representatives from the health and service sectors (e.g., local shelters, public health, mental health and addictions, pharmacies), researchers, policy-makers, knowledge brokers, and persons with lived experience of PG and/or poverty, homelessness, addiction and mental health concerns. We convened the CAC four times throughout the project (2016–2019) for their guidance in developing the study protocols, procedures, and processes. The study received approval from the St. Michael's Hospital and University of Toronto Research Ethics Boards.

Setting

Our partner organizations serve adults who experience poverty or homelessness or both. Good Shepherd Ministries offers a range of services including drop in and meal programs, clothing services, short stay addictions treatment programs, support groups, PG programming, individual case management, housing and resettlement programs, medical clinics, and employment training. Fred Victor offers services to adults experiencing mental illness and criminal justice involvement. Such services include access to affordable housing, transitional housing, emergency shelter, food, community mental health outreach and services, specialized support groups, counselling, and employment training. Jean Tweed Centre offers a wide range of services for women only, including residential and day programming, out-patient programming, family and trauma counselling, individualized counselling, gambling support, and continuing care. Services are available to women who have concurrent mental health/substance use problems and contact with the criminal justice system. Outreach services are accessible for pregnant and parenting women.

Participant Recruitment

Study participants were adult clients (aged 18 +) of one or more of our three partner organizations, spoke English, and were at risk for problematic gambling based on the NODS CLiP (Toce-Gerstein et al., 2009; Volberg et al., 2011; Wickwire et al., 2008). The NODS CLiP is a 3-item screen for problem gambling and gambling disorder, designed to identify persons at risk of PG in general population surveys and for triage in clinical settings (Volberg et al., 2011). A positive response to any of the NODS CLiP questions confirmed eligibility for study participation.

We recruited clients from each of three partner organizations through staff and self-referral. Staff shared plain-language study information sheets with clients, which included information on the purpose of the study and contact information for the study team. Eligibility was determined during telephone interactions between the research team contact and prospective participants.

We held five study information sessions at partner agencies to solicit self-referrals. At least two members of the research team were available at each information session,

where they introduced the study, distributed study information sheets, and answered any questions from potential participants (JLW, ET, DK, AH). We screened 29 prospective participants to assess their eligibility. We recruited 22 participants. Of those recruited, 19 completed qualitative interviews, which we conducted at a partner organization or research institution (JLW, GT, ET, AE, SHW). All participants provided written informed consent prior to the interview. We audiotaped the interviews on a password protected, encrypted device. An external service transcribed the interviews verbatim. We provided a $25.00 CAD gift card and two transit tokens to participants.

Study Instruments

Qualitative Interview

We co-developed the semi-structured interview guide with CAC members to capture (1) participant reflections on service use (e.g., access and types of services used); (2) experiences of gambling (e.g., urges, types of gambling activities, when and what types of problems emerged); (3) experiences of services for gambling; (4) health and well-being and the interconnection with gambling; (5) self-management strategies; and (6) technology use and access.

We piloted the interview guide with a person with lived experience of PG and multimorbidity and revised based on feedback. We developed a qualitative interview-training guide and provided this training to our research staff. Senior research team members shadowed research staff during five pilot interviews between January and February 2018. The pilot interviews allowed us to refine the interview guide with respect to comprehension, length and the order of questions, the latter to improve interview flow. The team completed the remaining 14 interviews during March-April 2018. Interview length averaged 55 minutes and ranged from 20 to 90 minutes.

Demographic Survey

Participants completed a short survey that included a socio-demographic profile (i.e., age, gender identity, racial identity, marital status, and education level), partner organization affiliation, and self-reported health information.

Data Analysis

This research study, grounded in the naturalistic interpretive paradigm, followed an inductive qualitative content analysis approach (Hsieh & Shannon, 2005) to thematically code the interview transcripts (Burnard, 1991). We used NVivo 11 to organize the data (QSR International Pty Ltd., Melbourne, Victoria, Australia). First, we conducted open inductive coding with a group of eight coders (GT, SHW, AB, JLW, FIM, SJTG, ET, LC) to determine themes within the 19 transcripts. Coding began with nine transcripts. Each coder was assigned two transcripts, thus each transcript was reviewed by two coders. We chose transcripts to reflect different

agencies and participant sex/gender. Each team member was assigned a transcript to review for higher-level concepts within the data. The team met to review and discuss initial concepts. The team collectively developed code names and descriptions for the concepts, which were integrated into a codebook. To pilot the codebook, we conducted focused coding where five team members (JLW, SHW, GT, DTK, LC) independently coded three transcripts. Throughout this phase, the team met to discuss the coding progress. New codes were integrated into the code list. In total we identified 23 codes to represent the themes that were identified. Focusing on the gambling self-management theme (Audulv et al., 2016), a smaller group of team members (AM, SHW, JS) developed the analysis that follows and met several times with FIM, SG, NT to discuss identified themes. Descriptive statistics (means, standard deviations, proportions, counts) were generated using IBM SPSS. Throughout the paper, participants are referred to with numeric identification numbers that were assigned at enrollment into the study.

Results

Participant Characteristics

We completed interviews with 19 participants (10 males, 9 females) between the ages of 40 and 79 years. Over half of the participants identified as Caucasian (n = 11, 57.9%). Ten (53%) participants reported being clients of Good Shepherd Ministries. Participants were generally longer term service users reporting involvement with their respective agencies for an average of 6.7 years. Most participants reported high use of addiction, case management, and meal program services. Coinciding with their patterns of service use, 11 (57.9%) participants reported ongoing mental health concerns and 6 (31.6%) reported ongoing physical health concerns.

Self-Management Context

This paper focuses on the strategies persons use to manage their gambling, but problem gambling often co-occurs with other challenges. We refer to this broader set of ongoing challenges as the self-management context, and we begin the analysis by situating gambling among the variety of other challenges participants reported.

In addition to problem gambling, participants also experienced poverty, homelessness, physical and mental health conditions,and addictions. These are illustrated in Table 1 and Table 2 where we show the sociodemographic and health/service use history for each participant in the study. For example, participant 1-007 is a non-Caucasian, single, male, 42 years old, on disability income and has used cheque cashing services (Table 1). He has a history of mental illness lasting 6 months or longer, and has accessed case management, housing, addiction, financial and food/meal services. He is taking one medication and, at the time of the study, had a 5-year history of service use. These problems were connected in a complex relational web that collectively challenged participants' well-being. For example:

Table 1
Socio-demographic Profile of the Sample

Participant ID	Age	Sex	White	Single	College/ University	Disability income*	Cheque Cashing Service +
1-003	61	M	x			~	x
2-105	68	F	x	x	x		x
2-104	58	F	x		x	x	x
1-006	79	M	x	x			
1-007	42	M		x	x	x	x
1-011	40	M		x		x	
1-012	48	M			x	x	
1-015	42	F	x			x	x
1-004	51	F		x	x	x	
1-005	53	F	x	x			
2-102	73	F	x				x
3-201	50	F			x	x	x
1-014	65	M	x	x			x
2-101	64	F	x	x	x		
2-103	69	F			x		x
1-008	57	M	x	x		x	~
3-202	56	M	x			x	
1-009	56	M		x	~	~	~
1-016	45	M		x		x	x

*Reflects sources of money other than from employment that includes Ontario Works (OW), Ontario Disability Support Program (ODSP), and Long-term Disability. The OW and ODSP programs provide money for people who need financial support for food and housing or who have a disability and are in financial need.
~ Not answered.
+ Used the services of cheque cashing / pay-day loan places.

> *It's always something when you're gambling … you have a bill to pay, you have a girl that needs something, your kids need something or you know the more you're behind in your mortgage, it's always something. It's always some everyday issue that you got to go through … Imagine this: you have an addiction to crack and you're also a gambler at the same time … this is the adversity that we face. You're addicted to drugs and you have a gambling problem at the same time and you're sick and you have all type of issues …. you're all over the place. You don't know what to do and the drugs that they're giving you, that you're taking is making you even more nuts, you're a psychopath you know you're just crazy and you have a gambling issue at the same time, so just imagine that.* (1-011)

For participants with multiple challenges to manage, gambling could represent a means of self-managing particular problems. Participants gambled when they had trouble sleeping: "If I couldn't sleep, I would get out of bed … get in my car and go there [casino]" (2-103). Others gambled to manage drug problems: "I choose gambling as the lesser of evils you know [Laugh] rather than pick up a drink or cocaine" (1-003). Still others gambled to manage stress, emotions, and mental health

Table 2
Experiences of Illness and Service Use

Participant ID	Mental illness	Physical Illness	Supports accessed								No. Medications	Years of Service Use
			Case Management	Housing	Mental Health	Medical support	Employment	Addiction	Financial	Food/ Meals		
1-003				x	x		x	x		x	3	0.42
2-105	x	x	x		x	x		x			7	1.00
2-104	x	x	x		x			x			6	10.00
1-006				x				x		x	1	0.25
1-007	x		x	x				x	x	x	1	5.00
1-011										x	0	11.00
1-012			x	x		x			x	x	0	10.00
1-015	x		x	x	x		x	x			1	~
1-004	x				x	x					2	0.17
1-005	x				x			x			2	0.67
2-102						x		x	x		0	10.00
3-201	x	x				x		x		x	10	14.25
1-014									x	x	0	28.00
2-101	x	x	x		x			x			0	5.00
2-103	x		x								2	5.50
1-008	x	x	x	x				x	x	x	6	0.67
3-202											0	7.25
1-009									x		0	10.92
1-016	x	x	x	x							1	0.00

problems: "If something is really stressful on me that's you know the first thing I think about is going out gambling …" (2-102).

Although gambling may provide temporary relief from particular problems, participants also acknowledged that it created and exacerbated others. Gambling depleted finances, contributing to housing instability and food insecurity; exacerbated mental health concerns, such as depression, and physical health challenges, such as sleep disruptions; and strained relationships with family and friends. The effects of problem gambling thus reverberated throughout people's lives. As one participant put it, "I don't have a dime to my name. [Gambling] made me homeless. I lost my family. And it just perpetuates your mental illness" (1-007).

The self-management context also comprised experiences of shame, stigma, and exclusion as well as tendencies toward secrecy, deception, and isolation. As participants became more involved in gambling, they anticipated and experienced the social disapproval of family and friends, and responded with increasing secrecy—"When I'm gambling or when I go to gamble, it's usually in secret. I don't want anybody to know that I'm doing it" (2-105)—and isolation—"you kind of become a recluse" (1-009). Deception and dishonesty, though unpleasant and disappointing, became regular practices for managing relationships and identity: "[When gambling] I am more deceitful, less honest … [I tend to] hide, and connive and control, and I don't want to be deceitful" (1-003). When dishonesty and deception involved debt, relational ruptures could occur, severing ties with family, friends, and employers: "I lost a few [Pause] friends because I lie when I borrow money" (1-004).

Increased frustration, discouragement, and self-loathing could result when urges and gambling continued despite negative consequences: "You only got 10 bucks, you got another week to get paid, and you're making excuses to buy this stuff [instant-win lottery tickets], and then you got to ask persons for money, and you don't want to do that—I hate doing that! And it just starts, you know, feeling like shit" (1-015). Shame can be a barrier to help-seeking: "I don't want to talk to anybody about it. I'm ashamed of it" (2-105).

Self-Management Strategies

In the process of the analysis, we identified five general types of self-management strategies: (1) seeking information on problem gambling, (2) talking about gambling problems, (3) limiting money spent on gambling, (4) avoiding gambling providers, and (5) engaging in alternative activities. In what follows, we introduce each gambling self-management strategy and consider how persons use these strategies to reduce gambling behaviours and harms.

Strategy 1: Seeking Information on Problem Gambling

Learning about PG—e.g., definitions, causes, consequences, and interventions—establishes a base of knowledge for attempting to manage problem gambling.

Participants noted multiple routes to learning about PG, such as reading recovery resources, watching recovery videos, and connecting with recovery programs. For example, recovery stories and strategies may resonate with one's own gambling problems and offer hope for a life beyond PG:

> *Sometimes they'll have videos, again, on people with personal stories who have gambled and succeeded in stopping … For me, it's inspiring, it's relatable. I really like that aspect of it so that I can see what other people have gone through and every story is different … there's always maybe a little bit of something that I remember I take away from certain gamblers.* (2-104)

Existing services for persons experiencing poverty and/or homelessness may be effective outlets for providing information about PG prevention and treatment programs:

> *I was standing in the [food bank] lineup when I saw the gambling, the piece of paper on the wall right. Yeah, and see, here I am. Oh that's something that we have to take. … I found help thank you to the Daily Food Bank and they told me about [Agency], which I had never heard of before. I wish more people knew about it, more women knew about it and I came here and that was it and then I didn't gamble for about 5 years after I did the program and everything here.* (2-102)

In sum, PG knowledge can be a gambling self-management resource. Becoming more aware of PG sets the stage for targeted interventions and strategies for managing PG.

Strategy 2: Talking About Gambling Problems

Talking about gambling problems, either with others or through self-talk, can enhance a person's gambling awareness and control. For example, one participant described how his gambling addiction counsellor challenged him to think about the wins vs. losses of his gambling over time, shifting his focus from particular gambling episodes to general gambling patterns:

> *[My counsellor] asked "How many times I won any money?" I said "Zero." … I've never really thought about it before you know like you just go and buy them and then you figure "Well, this one it's going to happen!" But when you realize that a whole bunch of times you've done it and not one of them has even got you a nickel … you just lost the money … I'm waking up … I've had my eyes opened to how few times it ever did work … you start looking at your history, you start to think "Wow, I wasted that much and I got nothing out of it. I could have done this, I could have done that with the money." … You just keep repeating the same thing again and again, and when you realize that what you've been doing is, you know, dumb, then it helps you to stop.* (1-006)

When gambling becomes habit, persons gamble with less intention and control, increasing the likelihood of gambling harms (e.g., chasing losses) and decreasing the

chances of recovery (e.g., monitoring is important for behavioural change). Without ongoing efforts to maintain awareness of their gambling, participants noted they could fall back into earlier gambling routines and habits.

A common strategy for staying focused on reducing gambling behaviours and harms was regularly talking about gambling problems. Participants often talked about their gambling in or around moments of urge or relapse, revealing temporal dimensions to self-management strategies. That is, whether the focus was pre-empting gambling urges, managing existing urges, or coming to terms with and learning from lapses, participants reflected on and talked about their gambling at various points in the everyday experience of PG, poverty, and/or homelessness:

> *When I [was] losing money and it start affecting my daily life, then I started writing [to] myself "Why you are doing this? You already have a lot of problems. You have this money to pay your bills, this money to pay your rent, this money to pay [for] your food."* (1-016)

> *This last week, because it's a little tight on money, the last couple of times when I was thinking you know "I've got a lotto ticket" … I did tell myself you know "Just go [to the store] and get what you need. Don't worry about the tickets right now, like you know a couple of dollars there and just wait until you get a little more money." I've been fighting through it this last couple of days.* (1-015)

These moments of talk and self-awareness also offered opportunities to envision a future beyond problem gambling and be accountable to self and others:

> *[If I were experiencing an urge to gamble] connect me to … my kids, then I can have a one-on-one and say "I'm thinking of doing this [gambling]." And [they would respond] "Papa, don't do it." … [Or I might connect with] my sponsor for drugs and alcohol, and [they would say] "Don't do it." [Or] connect me to another fellow heavy gambler who is now not gambling [who might] say "Look, I did it. You can do it too."* (1-003)

Similarly, certain participants experienced these moments of talk, reflection, accountability, and aspiration in spiritual or religious terms:

> *…the other day I was on a bus going to [Laugh] Niagara Falls [to gamble] … and I heard God's voice say "What? I thought you were going to trust me and put your stuff in my hands? And now you're changing your mind" … So the strategy is always God. Would God want me to go and risk and throw away my hard-earned money that could be better used for my kids and grandkids and everything else? No, I don't think that his goal for me … that's the other bad guy [the devil] that's calling me.* (1-003)

In sum, from promoting recovery possibilities to challenging gambling rationalizations, talking about and reflecting on gambling problems are important gambling self-management strategies in their own right: greater gambling awareness enables

greater gambling control. Greater gambling awareness is also central to other types of self-management strategies, such as limit, avoidance, and activity strategies.

Strategy 3: Limiting Money Spent on Gambling

As persons become more aware of their gambling, they may adopt specific strategies for managing their gambling triggers, habits, and harms, such as money-limiting strategies. Participants identified three types of money-limiting strategies: wager limits (e.g., limiting each bet), outing limits (e.g., limiting money available when gambling at casinos or racetracks), and everyday limits (e.g., restricting financial accounts). For example:

> *… making sure that I don't just have money lying around that I can, you know, get at so easily … I have one of these [tax]-free accounts … It's a savings account … you can't just get it by you know putting your card in the bank machine. If you need money from it then you have to call them … then they will download it within 48 hours or something like that, but I don't feel the urge to do that or to go…* (2-103)

Participants usually experienced gambling-related money troubles before they adopted money-limiting strategies. Certain participants initially viewed gambling as a viable solution to their financial problems, reinforcing their gambling behaviour and compounding its harms:

> *If I had bills maybe the depression of the bills—that I can't meet them at the end of each month—maybe that would be driving me there … with false hope, false hope that you're going to go to the casino, take this money, go there, and make money because that also affected my gambling in the stages where I was doing it so often. My bills piled up on me and I kept going. I kept going with false hope of winning the money to pay it back and owing my sister.* (2-103)

When participants recognized the false hope in gambling as a source of income, they could begin to resolve both their financial problems and gambling problems. For example, one participant said limiting his money spent on gambling was less difficult when "The wallet was getting empty. I need to buy my food. I need to take care of myself and pay bills" (1-005). Managing limited financial resources is an everyday challenge for persons experiencing poverty and homelessness. Problem gambling adds to that financial insecurity, and exacerbates other related issues, including food insecurity and housing instability. In the context of poverty and homelessness, money-limiting strategies served a dual purpose for the participants in our study: (1) managing gambling and (2) meeting basic needs and obligations.

Addressing financial needs and obligations before gambling could re-establish feelings of financial control and responsibility, and may also improve senses of self-efficacy and -esteem:

> *I had all kinds of debt … When the pension came in, I mean basically I would take that money and go and blow it … so the rent doesn't get paid … my cable doesn't get paid … my bills don't get paid. I have no money for groceries or whatever. Now when my payday comes in, I go to the bank and they send my rent, they send my back rent because I owe money for three months' rent … I pay my cable bill … As long as I know those are paid, I'm in control and then I have gone gambling after that with whatever money I had left over…* (2-102)

In sum, money-limiting strategies included wager, outing, and everyday limits. Participants who limited money spent on gambling found that they reduced both gambling behaviours and harms. For those experiencing poverty and/or homelessness, small amounts of money can have significant implications for health and wellbeing.

Strategy 4: Avoiding Gambling Providers

Persons experiencing PG may find their gambling habits difficult to manage when in or around gambling providers. Avoiding places that provide opportunities to gamble was thus another self-management strategy. The ubiquity of physical and virtual gambling providers makes avoiding close encounters with gambling opportunities challenging. For example, certain participants described the difficulties in avoiding gambling opportunities in managing their everyday tasks and obligations:

> *Every corner store [is tempting], but especially because I take a medication every day, I have to go to the pharmacy, so I'm right there, is the thing. So I have to like try to jet out of there not to buy one, you know, so yeah, it's pretty hard, right. And at the subway they got those little lotto things downstairs and it's like "Oh, just don't do it, don't do it," and then I, well I already have it in my hand going up the stairs—and I don't even realize I've done it sometimes. Yeah, so it's just like drinking. When you just don't realize, you know, you've started drinking already.* (1-015)

Participant's avoidance strategies often focused on providers that offered the type of gambling they tended to engage in and struggle with the most (e.g., casino slot machines). As one participant told us, "…when I am physically out of that environment I don't [gamble] … because that's my problem. I'm always needing those kinds of places [to gamble]" (1-008). Participants attempted to avoid gambling providers in a variety of ways, such as rerouting to avoid "lucky variety stores," relocating so that "it takes a very long time for me to get to a gambling establishment and a lot of effort" (1-007), and self-excluding from casinos. Self-exclusion agreements may include penalties for breaching the terms of the contract, such as a fine and/or charge for trespassing. Certain participants found their gambling thoughts and urges were reduced after they entered the agreements:

> *I excluded and I found with that I didn't think about it as much anyway because I mean I couldn't go, like the thought of being arrested and charged—that scares*

> *me … it wasn't worth it … I know I can't go, so I don't think about it as much. You still get the urges, but they're not to the point where they used to be.* (2-101)

In sum, avoidance strategies may be useful in reducing not only gambling harms (e.g., financial harms), but also gambling habits and urges. In limiting opportunities to gamble, however, participants often encountered another problem: what to do with the time and attention that would otherwise be committed to gambling. Engaging in alternative activities addresses that challenge.

Strategy 5: Engaging in Alternative Activities

Abstaining from gambling opened voids in participants' everyday routines. Engaging in alternative activities helped fill those voids with other forms of thinking, feeling, and acting, ranging from situational distractions to extended involvements.

Participants reported that they continued to experience urges when they began reducing or desisting from gambling. Urges occur in a wave-like fashion, increasing, peaking, and decreasing in intensity as they come and go. Participants engaged in alternative activities as a self-management strategy at two points in the urge cycle: (1) during the urge—becoming busy to ride out the storm and reduce its effects and (2) before, between, and after urges—keeping busy to inhibit, delay, or prevent their re-emergence.

Participants noted that when they felt an urge to gamble developing, they would "get busy" with something—such as going for coffee and talking to friends—to try to keep their mind off of gambling. Becoming busy redirected their focus until the urge subsided:

> *To keep my mind off gambling, [I get busy]. Basically, if you're busy doing something you don't think about it all the time.* (2-101)

As participants began to realize the benefits of becoming busy during urges, certain of them also started keeping busy to pre-empt the return of urges. Spanning the creative to the mundane, from doing crafts to watching television, keeping busy was a proactive attempt to occupy oneself with more regular or more extended projects and involvements, which redirected available time and attention away from gambling considerations:

> *I try to watch TV … I sometimes resort to the Treehouse channel. And it sounds silly, but [Laugh] because there's no commercials … And I sleep with Treehouse on because there's no commercials about gambling and nothing to do with gambling … and it's good to keep up in the preschoolers [Laugh].* (3-201)

More extended, protracted projects may be used to keep busy. For example, one participant described an innovative way to extend the duration of household tasks and chores, taking the long way to clean a home:

> *…sometimes I make my house … a mess. If I'm in it, I can make a big mess: "Oh, why did you do this?" But then I have to put everything back … I'm focused on what I'm doing, so other things won't come to my mind. Because [when] I'm sitting the sofa, I have to think about what am I going to do, and I'm scared what's oing to come to my mind to do. So, this way I'm occupied with something that is healthy, something that makes you feel like good like putting your clothes away, doing the laundry. I do everything by hand, so it takes longer, so I'm busier. If I put it in the machine it's faster. In the meantime, while the machine is going, I can go to the store and get a scratch ticket, this and that. If I do laundry at home, scrub, I mean I'm there swish-swish, then I don't have time to think about that…* (1-005)

In sum, for those experiencing problem gambling, idle hands can lead to gambling plans. Sometimes persons gamble to curb boredom, seek thrills, or socialize with others. Other times, persons instead gamble out of habit, involving a complex of fallacious thoughts, powerful urges, and routine responses. What begins as "personal intrigue"—that is, the excitement and entertainment associated with gambling—becomes "persistent involvement" (Prus, 2004)—that is, the personal and social entanglements associated with gambling. Developing an alternative focus can pre-empt or push out gambling thoughts, occupying attention that would otherwise be grabbed by gambling, for "if you're busy doing something, you don't think about it all the time." Alternative activities may also offer new possibilities for the self, providing sources of self-esteem, -efficacy, and -worth.

Discussion

In this study, we described the strategies that persons use to self-manage their gambling in the context of poverty and/or homelessness and the impact of gambling on their everyday life. We recruited persons who accessed social service agencies for support with shelter, housing, financial and employment security, health, mental health, and addictions. Although the association between gambling problems and health challenges is well documented (Ford & Håkansson, 2020; Morasco, Pietrzak, et al., 2006), and the relationship between problem gambling, poverty, and homelessness is an emerging area of research (Hahmann et al. 2020), few studies to date have examined the everyday experiences, needs, challenges, and strategies of persons contending with the triple burden of PG, poverty/homelessness, and complex health issues (Guilcher et al., 2016; Hamilton-Wright et al., 2016; Holdsworth & Tiyce, 2013). While the specific causal mechanisms are not well understood (Hahmann et al., 2020), emerging evidence suggests that an interrelated set of structural (e.g., material deprivation), developmental (e.g., early life events), environmental (e.g., density of gambling providers), cultural (i.e., a set of shared perspectives, practices, and problems), interactional (e.g., erosion of trust and dissolution of relationships), and reputational (e.g., self-identity concerns and contingencies) conditions shape the meaning, function, trajectory, and harm of gambling in the lives of persons experiencing poverty/homelessness and complex health issues.

For example, the origins of current PG, poverty/homelessness, and health challenges may be traced to early life experiences, in which gambling becomes a learned strategy

for coping with "complex vulnerabilities," such as abuse, neglect, isolation, and material deprivation (Hamilton-Wright et al., 2016). Some of the participants in this study, for instance, reported formative moments where gambling became a way for them to fit in, feel better, or forge on in difficult circumstances, establishing the early experiential foundations for later gambling problems. Relatedly, while the problem gambling literature has tended to emphasize the maladaptive, irrational nature of continued gambling in the face of financial difficulties and mounting gambling harms, rational action is always situated action—embedded in particular settings, interactions, relationships, organizations, groups, and histories. If persons tend to "develop a life of their own that becomes meaningful, reasonable and normal" (Goffman, 1961, pp. ix-x), then gambling may come to represent an adaptive, indeed normal and rational response (Misztal, 2001) to the enduring everyday challenges endemic to living with poverty, homelessness, and complex health needs (Hahmann et al., 2020; Holdsworth & Tiyce, 2013), where "a small win could be the difference between eating or not eating, or between sleeping in a hostel or on the street" and a big win has the potential to transform living conditions, care options, and health status in durable ways (Sharman, 2019). The participants in this study reported similar orientations to gambling, adversity, and hope.

Regardless of the temporal sequence or etiology of their emergence in any particular case, once PG, poverty/homelessness, and complex health issues are co-occurring challenges, the effect of their relationship becomes an obdurate everyday reality with which those "down and out" (Sharman et al., 2016) must manage (Holdsworth & Tiyce, 2013). Consistent with previous research, a tangled web of concatenations, reverberations, amplifications characterized the PG-poverty/homelessness-health relationship. Participants emphasized that as their gambling problems escalated, gambling-related secrecy, dishonesty, and distrust (Holdsworth & Tiyce, 2012, 2013) weakened social support networks, reducing their relational resources for responding to financial, housing, and health challenges (Holdsworth & Tiyce, 2013). Problems in one domain tended to spillover and exacerbate problems in others, setting in motion a cascade of "seemingly insurmountable problems and barriers" (Holdsworth & Tiyce, 2013). Sometimes the effect of this "downward spiral" (Guilcher et al., 2016) was increased readiness for change. Still, limited financial resources coupled with multiple health needs restricted their accommodation and transportation options. Neighbourhood deprivation is related to the relative density of gambling venues, and poverty and poor health restrict mobility, immersing a PG-vulnerable population in an environment replete with gambling opportunities (Hahmann et al., 2020). Certain of the participants in this study expressed that accomplishing everyday tasks and accessing basic services (e.g., attending medical appointments, filling prescriptions, accessing foodbanks and meal programs, seeking shelter) involved navigating a minefield of triggers (Guilcher et al., 2016). Ostensibly routine outings were persistently problematic situations, requiring hyper-vigilance to avoid triggers, manage urges, and reduce harms. Undesirable identity imputations—e.g., discredited, devalued, and stigmatized selves (Goffman, 1963)—and associated negative role-taking emotions—e.g., embarrassment, shame, guilt, worthlessness (Burke & Stet, 2009; Shott, 1979)—could be barriers to PG self-disclosure and treatment-seeking (Gainsbury et al., 2014;

Guilcher et al., 2016; Hing et al., 2014; Holdsworth & Tiyce, 2012). Relatedly, the nested nature of gambling problems within a set of other, more visible social, financial, and health problems could challenge service providers' awareness, identification, and treatment of PG (Holdsworth & Tiyce, 2012, 2013).

Those challenges may increase the appeal of self-management as an alternative or complement to formal problem gambling interventions. Participant responses revealed five main types of strategies to manage gambling, including gathering information about gambling, talking about their gambling with others, finding ways to limit the amount of money they spend on gambling, staying away from gambling providers, and trying out alternative activities to gambling. Previous research indicates that these self-management strategies are relatively generic across different populations (Brown & Newby-Clark, 2005; Matheson et al., 2019; Moore et al., 2012; Shaffer, 2005). For example, in this study participants used alternative activities to curb their gambling urges. Similar to mindfulness and cognitive behavioural therapy strategies (Toneatto et al., 2007), participants engaged in this reflective process based on the urge cycle. Persons spoke of becoming busy during the urge to manage the compulsion to gamble, but also talked of the need to be ready for the urge or to suppress the urge before onset, between urges, or after an urge. They used distraction techniques and created "jobs" to fill up time. We know from past research that distractions are important to reduce thoughts that can lead to gambling (Dowling et al., 2008; Hodgins, 2001).

As noted in other studies, participants also used strategies to reduce harms associated with gambling by limiting the amount of money they dedicated to gambling or by limiting access to gambling providers through self-exclusion (Auer & Griffiths, 2013; Kotter et al., 2019). Consistent with previous research (Jauregui et al., 2017; Moore et al., 2012; Toneatto et al., 2014), participants practiced a variety of strategies to cope with the consequences of gambling including building awareness of past losses, using connections with others to address negative self-images, and in certain cases appealing to a higher power for strength and direction.

The gambling literature uses a variety of terms interchangeably to reflect strategies to control gambling including self-regulation, self-management, self-monitoring, and coping (Brown & Newby-Clark, 2005; Jauregui et al., 2017; Matheson et al., 2019; McCormick, 1994; Moore et al., 2012; Shaffer, 2005; Turner et al., 2008; Wood & Griffiths, 2007). Most PG research examines these strategies among clinical or general population samples (Ledgerwood et al., 2007; Matheson et al., 2019; Moore et al., 2012; Turner et al., 2008; Wood & Griffiths, 2007). Notwithstanding the similar strategies for addressing gambling problems documented in the more general PG literature, the specific contexts in which persons experience gambling may increase the complexity and difficulty of gambling self-management for particular populations. Thus, while there have been other studies that explored self-management strategies, to our knowledge none has examined them within the context of persons experiencing homelessness and poverty (Matheson et al., 2019). For example, as reflected in participants' self-talk, group talk, and limiting strategies, the

everyday challenges of poverty and homelessness informed the perceived seriousness of their gambling problems, where small amounts of money often determine whether one can afford food and rent. Likewise, avoiding lottery retailers (i.e., convenience-type stores and pharmacies) was difficult for participants with limited transportation options beyond public transit and chronic health conditions that required regular outings to access care and adhere to treatment regimens. Similarly, while engaging in alternative activities is a well-documented strategy in the PG and broader addiction literature (Hogarth & Field, 2020; Shi, Renwick et al., 2019), health and social inequities can constrain the available alternatives for certain populations. The participants in this study demonstrated creative ways of pursuing alternative activities with few financial resources: watching television, tidying their accommodations, talking to a friend, going for a coffee, and doing art and crafts with dollar store supplies.

It is clear from previous research that PG has an impact on physical health, emotional wellbeing, and substance use (Morasco & Petry, 2006; Morasco, Pietrzak et al., 2006; Morasco, Vom Eigen et al., 2006; Pietrzak et al., 2007). In this study, persons faced poverty and homelessness as well as multiple health needs. Our findings suggest that co-occurring social and health issues may also inform, shape, and constrain the strategies persons use to manage their gambling. Participants contended with manifold health and social challenges, and at times viewed gambling as a way to deal with particular problems, such as concerns with sleep, drug use, daily stress, and mental health. Rather than resolving their difficulties, gambling often exacerbated existing challenges and created new ones, including depleted finances, housing instability, food insecurity, mental and physical health concerns, as well as relational strain, and weakened support networks. The entanglement and interaction of these multiple challenges in the PG self-management process merits further study, especially in the context of poverty, homelessness, and other populations with high prevalence of PG.

Wraparound services that address these multiple concerns would move standard PG treatment approaches toward more holistic models of care. For example, a multi-service shelter service agency, Good Shepherd Ministries in Ontario, Canada, designed and implemented an innovative gambling addiction program. This program emerged in response to the very high prevalence of lifetime problem gambling and gambling disorder (35%) among their clients (Matheson et al., 2014). The program aligns with evidence-based interventions for persons facing homelessness, many of whom experience overlapping comorbidities and social complexities, such as substance abuse and mental health problems. The program provides in-person, client-centred case management (e.g., counselling, skills training, goal setting, and crisis intervention) and recovery groups focused on Cognitive Behavioral Therapy and Life-Skills development. The shelter service also created a partnership with Gamblers Anonymous (GA) to provide mutual support in a shelter service agency, the first GA group situated in a shelter service in North America. Similarly, another agency, Jean Tweed Centre focuses on meeting the needs of women. Not only is the gambling program designed, developed, and delivered using a gender and trauma-informed lens, but the gambling program is also nested within other services specific to women that address families/

parenting, relationships, criminal justice involvement, addiction and mental health, and trauma. PG does not occur in isolation from other challenges. Thus, approaches to treatment and care should attend to the broader context in which persons experience PG (Guilcher et al., 2016; Matheson et al., 2014).

Strengths and limitations

One of the aims of this article was to highlight the specific rather than generic character of self-management strategies—specifically that context matters. A strength of this study is that the authors, working with community partners on research design and execution, focused on an understudied segment of the population who are more adversely affected by problem gambling than the general population, namely persons facing poverty and homelessness. While the types of strategies the participants in this study described have been found in a variety of other populations and settings, the specific meaning, shape, function, and effectiveness of the strategies were tethered to context.

We recognize, however, that poverty and homelessness comprise manifold experiences, challenges, identities, and communities, and we acknowledge that complexity is unlikely to be fully represented in any single study. In our case, study participants resided in a single, large urban centre in Canada with a comparatively small network of population-specific community service providers. Participants self-selected into the study, and more than half of study participants identified as Caucasian. It should be emphasized that inclusion of race as a categorical construct does not capture structural racism in health and social systems (Boyd et al., 2020; Paradies et al., 2015). The data did not allow for an examination of racism within the context of self-management of problematic gambling behaviour. A recent scoping review of self-management strategies for problem and disordered gambling called for greater examination of what self-management strategies may be appropriate and effective within different cultural groups (Matheson et al, 2019). We recruited across three community service organizations in an effort to capture greater breadth and variation of experiences, but more than half of study participants were clients of Good Shepherd Ministries. And yet, notwithstanding the more specific or particular features of our case, participant accounts were consistent with studies of PG in the context of poverty/homelessness elsewhere, such as in Australia (Holdsworth & Tiyce, 2013), the UK (Sharman et al., 2016), and the USA (Nower et al., 2015), suggesting the "transferability" (i.e., trans-contextual relevance) potential of the study findings (Lincoln & Guba, 1985). Still, following our colleagues, we would also emphasize that "it is important that similar studies are undertaken across a broad range of locations so that the experiences, concerns and perspectives of persons who are homeless and experiencing complex issues, such as gambling, are further heard and understood" (Holdsworth & Tiyce, 2013).

Conclusion

This qualitative study of gambling self-management among persons experiencing poverty and/or homelessness identified five types of strategies: (1) seeking

information on problem gambling, (2) talking about gambling problems, (3) limiting money spent on gambling, (4) avoiding gambling providers, and (5) engaging in alternative activities. Engaging in qualitative and participatory methods allowed participants to reflect on and share their self-management experiences and strategies. When developing tailored PG interventions for persons experiencing poverty and/or homelessness, service providers should take into account the self-management context of this population. A need exists for greater awareness of PG prevalence and co-occurring conditions among persons experiencing poverty and/or homelessness. Although PG is often considered a behavioral disorder that is distinct from other chronic conditions, such as degenerative neurological conditions, many persons in this study had social and health comorbidities. Considering the high frequency of comorbidities with PG and other behavioral disorders, it may be beneficial to develop an overarching self-management framework across the health spectrum. Future research should also assess the transferability of these findings within this population and other populations with a high prevalence of PG.

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