The nature of gambling-related harms for adults at risk: a review

Stephanie Bramley, Caroline Norrie and Jill Manthorpe

Social Care Workforce Research Unit

March 2017
About the Policy Institute at King’s

The Policy Institute at King’s College London acts as a hub, linking insightful research with rapid, relevant policy analysis to stimulate debate, inform and shape policy agendas. Building on King’s central London location at the heart of the global policy conversation, our vision is to enable the translation of academic research into policy and practice by facilitating engagement between academic, business and policy communities around current and future policy needs, both in the UK and globally. We combine the academic excellence of King’s with the connectedness of a think tank and the professionalism of a consultancy.

About the Social Care Workforce Research Unit

The Social Care Workforce Research Unit (SCWRU) at King’s College London is funded by the Department of Health Policy Research Programme and a range of other funders to undertake research on adult social care and its interfaces with housing and health sectors and complex challenges facing contemporary societies.

Acknowledgments

This review is part of a study of gambling and adults at risk funded by Ridgeway Information Ltd. The views contained in this review are of the authors alone.
Contents

Introduction ...................................................................................................................... 4
Background ....................................................................................................................... 5
  Non-remote gambling ...................................................................................................... 9
  Defining and protecting ‘vulnerable’ groups ................................................................. 13
  Defining gambling-related harm ................................................................................... 14
  Responding to gambling-related harm ......................................................................... 16
  Health problems associated with gambling and addressed in gambling support services .................................................................................................................. 15
  Gambling from an adult safeguarding perspective ......................................................... 16
  Recent initiatives designed to protect ‘vulnerable persons’ ......................................... 18
  Gambling scams ........................................................................................................... 19
  Summary ....................................................................................................................... 20

Aims of this scoping review .......................................................................................... 22
Methodology .................................................................................................................... 23

Findings .......................................................................................................................... 25
  Gambling-related harm and adults at risk ..................................................................... 25
  Acquired brain injury/intellectual difficulty .................................................................. 28
  Learning disability/difficulty ......................................................................................... 29
  Other disabilities .......................................................................................................... 30
  Use of benefit payments to fund gambling .................................................................. 30
  Homeless people .......................................................................................................... 30
  Older people ................................................................................................................ 35
  Gambling participation among ‘perpetrators’ of abuse .................................................. 38
  Potential dilemmas when dealing with incidences of gambling-related theft .......... 41
  Social work .................................................................................................................. 42
  Social work and gambling ............................................................................................ 42
  Wider education in the care sector .............................................................................. 43
  Human services provision and practice ...................................................................... 43
  Local partnership working ............................................................................................ 46

Discussion ........................................................................................................................ 47
  Research question one: What is the evidence of gambling participation among adults at risk? .................................................................................................................... 47
  Research question two: What is known about the impact of gambling participation for adults at risk? .................................................................................................................. 48
  Research question three: Is there evidence that perpetrators of abuse against adults at risk are committing these acts or crimes to fund gambling addictions? .................................................................................................................. 49
  Research question four: What is the evidence about how social work and/or adult safeguarding teams manage gambling-related harm? ................................................. 49

References ....................................................................................................................... 51
This scoping review is part of a wider research project focusing on the prevalence of gambling-related harm affecting a particular group in society who have often been referred to as vulnerable people and on local authority (LA) practices to help them. While in many circumstances such individuals may be referred to as vulnerable people or individuals (indeed, this term is used in and about the gambling industry [Gambling Review Body, 2001:2]), this report uses the more recent terminology, as defined in English law under the Care Act 2014. Under the Act, the term ‘adult(s) at risk’ is defined as any person aged 18 years and over who:

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (s 42 (1) Care Act, 2014).

Our synthesis of the research evidence therefore includes studies of people with dementia, people with mental health problems, people with learning disabilities and other cognitive impairments (such as acquired head injury) who may be affected by gambling-related harm.

This review of the evidence also addresses what is known and not known about possible links between gambling and people who cause harm to adults at risk or vulnerable adults: that is, where people who have harmed adults at risk cite gambling as an explanation for their behaviour, or where others view it as a possible causal or contextual factor. In such circumstances, these individuals may be called the perpetrators of harm or abuse, and may be abusing the trust of an adult at risk to fund their gambling behaviour or addiction in some form. The evidence for non-regulated gambling being used as a means to exploit adults at risk is further explored – through scams, fake lotteries and other activities.
Background

Gambling participation

Gambling is a popular activity in the UK. Recent figures estimate that 46 per cent of people participated in at least one form of gambling during the first six months of 2016 (Gambling Commission, 2016a). The most popular gambling activity is National Lottery draws, with 30 per cent of the UK public taking part in them. Other popular forms of gambling are online gambling (16 per cent participation rate), scratchcards (11 per cent participation rate), other lotteries (11 per cent participation rate), sports betting (5 per cent participation rate), private betting (5 per cent participation rate), horse races (4 per cent participation rate) and online betting (4 per cent participation rate) (Gambling Commission, 2016a).

During the period October 2014 to September 2015, the regulated gambling industry in Great Britain generated a gross gambling yield of £12.6 billion, an increase of 11.6 per cent compared to the period April 2014 to March 2015 (Gambling Commission, 2015). Remote gambling accounts for 29 per cent of the market share, followed by the National Lottery (26 per cent), betting (25 per cent), casinos (8 per cent), bingo (6 per cent), arcades (3 per cent) and large society lotteries (3 per cent) (Gambling Commission, 2015). The tax revenue raised from betting and gaming duties increased from £0.9 billion during the 2007-2008 tax year in which the Gambling Act 2005 came into force, to £2.7 billion during the 2015-2016 tax year (Her Majesty’s Revenue and Customs, 2016). Furthermore, the gambling industry provides employment for over 108,000 people as of 30 September 2015 (Gambling Commission, 2015).

UK gambling policy changed dramatically over the 20th century (Orford, 2011). From 1906 until 1959, gambling in Britain was partially prohibited, before the law was gradually relaxed (Orford, 2011). The Betting and Gaming Act 1960 legalised almost all forms of gambling, and in 1978 the Royal Commission on Gambling, chaired by Lord Rothschild, concluded that the legalisation of gambling had been successful, that gambling was being well-regulated and that some relaxation of the regulations was warranted (Orford, 2011). The Commission also recommended the setting up of a National Lottery (public lotteries had been illegal since 1826) (Orford, 2011).

From 1960 to 1978 gambling was therefore permitted and tolerated, but not encouraged (Orford, 2011). However, the Commission’s report encouraged the Home Office to soften its regulatory approach. The Betting, Gaming and Lotteries (Amendment) Act 1984, together with occasional ‘statutory instruments’, allowed a number of gambling rules – such as controls on bingo advertising – to be relaxed, and permitted the broadcasting of live or recorded racing and other sports events on television in betting shops (Orford, 2011). The era of gambling liberalisation began in the 1990s, with the 1993 National Lottery Act providing for the setting up of a National Lottery, and the first draw being held in November 1994 (Orford, 2011).

Gambling regulation

As most of us will have witnessed, in the last years of the 20th century, regulations were further eased in almost all gambling sectors. Taking betting as an example, Sunday racing with on- and off-course betting was introduced, betting shops were allowed to provide non-alcoholic drinks and snacks to their customers, and betting shops’ windows were allowed to be transparent and to display advertising (Orford, 2011). Jackpot gaming machines and fixed-odds betting games were also permitted (Orford, 2011). Furthermore, in 1999, the Home Office asked for a complete review of gambling in Britain, along with recommendations for legislative changes.

In 1999, the first British Gambling Prevalence Survey was conducted with the aim of providing baseline data on adult gambling behaviour and to examine the extent of ‘problem gambling’ within the country (Sproston, Erens & Orford, 2000).
Problem gambling was defined as ‘gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits’ (Sproston et al., 2000). A random sample of 7,680 people (aged 16 and over) completed the survey, and its findings provided valuable insight into the prevalence of gambling and problem gambling prior to the subsequent further removal of restrictions (Sproston et al., 2000). In 1999, 72 per cent of the adult population (over 16) took part in some form of gambling activity within the last year, the National Lottery was the most popular form of gambling and the prevalence of problem gambling was between 0.6 per cent and 0.8 per cent depending on which screen was utilised (Sproston et al., 2000). Problem gambling was also associated with a number of socio-demographic factors, including being male, reporting that a parent was or had been a problem gambler, and being in the lowest income category (Sproston et al., 2000).

A review of gambling in Britain was undertaken by the Gambling Review Body (GRB), which published its report in 2001. The report made 176 recommendations designed to ‘simplify the regulation of gambling’ and to ‘extend choice for adult gamblers’, while seeking to ensure that permitted forms of gambling were crime-free, players’ expectations were met, players were not exploited, and that protections existed for children and vulnerable people (Gambling Review Body, 2001:2). The report recommended that all gambling regulation should be incorporated in a single Act of Parliament, all gambling activities be should be regulated by a single regulator, and licensing of premises should be undertaken by local authorities (Gambling Review Body, 2001:2). Other recommendations within this report included removing the demand test for betting shops, bingo halls and casinos; abolishing the previous restriction of casinos to a limited number of permitted areas; abolishing the rule that a new member of a casino was required to wait 24 hours before playing; introducing gaming machines, increasing the variety of games permitted in casinos and bingo halls; allowing unlimited stakes and prizes, multiple games and rollovers in relation to bingo; permitting gambling advertising; lifting the prohibition on British-based online gambling sites and the possible introduction of resort casinos such as those found in Las Vegas (GRB, 2001; Orford, 2011). Gambling in the early 21st century therefore became more liberalised, more varied and more accessible. Orford (2011) argues that this new era in British gambling represented the culmination of the process of deregulation.

With regards to protecting children and vulnerable people, the GRB recognised that gamblers, their families and potentially the general public might experience harm from gambling. The GRB therefore argued that the gambling industry, the regulator and regulation itself all had a role to play in limiting the risk of problem gambling (GRB, 2001). It proposed that the regulator should have powers to ban activities that are likely to cause
harm, should develop an advertising code, should develop formal codes of social responsibility for the industry, and recommended that the industry should provide training for their employees, so that they could identify problem gamblers and signpost them to help (GRB, 2001).

The government’s response to the GRB report outlined the vision for a modern regulatory system for the gambling industry (Department of Culture, Media and Sport, 2002). In the report, the Secretary of State for Culture, Media and Sport argued that ‘gambling must continue to be conducted fairly, remain free of criminal influence and infiltration, and operate within a regulatory framework that offers protection for children and vulnerable adults’ (Department of Culture, Media and Sport [DCMS], 2002: 2). The government agreed with the GRB that codes of practice in relation to social responsibility should become part of operators’ licence conditions and that the regulator would be responsible for monitoring compliance and the social impact of the increased access to gambling products (Department of Culture, Media and Sport, 2002). The government also agreed to remove the legal restrictions on the advertising and promotion of gambling products so that they become ‘more visible and accessible’ and therefore create ‘a fairer and more competitive operating environment’ (ibid, 2002:13). The DCMS pledged to work with the gambling and advertising industries, and with advertising regulators, to establish a code of practice to ensure that ‘advertising is honest and fair and does not exploit children or vulnerable adults’ (ibid). The number of television advertising spots for gambling was 90,000 in 2005, representing 0.5 per cent of the total amount of television advertising spots (Ofcom, 2013). Following an inquiry into gambling by the Culture, Media and Sport Select Committee, and the government’s response to it, the Gambling Bill was drafted. After a period of consultation and Parliamentary debate, the Gambling Act 2005 (GA) became law (Wardle et al., 2007).

Problem and at-risk gambling

The second British Gambling Prevalence Survey 2007 aimed to ‘provide a benchmark and picture of the landscape prior to 1 September 2007 when the Gambling Act 2005 was implemented’ (Wardle et al., 2007:7). The survey was completed by a random sample of 9,003 individuals (aged 16 and over), and its findings indicated that fewer individuals – 68 per cent of the population, compared to 72 per cent in 1999 – had participated in some form of gambling within the past year (Wardle et al., 2007). The rates of problem gambling in the general population were estimated to be between 0.5 per cent and 0.6 per cent depending on the screen utilised (Wardle et al., 2007). In 2007, a significant association was found between problem gambling and being male, and also parental regular gambling (particularly if a parent had a gambling problem). Problem gambling was also associated with poor health and being single. For general health status, respondents who reported that their general health was fair had odds 4.15 times higher of being a problem gambler than those who stated their health was good/very good. Odds were 3.53 times higher for those whose health was bad/very bad, but this was not significantly different from the reference category of good/very good (Wardle et al., 2007). The survey also collected data about whether respondents had any long-term illnesses, disability or infirmity, and if so, whether this illness limited their activities in any way. Longstanding was defined as ‘anything that has troubled you over a long period of time, or that is likely to affect you over a period of time’. Of those who had a longstanding illness, those whose illness was limiting showed lower rates of gambling over the past year (66 per cent) than those whose illness was not limiting (72 per cent). Three per cent of respondents with a limiting longstanding illness participated in six or more different gambling activities, compared to 5 per cent for those with no longstanding illness and 6 per cent for those with a non-limiting longstanding illness. Participation in bingo was more common among those with a limiting longstanding illness. With regards to problem gambling, 0.9 per cent of individuals who indicated that they had a limiting longstanding illness were classified as a problem gambler using the Diagnostic and Statistical Manual (DSM-IV) screen, compared to 0.3 per cent of those who had a non-limiting longstanding illness and 0.5 per cent of those who had no longstanding illness, but no significant differences were observed (Wardle et al., 2007).

In 2007, the new gambling regulator, the Gambling Commission, was established, and the 2005 Gambling Act came fully into force. Local authorities became responsible for the licensing or issue of permits/notifications to non-remote
gambling premises in England and Wales, such as gambling in betting shops, bingo halls, adult gaming centres, family entertainment centres, casinos, race courses, other tracks/sporting venues; to alcohol-licensed premises and clubs that have gambling (eg fruit machines); and to members' clubs with gaming permits (Local Government Association, 2015). In Scotland, ministers have powers to set fees and licence conditions for all gambling premises via licensing boards (Scottish Government, 2010). Under the Scotland Act 2016, the Scottish Parliament and Scottish Ministers have the power to vary the number of B2 gaming machines (or fixed-odds betting terminals) authorised by a new betting premises licence, although existing licences remain the responsibility of the Secretary of State (Department for Culture, Media and Sport, 2016b). In Northern Ireland, gambling is a devolved matter therefore decisions are taken by the Northern Ireland Assembly.

The third British Gambling Prevalence Survey was conducted in 2010 with a random sample of 7,765 individuals, after the 2005 Gambling Act had been fully implemented. Its findings suggested that nearly three quarters, 73 per cent of the UK adult population, participated in gambling in 2010, relative to 68 per cent in 2007 and 72 per cent in 1999 (Wardle et al., 2011). DSM-IV-defined problem gambling was significantly higher in 2010 (0.9 per cent) than in 2007 and 1999 (0.6 per cent for both years), however the p-value was 0.049, indicating that the increase was at the margins of statistical significance. Using the Problem Gambling Severity Index (PGSI), problem gambling prevalence was 0.7 per cent in 2010 compared to 0.5 per cent in 2007, however the difference was not significant. Problem gambling was associated with being male, younger, having a parent who gambled regularly and had experienced problems with their gambling behaviour, and being a current cigarette smoker (Wardle et al., 2011).

This survey also reported data on at-risk gambling, reflecting the view that gambling behaviour can be viewed as existing on a continuum, ranging from those who experience no problems, some problems, through to those who can be classified as problem gamblers (Wardle et al., 2011). In 2010, 7.3 per cent of the sample were categorised as at-risk gamblers (classified as either a low-risk or moderate-risk gambler) compared to 6.5 per cent in 2007 (Wardle et al., 2011). At-risk gambling was associated with age and gender (Wardle et al., 2011). Rates were higher among men and younger adults aged 16-24, and lower among older adults aged 75 and over. The prevalence of low-risk gambling was 5.5 per cent (5.1 per cent in 2007) and the prevalence of moderate risk gambling was 1.8 per cent (1.4 per cent in 2007) (Wardle et al., 2011). Low-risk gambling was associated with having parents who regularly gambled, being a current cigarette smoker, having fair health, drinking over 10 units of alcohol on the heaviest drinking day in the last week, having lower educational qualifications and living in low-income households (Wardle et al., 2011). Moderate-risk gambling was associated with parental gambling behaviour, being a current cigarette smoker and being Black/Black British (Wardle et al., 2011). Problem gambling prevalence did not differ in relation to general health status or presence of a longstanding limiting illness (Wardle et al., 2011).

According to the 2012 Health Survey for England, which is conducted annually to monitor the health of the nation, in the last 12 months, 68 per cent of men and 61 per cent of women had participated in gambling, and problem gambling prevalence was between 0.6 per cent and 0.8 per cent for men and between 0.1 per cent and 0.2 per cent for women, depending on the screen administered (Wardle & Seabury, 2013). Among men, problem gambling prevalence varied with age, being typically higher among younger age groups and decreasing as people get older. There were too few observations (responses) to be able to discern a distinct pattern for problem gambling by age for women. Overall, 7.1 per cent of men and 2.1 per cent of women were identified as at risk of harm from their gambling behaviour in the last 12 months. In addition, several factors were found to be significantly associated with moderate-risk or problem gambling using the Problem Gambling Severity Index – sex, age, whether participants resided in a Spearhead Primary Care Trust area (ie areas which are the most health-deprived in England) and an increased General Health Questionnaire-12 (GHQ-12) score, indicating possible mental health needs. From 2013, the Gambling Commission adopted a decoupled approach to the collection of adult gambling behaviour and problem gambling, and commissioned chapters in the Health Survey for England and the Scottish Health Survey. Findings of both studies were combined to provide information based on a representative sample of England and Scotland together (Seabury &
Wardle, 2014). This found that 65 per cent of English and Scottish adults gambled in the past year. Problem gambling prevalence was between 0.5 per cent and 0.6 per cent depending on which screen was administered. Rates of at-risk gambling were 4.2 per cent of adults, with 3.2 per cent of adults categorised as low-risk gamblers and 1.0 per cent of adults categorised as moderate-risk gamblers.

The Gambling Commission regularly publishes statistics about the number of licenses and permits/notifications, gambling participation and rates of problem gambling. For example, survey data on gambling participation is published quarterly and shows past-four-week participation in gambling activities, mode of play and rates of problem gambling. Latest figures suggest that 46 per cent of participants participated in at least one form of gambling during the year to June 2016, which represents a fall in participation since the year to June in 2013 (57 per cent participation rate). Nevertheless, the proportion of respondents playing in at least one form of gambling, excluding those only playing National Lottery draw products, has seen less variability – 30 per cent (year to June 2013), 34 per cent (year to June 2014), 29 per cent (year to June 2015) and 30 per cent (year to June 2016). This can also be observed in relation to the proportion of respondents participating in at least one form of online gambling – 15 per cent (year to June 2013, year to June 2014, year to June 2015) and 16 per cent (year to June 2016). Problem gambling rates remained stable at 0.4 per cent (year to June 2013, year to June 2014, year to June 2015) but the rate increased to 0.7 per cent during the period year to June 2016. Over the same period, moderate-risk gambling rates have decreased from 1.4 per cent (year to June 2013) to 0.6 per cent (year to June 2016). The same can be observed for low-risk gambling, rates of which decreased from 1.8 to 1.1 per cent (June 2013-16).

Gambling and media advertising

During 2005 to 2012, the total amount of television advertising broadcast almost doubled, from 17.4 million to 34.2 million spots (Ofcom, 2013). In 2007, when the GA was passed, there were 234,000 television advertising spots for gambling (0.4 per cent of the total television advertising spots), with 45.4 per cent of those spots containing adverts for lottery and scratch cards, 45.9 per cent concerning bingo, 4.7 per cent concerning sports gambling, and 4.1 per cent concerning online casino and poker (ibid). In 2007, 234,000 advertisements produced 9.9 billion ‘impacts’, the number of times an advertisement was seen by viewers (ibid). Since 2007, the number of television advertising spots for gambling has increased to almost 1.4 million (4.1 per cent of the total television advertising spots), resulting in 30.9 billion impacts. (ibid). The share of sports by sub-category of the gambling industry has also shifted – fewer lottery and scratch card advertisements (25.6 per cent), fewer bingo advertisements (38.3 per cent), more sports gambling advertisements (6.6 per cent), and more online casino and poker advertisements (29.65 per cent) (ibid). The spend on television advertisements by gambling companies offering sports betting, bingo, online casino games and poker has increased from £81.2 million in 2012 to £118.5 million in 2015, with spending expected to be in the region of £123.4 million by the end of 2016 (Davies, 2016). These figures do not include gambling operators’ expenditure on other forms of advertising such as print, online and social media.

Non-remote gambling

The non-remote gambling sector refers to forms of gambling including betting, bingo, gaming machines, lotteries, casino gambling and arcade gambling which are not participated in by using remote communication including the internet, telephone, television, radio or any other kind of electronic or other technology for facilitating communication (Gambling Commission, 2016h). The introduction of the 2005 GA led to local authorities in England and Wales (and licensing boards in Scotland) being involved in a number of regulatory functions such as issuing premises’ licences, regulating gaming and gaming machines in clubs on licensed premises, licensing horse and dog tracks, and inspecting premises so as to enforce licences, permits and permissions. The number of permits and notifications issued by licensing authorities in 2009/10 was 40,165, which rose to 56,218 in 2011/12 and fell to 53,395 in 2015/16 (Gambling Commission, 2016b). In addition, there are currently 11,277 active gambling premises in Great Britain (as of March 2016), however, this figure has fallen from 12,462 in March 2012 (Gambling Commission, 2016c). The betting gambling sector accounts for 76.5 per cent of all active Gambling Commission-licensed premises and there are currently 8,809 betting shops in
Great Britain (Gambling Commission, 2016c). Other active premises include adult gaming centres (13.7 per cent), bingo halls (5.7 per cent), family entertainment centres (2.8 per cent) and casinos (1.3 per cent) (Gambling Commission, 2016c). Gaming machines can be found within various gambling premises, including casinos, betting shops, bingo halls, family entertainment centres, pubs, clubs, and motorway service stations. Such machines fall into categories depending on the maximum stake (amount allowed to be gambled at one time), the prize available (the amount the machines are allowed to pay out) and where they can be located (Local Government Association, 2015). One type of machine which has received considerable attention from the press and gambling researchers is category B2 machines, also known as fixed-odds betting terminals (FOBTs). FOBTs are only permitted in casinos, betting premises (ie betting shops) and tracks occupied by pool betting (ie betting at a racecourse, football and other sports venues) (Local Government Association, 2015). There has been an increase in the number of B2 machines over the last few years within the non-remote gambling sector. As of March 2012 there were 33,350 machines compared to 35,067 machines in March 2015, representing an increase of 4.9 per cent (Gambling Commission, 2016d). Furthermore, the gross gambling yield for B2 machines during the same period rose from over £1.4 billion to over £1.6 billion, representing an increase of more than 15 per cent (Gambling Commission, 2016d). Participation in this form of gambling has also increased from 3 per cent in 2007 to 4 per cent in 2010, according to the latest British Gambling Prevalence Survey (Wardle et al., 2011).

FOBTs have been subjected to intense scrutiny partly due to their structural characteristics. Structural characteristics are features which induce individuals to begin or continue to gamble (Griffiths, 1993; Parke & Griffiths, 2007). Examples include characteristics that involve payment, playability, speed and frequency of play, reward schedules and ambient features (Parke & Griffiths, 2007). The structural characteristics of gambling can vary between activities and can potentially induce excessive gambling by reinforcing or satisfying gamblers’ needs (Parke & Griffiths, 2007). In relation to FOBTs, gamblers can place bets of up to £100, and the interval between betting, being informed of the result, receiving winnings or losing, and being able to place another bet is approximately 20 seconds, therefore its speed of play is quick and continuous. Furthermore, FOBTs have a random ratio schedule of reinforcement, so the overall likelihood of a win remains constant, there is no way of knowing when gamblers might experience a win, and the chances of winning on subsequent spins do not increase irrespective of the length of the run of losses (Orford, 2011). Research has also suggested a link between FOBTs and problem gambling: the British Gambling Prevalence Survey 2010 found that, among those who had gambled in the past year, problem gambling prevalence was highest among those who played poker at a pub/club (12.8 per cent), followed by those who had played online slot machine-style games (9.1 per cent) and FOBTs (8.8 per cent) (Wardle et al., 2011). This link was also suggested within the findings of the Health Surveys for England 2012 and the Scottish Health Survey 2012: problem gambling prevalence rates were highest among those who had played poker in pubs or clubs (13 per cent), bet on other events or sports (13 per cent), bet with a betting exchange (11 per cent), and played machines in bookmakers (7 per cent) (Seabury & Wardle, 2014).

Concerns about FOBTs have also been raised in relation to the maximum stake of £100 per spin, which is disproportionate compared with the maximum stake available on other categories on gaming machines and also because over 99 per cent of FOBTs are within betting shops located on the high street (Gambling Commission, 2016d). The
number of betting shops has fallen by 3.5 per cent since March 2012 – from 9,128 to 8,809 (Gambling Commission, 2016d). However, the numbers of FOBTs have increased, and concerns about stake size and the ‘clustering’ of betting shops on the high street have led to 93 local authorities demanding under the Sustainable Communities Act that ministers consider reducing the £100 maximum stake to £2 (Ramesh, 2014). In April 2015, the Government implemented The Gaming Machine (Circumstances of Use) (Amendment) Regulations SI 2015 No. 121. The policy aimed to help those playing FOBTs in betting premises and tracks occupied by pool betting to stay in control of their gambling behaviour by requiring that individuals who wish to place bets over £50 have to load cash via staff interaction or through account-based play. However, a subsequent evaluation of this policy published in 2016 found that there was a relatively low uptake of verified accounts, and over-the-counter authorisation with trained staff occurred in only approximately 1 per cent of sessions. A large number of players therefore opted to stake below £50 and increase the duration of their gambling session (Department for Culture, Media and Sport, 2016a).

In 2016, the Campaign for Fairer Gambling, an organisation ‘striving for fairness in gambling’ (Campaign for Fairer Gambling, 2016) commissioned ComRes to conduct a survey of Members of Parliament (MPs), to find out their views about betting shop numbers, the impact of FOBTs in the UK, whether FOBTs require greater regulation and a smaller stake size (ComRes, 2016). Of the 150 MPs who completed the survey, 52 per cent felt that there were too many FOBTs within their constituency, 69 per cent thought that FOBTs had a negative impact on the local community, 81 per cent thought that FOBTs had a negative impact on vulnerable groups within UK society (eg ‘problem gamblers’), 34 per cent thought that FOBTs neither had a positive or negative effect on the UK economy, 61 per cent thought that FOBTs had a positive impact on gambling companies, and 62 per cent felt that FOBTs had a negative impact on UK high streets. Over 70 per cent of those surveyed felt that there was a need for greater government regulation of FOBTs and 67 per cent felt that the £100 maximum stake was too high (ComRes, 2016).

In October 2016, a call for evidence was published by the Department for Culture, Media and Sport in relation to a review of gaming machines and social responsibility measures. The government sought views on three areas – the maximum stakes and prizes for all categories of gaming machines permitted under the GA 2005; allocations of gaming machines permitted in all licensed premises under the GA 2005; and social responsibility measures to minimise the risk of gambling-related harm across the whole gambling industry, including advertising, in order to understand whether the right measures are in place to ensure the protection of the young and the vulnerable (Department for Culture, Media and Sport, 2016b). The government is currently (March 2017) considering the evidence submitted. Within the call for evidence, social responsibility was mentioned with regards to FOBTs in relation to the introduction of the opportunity for gamblers to load cash via staff interaction or via account-based play if they want to bet over £50, but also in relation to other measures, including industry codes which introduced improved staff training on social responsibility issues, controls on marketing of gambling products, improved age verification testing, cross-industry self-exclusion schemes, enhanced player monitoring, and advertising codes (ibid). Discussions about FOBTs are ongoing, an All-Party Parliamentary Group on FOBTs has been established ‘to address the issues associated
with FOBTs’ (Parliament UK, 2016). The group is expected to report its conclusions in August 2017 (Parliament UK, 2016).

Two types of code provision are outlined within the regulator’s Licence Conditions and Codes of Practice: social responsibility code provisions and ordinary code provisions (Gambling Commission, 2016i). Provisions outlined within the social responsibility code provisions describe arrangements which should be made by persons providing facilities for gambling so as to comply with the objectives of the GA 2005 (ibid). Compliance with the social responsibility code provisions is a condition of licences and failure to comply may lead the regulator to review, suspend or revoke an operator’s licence, impose a financial penalty and expose the operator to risk of prosecution. Ordinary code provisions do not have the status of licence conditions in the case of licensed operators but set out good practice. The social responsibility code provision describes arrangements which should be made by persons providing facilities for gambling concerning: responsibility for third parties; combating problem gambling; preventing underage gambling; provision of responsible gambling information; time and monetary thresholds for FOBTs; a ‘time out’ facility, so that online gamblers can exclude themselves from accessing the sites for a specified period of time; customer interaction where the operator has concerns that a customer’s behaviour may indicate problem gambling; self-exclusion; use of credit cards; provision of credit; identification of individual customers; fair terms; display of rules; supervision of games; rewards and bonuses; alcoholic drinks; promotion by agents; marketing of offers; complaints and disputes; gambling staff; responsible gambling information for staff; gaming machines; and assessing local risks (ibid). The ordinary code provision describes arrangements which should be made by persons providing facilities for gambling concerning: co-operation with the Commission; anti-money laundering; access to gambling by children and young people; providing responsible gambling information in languages other than English; customer interaction; self-exclusion; employment of children and young people; money-lending; display of rules; betting integrity; proportionate rewards; mailing of lottery tickets; compliance with advertising codes; online marketing in proximity to information on responsible gambling; gambling staff and irregular betting; information requirements; provision of information in respect of cheating; and sharing local risk assessments (ibid).

From April 2016, all non-remote operators who are premises licence holders in the arcade, betting, bingo and casino sectors are required to participate in a multi-operator self-exclusion scheme (Gambling Commission, 2016j). Self-exclusion is when individuals ask a gambling operator to prevent them from accessing the services they provide for a period of time. The minimum period of time for self-exclusion is usually six months, following which the self-exclusion period can be extended or cancelled. The onus is on the individual to adhere to a self-exclusion agreement with a gambling company (Gambling Commission, 2016k). The gambling operator can remove the name and contact details of someone who has self-excluded from their marketing databases so that they will not receive any marketing materials. For the non-remote arcade, bingo, casino and betting sectors, gambling operators must offer individuals the ability to self-exclude from the same kind of gambling offered in their locality. For these sectors, self-exclusion usually involves an individual completing a form either via telephone, face-to-face, online, post or email, providing a digital image or photograph of themselves, with this information then added to a database which other gambling operators can access. From October 2014 to September 2015, there were 41,714 new self-exclusions within the non-remote arcade (3,103), bingo (1,235), casino (7,430) and betting (29,946) sectors. There were 21,273 known breaches of
self-exclusion, which ‘includes the number of times any self-excluded customer has attempted to gain access to operators’ facilities, attempted to gamble, or actually gambled and is not limited to an attempt to gamble, and includes attempts to enter premises or access online gambling facilities’ (ibid: 40). During the same timeframe, there were 10,446 instances where individuals cancelled their self-exclusion after the minimum self-exclusion period (Gambling Commission, 2016d).

For the remote gambling sector, individuals cannot yet self-exclude via a multi-operator self-exclusion scheme. Individuals need to contact each gambling operator that they hold accounts with in order to take a time-out (ie short break from gambling) or to self-exclude. From November 2014 to September 2015, there were 417,176 new self-exclusions, 22,795 breaches of self-exclusion, and 42,411 instances where individuals cancelled their self-exclusion after the minimum self-exclusion period (ibid). GamCare encourages individuals to install blocking software that limits access to websites offering gambling services (GamCare, no date). The Gambling Commission has been working with the Remote Gambling Association and some of its members to consider the ‘strategic scope and practical implementation of an online multi-operator self-exclusion scheme’, which it intends to develop and put in place by the end of 2017 (Gambling Commission, 2016).

**Defining and protecting ‘vulnerable’ groups?**

In the GA 2005, ‘vulnerable persons’ are not defined. The term ‘vulnerable persons’ is also not defined by the Gambling Commission, but it does, for regulatory purposes, ‘assume that this group includes people who gamble more than they want to, people who gamble beyond their means and people who may not be able to make informed or balanced decisions about gambling due to, for example, mental health, a learning disability or substance misuse relating to alcohol or drugs’ (Gambling Commission, 2016e:5.17). An indication of the characteristics of potential vulnerable groups in relation to gambling was recently suggested by Wardle (2015), who conducted interviews with a range of stakeholders (academics, policy makers, industry, treatment providers and legal professionals) in Great Britain to explore understanding of terms, including gambling-related harm, and who they believed may be vulnerable to harm from gambling. One-to-one semi-structured interviews were conducted with four academics, four policymakers and six legal professionals. Three workshops were conducted with industry stakeholders (total 14 participants) and two workshops with treatment providers (total 10 participants) (Wardle, 2015). The stakeholders considered that, along with problem gamblers, the following groups may be more susceptible and potentially vulnerable to harm: young people; students; those with mental health problems, learning difficulties (disabilities or intellectual impairment), and/or low levels of education; those with substance use/misuse issues; migrants; homeless people; those with constrained economic circumstances or living in deprived areas; prisoners; older people; those with personality/cognitive impairments; and women (Wardle, 2015).

Wardle (2015) also conducted quick scoping reviews of the research to examine the evidence base for each identified group or characteristic. She found good evidence that young people, those with substance use/misuse issues, poorer mental health, those living in deprived areas, from certain ethnic groups, those with ‘low IQs’, those with certain ‘personality traits’ (ie cognitive impairments/impulsivity), existing problem gamblers (especially those seeking treatment), and those who are unemployed are potentially more vulnerable to harm (Wardle, 2015). There was a smaller but emerging evidence base suggesting that homeless people, those experiencing financial difficulties and debt, prisoners, and younger men with learning difficulties/disabilities may also be vulnerable groups (Wardle, 2015). Inconsistent patterns of evidence were found in relation to students, people with few educational qualifications, and people living on low incomes. Furthermore, evidence relating to migrants, older people or women was sparse (Wardle, 2015). Despite the identification of potential vulnerable groups, Wardle (2015) acknowledged that the scoping review relied on studies looking at problem and at-risk gambling and did not include gambling-related harm (ie ‘the adverse financial, personal and social consequences to players, their families and wider social networks that can be caused by uncontrolled gambling’) (Responsible Gambling Strategy Board, 2009)). Consequently, some groups or characteristics may have failed to be identified.
Defining gambling-related harm

Wardle (2015) discussed the policy perspectives in relation to the term ‘gambling-related harm’. The GA 2005 does not define ‘harm’ or ‘exploitation’, nor the types of harms or exploitation that are related to gambling, however, she considered that the definitions of a ‘responsible authority’ and ‘authorised person’ suggest that the GA 2005 does in some way focus on harm to the health of the public. The concept of harm was mentioned within the GRB report, but again, not defined – although as noted earlier, the GRB did recognise that gamblers may do ‘great harm not only to themselves but also to their families and possibly to the general public’, and therefore felt that it was a ‘legitimate role of regulation to limit the risk of problem gambling even if this means restricting the freedom of those who can gamble harmlessly’ (GRB, 2001:4). The GRB considered there was a dilemma between ‘the desire to permit free choice and the fear that such choice may lead to harm either to the individual or to society more widely’ (GRB, 2001:7).

The GRB discussed three arguments: the danger argument – that gambling can ‘cause serious financial and psychological harm to some of those who do it (and to their families)’; the moral argument – that gambling is ‘intrinsically undesirable because of the attitudes it sustains or encourages’; and a third-party extension of the danger argument – that ‘the activity of gambling can adversely affect the lives of those who do not themselves gamble’ (ibid). In relation to these three arguments, the GRB acknowledged that a gambler might ‘cease to play a normal part in social and family life and may, indeed commit crimes to sustain the activity’, that gamblers may face moral disapproval, and that problem gamblers may directly harm others through criminal acts or through abandonment of their family responsibilities, possibly leading to costs being incurred by law enforcement agencies or by the health service (ibid). The GRB stated that, in their view, ‘the state should respect the right of the individual to behave as he or she wishes, provided there is no harm to others’, which might be considered a compromise between the danger and libertarian arguments.

Wardle (2015) noted that the term ‘gambling-related harm’ was adopted by the Responsible Gambling Strategy Board (RGSB) in 2009, and, since then, the RGSB has put forward the view that gambling-related harm should be recognised as a public health concern. The term has featured within the regulator’s Licensing Conditions and Codes of Practice and within the latest National Responsible Gambling Strategy produced by the RGSB. In its 2016-17 to 2019 strategy, the overarching aim is stated as being to ‘minimise gambling-related harm’, which is defined as something that ‘goes wider than the harm experienced by those identified as problem gamblers by existing screening tools. It can also affect the families of gamblers, their employers, their communities and society more widely’ (RGSB, 2016:4). The RGSB also outlined five priority objectives which included ‘to encourage a wider range of organisations in the public and private sector to accept their responsibility to tackle gambling-related harm’ and ‘to progress towards a better understanding of gambling-related harm and its measurement’ (ibid). Wardle (2015:17) concluded that the ‘new emphasis on gambling-related harm’ in the regulator’s licensing conditions and codes of practice ‘is symptomatic of a broader step change in policy and regulatory circles towards considering wider harms from gambling rather than problem individuals’.

A report by the Institute for Public Policy Research (Thorley et al., 2016) calculated the cost to government associated with individuals whose lives are ‘blighted’ by the ‘hidden addiction’ of problem gambling. The report focused on the costs of health problems (primary care [mental health] services, secondary mental health services, and hospital inpatient services), housing (statutory homelessness applications), criminal activity (incarcerations) and work difficulties (jobseeker’s allowance claimant costs and lost labour tax receipts). It calculated that ‘summing the costs across different interactions gives a total excess fiscal cost of between £260 million and £1.16 billion per year for Great Britain as a whole’ (Thorley et al., 2016:5). The authors argued, ‘There is a strong moral case for government to be concerned with this, as problem gambling acts to entrench and exacerbate socioeconomic disadvantages by disproportionately affecting individuals on low incomes and those with comorbid health problems.’ (Thorley et al., 2016:3). They concluded there is an urgent need to fill the gaps in the available evidence base, in particular around the costs to local authorities of problem gambling. At times, however, the direct harm of gambling to adults at risk is not always
reported, although Valentine and Hughes (2011) noted that online gamblers with problems were sometimes funding their activities by stealing from family members. Internationally, Singapore has been one of the first countries to implement a harm minimization model known as the Family Exclusion Order (FEO) whereby family members are able to apply for FEOs to prevent a gambler from entering the casinos, if the family has experienced harm caused by his/her gambling (Goh, Ng and Yeoh, 2016).

Responding to gambling-related harm

The move to local authorities being responsible for the licensing or issue of permits/notifications to non-remote gambling premises arguably puts them in a difficult position. Local authorities work with charities, businesses, the police, the NHS and residents to determine and deliver local priorities by providing a range of services or commissioning services from outside organisations (Local Government Association, 2011). The principal services provided by local authorities include children's services; highways, roads and transport; housing; cultural services; environmental services (eg licensing); planning and development; protective services (eg fire and rescue services); central and other services (eg local tax collection) and adult services (ie funding of social care services for older people, services for people with a physical disability, learning disability or mental health need and services for asylum seekers) (Local Government Association, 2011). In addition, the 2012 Health and Social Care Act requires local authorities to be responsible for the delivery of public health services and established Health and Wellbeing Boards to bring together the NHS, public health, adult social care and children's services, including elected representatives and local Healthwatch organisations in order to plan how best to meet the needs of their local population and tackle health inequalities (King’s Fund, 2016). A dilemma might therefore exist for local authorities with regards to the costs and benefits of gambling among its populations.

Under the GA 2005, local authorities in their role as licensing authorities should ‘aim to permit the use of premises for gambling’ but also protect ‘children and other vulnerable persons from being harmed or exploited from gambling’. On the one hand, gambling creates revenue and can provide employment opportunities. On the other hand, the costs associated with gambling might include crime, employment costs (eg lost productivity/employment time), business costs associated with new gambling facilities (eg displacement of other businesses), bankruptcy, personal costs to those with gambling problems and their family members or friends, ‘abused dollars’ (eg money or possessions acquired from family, friends or employers under false pretences), costs associated with treatment and social services, damage to the environment, and costs associated with government regulation of gambling (Orford, 2011). Local authorities therefore face the challenge of protecting vulnerable people, providing gambling opportunities, promoting wellbeing, and providing services for the community.

Health problems associated with gambling and addressed in gambling support services

There is a substantial literature on problem gambling and its associations with high-risk behaviours in the UK (eg smoking, alcohol consumption, illicit drug use), various mental health problems (eg anxiety, neurotic symptoms, panic disorders, generalised anxiety disorder), as well as psychosocial risk factors (eg suicidality, financial difficulties, smaller social networks) (Cowlishaw & Kessler, 2016). Wardle (2015) conducted a secondary analysis of data collected within the English Adult Psychiatric Morbidity Survey (APMS), which produces statistics on the prevalence of mental ill health in England and found higher rates of problem gambling and at-risk gambling among people with several mental health conditions. Such conditions included mixed anxiety and depressive disorder, general anxiety disorder, phobia, obsessive compulsive disorder, panic disorders, eating disorders, probably psychosis, ADHD and post-traumatic stress disorder (Wardle, 2015). She noted that while the majority of people with certain mental health problems may not experience problems with gambling, it appears that the majority of problem gamblers experience other mental health problems. Cowlishaw and Kessler (2016) found associations between primary care use for mental health and problem gambling, in addition to associations between problem gambling and hospital inpatient visits. Problem gamblers were also found to be 8.5 times more likely to currently use psychological services with an over-representation of problem gamblers in healthcare...
settings, including primary care, counselling or therapy and hospital beds (Cowlishaw & Kessler, 2016). The disproportionate burden of problem gamblers on UK healthcare systems arguably has possible implications for individuals (eg poor mental health), families (eg suicidality), and communities (eg elevated healthcare costs) (Cowlishaw & Kessler, 2016).

In the UK, specialist gambling support services are delivered mainly by the third sector (not-for-profit) and funded through donations from the gambling industry (in 2014-2015, £4,833,140 was spent by the gambling industry on treatment services) (Responsible Gambling Trust, now GambleAware, since 24 October 2016). Notwithstanding this, take-up of such treatment services is low: the Responsible Gambling Trust estimated that there are approximately 590,000 problem gamblers in Great Britain, but the services available to them – which include the National Gambling Helpline, counselling services, residential care facilities and an NHS clinic for those with more complex social or psychiatric presentations – only treat approximately 1 per cent (5,900) of problem gamblers (Responsible Gambling Trust, 2016). Two of the frontline services offered by GamCare do not operate between the hours of midnight and 8am (GamCare, no date). As people can gamble online 24 hours a day, seven days a week, night-time gamblers may regret their spending but be less able to obtain gambling-specific support, a phenomenon that has been discussed in relation to ‘vampire’ retailers (Evans, 2016). Figures obtained via the 2010 British Gambling Prevalence Survey have suggested that around 64 per cent of those experiencing severe problems with gambling do not seek formal or informal support. Of those who do seek help, only 9 per cent had contacted a dedicated gambling support system (Wardle et al., 2011). Moreover, if all 590,000 problem gamblers did seek help, then spending per head using gambling industry funds alone would be only £8.19, potentially leading to a funding shortfall. Such figures do not include the potential for those classified as at-risk gamblers to engage in help-seeking behaviour.

In 2007, the British Medical Association recommended that those experiencing gambling problems should receive treatment from the NHS (Griffiths, 2007). In 2008, the NHS’s first and only specialist gambling clinic opened; it is operated by the Central and North West London NHS Foundation Trust but primarily commissioned through the Responsible Gambling Trust (Gentleman, 2016; Central and North West London NHS Foundation Trust, 2016). However, research conducted in 2010 found that 97 per cent of NHS Trusts still do not provide any service (specialist or otherwise) for treating individuals with gambling problems (Rigbye & Griffiths, 2010). For the 2014-15 financial year, the National Problem Gambling Clinic was accessed by 853 clients with a grant of £339,016 from the Responsible Gambling Trust to deliver community-based problem gambling treatment services (Responsible Gambling Trust, 2016).

**Gambling from an adult safeguarding perspective**

Gambling may be brought to the attention of local authority adult social care departments and safeguarding services in relation to people with care and support needs possibly experiencing gambling-related harm, or in relation to such people suffering alleged abuse or neglect as a result of the gambling habits of family carers, care providers, neighbours, acquaintances and friends, online contacts, or those in positions of trust. Under the Care Act 2014 in England, local authorities are responsible for promoting individual wellbeing in so far as it relates to personal dignity; physical, mental health and emotional wellbeing; protection from abuse and neglect; control by the individual over day-to-day life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living accommodation and the individual’s contribution to society (s 1 (2) Care Act, 2014). With other agencies, local authorities are responsible for safeguarding, defined as ‘protecting people’s health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect’ (Care Quality Commission, 2016). As noted above, the Care Act 2014 defines ‘adult(s) at risk’ as any person aged 18 years and over who:

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and,
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (s 42 (1) Care Act, 2014).
The national Safeguarding Adults Annual Report provides an insight into types of needs for care and support of adults who have been the subject of enquiries by local safeguarding services within England (Health and Social Care Information Centre [now NHS Digital], 2015). During the period 1 April 2015 to 31 March 2016, 102,970 safeguarding enquiries (ie action taken or instigated by a local authority in response to a concern that abuse or neglect may be taking place) were opened (Health and Social Care Information Centre, 2016). The main reason why a person had needs for care and support was reported in this data collection. Nearly half (42 per cent) of these adults at risk had physical disabilities, 14 per cent had a learning disability, 12 per cent had mental health problems, 9 per cent had memory and/or cognition impairments, 4 per cent required social support (it is hard to specify what this category means), and 1 per cent had sensory impairments. For 18 per cent of referrals about which an enquiry commenced, either no support reason was provided or the reason was not known. Such data highlight the heterogeneous conditions of people termed adults at risk.

There is some suggestion that people with care and support needs may be more likely to be abused or neglected because they may be perceived as an easy target and may be less likely to identify abuse, be unaware that they are being abused, and less likely to report abuse or alert others (Social Care Institute for Excellence, 2016). Using Care Act classifications, types of abuse include physical abuse, sexual abuse, psychological or emotional abuse, financial and material abuse, neglect and omission, discriminatory and institutional abuse (Health and Social Care Information Centre/NHS Digital, 2016). Under the Care Act, financial abuse includes (a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused (s 42 (3) Care Act, 2014). As mentioned above, local authorities, under the Care Act, have a duty to make enquiries to decide whether any action should be taken in respect of cases of alleged abuse or neglect, and if so, what and by whom (s 42(2) Care Act). During the period 1 April 2015 to 31 March 2016, there were 124,940 concluded safeguarding referrals in England (ie those enquiries that are termed ‘concluded’ when the investigation is complete and conclusions and any actions have been decided upon). The most common type of abuse investigated was neglect and omission, which accounted for 34 per cent of recorded cases (Health and Social Care Information Centre, 2016).

Of concluded safeguarding referrals 16 per cent concerned the risk of financial and material abuse (Health and Social Care Information Centre, 2016). Currently there are no data to indicate whether gambling featured in such allegations, however some media reports have highlighted that gambling can be associated with alleged cases of abuse or neglect of adults at risk. For example, the Liverpool Echo recently reported that a manager of a supported living home who had an addiction to gambling stole nearly £5,000 from a tenant with learning difficulties (Docking, 2016). The Leicester Mercury reported the case of a man who stole almost £15,000 from his mother in order to gamble (Gibson, 2016). The newspaper reported that his mother had dementia, and he was able to steal the money because he had joint control over her funds. These two examples are accounts of individuals committing financial abuse (theft) where their gambling problems were possible motives and there are probably more in our view.

One question potentially encountered by health and social care professionals in relation to participation in gambling is whether the person in focus has the decision-making capacity to make the decision to participate (see Samsi, 2015). The Mental Capacity Act (MCA) 2005 provides the legal framework for people aged 16 and over living...
in England and Wales who are unable to make all or some decisions for themselves (Social Care Institute for Excellence, 2010). Section 3 (1) of the MCA outlines that ‘a person is unable to make a specific decision for himself if s/he is unable –

(a) to understand the information relevant to the decision
(b) to retain that information
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or other means).’

The MCA is underpinned by five key principles: a presumption of capacity; individuals being supported to make their own decisions; unwise decisions (ie people have the right to make decisions that others might regard as unwise or eccentric but they cannot be treated as lacking capacity for this reason); best interests (anything done for or on behalf of a person who lacks mental capacity must be done in their best interests); and less restrictive option (ie someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person’s rights and freedoms of action, or whether there is a need to decide or act at all) (Social Care Institute for Excellence, 2010). In 2015-2016, 27 per cent of individuals about whom there were concluded safeguarding enquiries lacked decision-making capacity (Health and Social Care Information Centre, 2016). If an individual is assessed as lacking capacity to make a specific decision, then any action taken or decision made for or on behalf of that person should be made in his or her best interests.

Recent initiatives designed to protect ‘vulnerable persons’

Recently, the Gambling Commission brought in new rules with the aim of protecting ‘vulnerable persons’ (Gambling Commission, 2015). The rules include requiring customers to be able to set time and monetary limits on FOBTs, online gambling operators offering their customers a time out facility (came into force on 31 October 2015), licensees offering customers the opportunity to self-exclude from facilities for the same kind of gambling offered in their locality through participation in one or more available multi-operator self-exclusion schemes (came into force on 6 April 2016), and the introduction of Local Risk Assessments prepared by licensees (Gambling Commission, 2015). Licensees must assess the local risks to the licensing objectives posed by the provision of gambling facilities at each of their premises, and have policies, procedures and control measures to mitigate those risks (Gambling Commission, 2015: 10.1).

Since April 2016, local authorities are required to create a ‘Statement of Licensing Policy’, which sets out the ‘local issues, priorities and risks that inform and underpin its approach to local regulation’ (Gambling Commission, 2016e: 1.30). The idea is that ‘the statement of licensing policy provides the opportunity for licensing authorities to agree and set out how gambling is to be managed in different parts of the local authority area to deal with local risks and issues, in doing so, it will provide greater scope for licensing authorities to work in partnership with local businesses, communities and responsible authorities to identify and mitigate local risks to the licensing objectives’ (Gambling Commission, 2016e: 1.31). The statement of licensing policy is seen as the ‘primary vehicle for setting out the licensing authority’s approach to regulation having taken into account local circumstances’ by the regulator, and it ‘encourages licensing authorities to have a statement of policy that is genuinely reflective of local issues, local data, local risk and the expectations that a licensing authority has of operators who either currently offer gambling facilities or wish to do so in the future’ (Gambling Commission, 2016e:6.2-6.4). Licensees must take into account relevant matters identified in the licensing authority’s statement of licensing policy and should also share their own risk assessment with licensing authorities when applying for a premises licence or applying for a variation to existing licensed premises, or otherwise on request (Gambling Commission, 2015:10.1).

The Gambling Commission has provided examples of how statements of policy are likely to reflect differences in approach between different licensing authorities. For example, a statement of policy produced by an ‘inner city authority … may be more concerned with impact on the vulnerable’ (Gambling Commission, 2016e: 6.3), and ‘a licensing authority might identify the safeguarding of children as a key priority … its statement would set out those policies, procedures and control measures. It would expect licensees to follow to
mitigate any risks relating to underage gambling’ (Gambling Commission, 2016e: 6.2). The Gambling Commission also advocates licensing authorities to complete ‘local area profiles’, which involve assessing the local environment to map out the key characteristics of the area in order to identify potential and actual risks which gambling operators should attempt to mitigate by incorporating controls and measures within their license application (Gambling Commission, 2016e: 6.47). The Gambling Commission states that licensing authorities can consider whether any special considerations apply in the protection of ‘vulnerable persons’ so long as any such considerations are balanced against the licensing objective of permitting the use of premises for gambling (Gambling Commission, 2016e).

A local risk index model has recently been developed for two local authorities, the London Borough of Westminster and the city of Manchester, by Wardle, Astbury, Thurstain-Goodwin and Parker (2016). The researchers used national (eg census) and local (eg local authority) data to identify areas with a greater concentration of people who were identified in previous research (Wardle, 2015) as more likely to be vulnerable to harm in Westminster and Manchester. The authors noted that for some characteristics there were good data available (eg problem gamblers who are seeking treatment, substance abuse/misuse, poor mental health, unemployment, minority ethnic groups, youth, financial difficulties/debt). There was a lack of local-level data for potentially vulnerable groups (eg immigrants, those on probation, those under the influence of alcohol, those with a ‘low IQ’, personality traits and cognitions), which led to the immigrant population and those on probation being excluded from their models. Data were grouped into two different indices, based on whether they related to the characteristics of people who live in an area and/or the location of local services that are likely to attract potentially vulnerable people to a specific place (eg GamCare counselling locations). Data from the two indices were then combined to produce an overall gambling risk index for each area. In Westminster, four broad areas of greater risk were identified, and the heightened risk in each area was driven by a range of different factors, such as a greater number of homelessness shelters and substance abuse treatment providers. In Manchester, risk was driven by rates of unemployment, ethnic make-up and large numbers of resident young people. In Manchester, there were many different areas of risk: in the city centre, risk was driven primarily by the concentration of pay-day loan shops, educational establishments, younger residents and support centres for problem gamblers. The authors also highlighted that the Index of Multiple Deprivation may not be a sufficient proxy to represent risk of gambling-related harm at a local level, because although Manchester had a relatively low score, it had a higher risk of gambling harm, as there was a range of services offered that may draw potentially vulnerable people into the city centre. The authors concluded that local authorities could consider the different types of data they have available, identify any gaps and how they could be filled, and explore how such data can be used in local area profiles (Wardle et al., 2016).

Gambling scams

Gambling can be associated with negative outcomes (eg losing money or accommodation), but because people have the right to make decisions that others might regard as unwise or eccentric (Samsi, et al 2015; Social Care Institute for Excellence, 2010), those who have capacity may continue to participate despite the potential for loss. Within a literature review of types of fraud, the perpetrators of fraud, and typologies of victims, four types of gambling scams were identified. Gambling scams were defined as ‘where the victim
is invited to become involved in lotteries and other gambling orientated schemes’. The four identified types were prize draw and sweepstake scams, foreign lottery scams, bogus tipsters, and premium-rate and telephone-prize scams (Button, Lewis & Tapley, 2009:8). Prize-draw and sweepstake scams involve fraudsters circulating letters and emails to potential victims informing them that they have won a prize or are entitled to a financial reward, but must pay a small ‘administrative fee’ to claim their prize or receive the reward. Foreign lottery scams are similar to prize draws and sweepstake scams, but victims are informed about their supposed overseas prize by post or email, or are asked to contact an ‘agent’ by telephone in order to pay the ‘administrative fee’ or ‘tax’ and receive the money. Bogus tipsters involve scammers circulating brochures and charging fees for tips which are meant to be guaranteed due to ‘inside’ information, thereby resulting in certain winnings for victims. However, the tipsters often do not have any specialist knowledge. Premium-rate and telephone-prize scams are where victims receive a letter, text message or automated telephone call which informs them that they have won a prize, but that in order to claim it, they must call a premium rate number. This call generally lasts several minutes, so victims end up with a prize worth less than the cost of the telephone call or nothing (Button et al., 2009).

In terms of the victim profiles of gambling or gaming fraud, this report calculated that for gambling prize draw and sweepstake scams, the typical victim profile by gender was slightly more often female (57 per cent) than male, with an age profile of mainly 35–64 years (66 per cent). There was extremely low reporting to police (2 per cent), but an estimated 380,000 victims each losing a median £33, totalling losses of £60 million annually. In terms of foreign lottery scams, the profile was similarly even by gender (male = 53 per cent) and the main age band affected was 35–64 years (58 per cent) – although 24 per cent were over 65 years. Again there was also very low reporting to police (3 per cent) or a local authority (2 per cent). An estimated 140,000 people were affected annually, each losing a median £42, totalling £260 million annually. With respect to bogus tipsters, there is little detail, save that an estimated £5 million was being lost annually (Button et al., 2009: 38).

Summary

This section has discussed gambling in relation to its popularity within much of UK society, the prevalence of problem gambling, the policy context, the provision of treatment and the identification of vulnerable populations. The section has identified the challenges in terms of protecting vulnerable populations from harm while permitting gambling to take place in local communities.

Public bodies such as local authorities are obliged to promote the wellbeing of their populations, including vulnerable people such as adults at risk, as a priority, and reflect this in their statement of policies. Gambling is an easily accessible activity. There are opportunities for people to gamble in person, at premises located within local communities, and also remotely, using electronic devices. Gambling is also a highly promoted activity, in that individuals are exposed to television, print and online advertising. Certain people are considered to be vulnerable to gambling, and may develop problems with gambling, with risks related to demographics, socioeconomic circumstances, poor judgement/impairment and poor mental health, currently being a problem gambler, and substance misuse/abuse (Wardle et al., 2016). However, vulnerability has generally been discussed in relation to people becoming problem gamblers – but there is evidence which suggests the processes by which some people may become at-risk gamblers and/or experience gambling-related harm. There is therefore a need to consider vulnerability more broadly in relation to at-risk gambling and the nature
The broadening of the discussion of vulnerability and identification of vulnerable or at-risk groups may be particularly important when considering adults at risk who have care and support needs. Many adults with care and support needs do not have problems in this area, and indeed many benefit from participation in ordinary life social activities. However, five themes have emerged from the literature consulted.

Firstly, some people who are vulnerable to gambling-related harm because of their demographics, financial circumstances, poor judgement/impairment, and/or poor mental health may also be in situations that lead to concerns about abuse and neglect and contact with adult safeguarding teams. It may be that some adults at risk (using the Care Act terminology) are participating in gambling and experiencing gambling-related harm, which is related to poor outcomes for health and wellbeing. Gambling therefore may be encountered by adult social care and safeguarding practitioners, although there is no data to show to what extent gambling features within adult safeguarding referrals or responses.

Second, for adults at risk there are wider risks beyond their own possible participation in gambling at problematic levels. For example, participation in gambling by family members or others in a position of trust may lead to abuse, neglect, or acts of omission being perpetrated against adults at risk in order to raise money to fund gambling.

Third, gambling may be used to entice adults at risk into participating in lotteries and other gambling-oriented schemes. Participation may lead to their becoming the victim of a scam and consequently experiencing financial loss and/or emotional distress.

Fourth, local authorities are tasked with offering gambling opportunities in their role as giving approval of licenses, but they are also responsible for protecting vulnerable people and improving the local population’s health and wellbeing. It may be that adults at risk who are experiencing gambling-related harm are seeking support, advice or treatment from services that are funded by local authorities rather than by the Responsible Gambling Trust; such services may be experiencing a similar disproportionate overburden of problem gamblers, as identified within the NHS by Cowlishaw and Kessler (2016).

Fifth, the requirement for local authorities to produce a ‘Statement of Licensing Policy’ presents an opportunity for different stakeholders to provide data in order to identify issues, priorities and risks associated with local regulation. The inclusion of such data may help local authorities, local services and gambling operators to identify and mitigate local risks, thereby possibly helping to safeguard adults at risk from experiencing gambling-related harm as broadly defined. However, there are gaps in data pertaining to whether gambling problems are encountered by local authorities and to what extent gambling is a risk factor for the abuse and neglect of adults at risk.
Aims of this scoping review

The aims of this review were to improve the understanding of gambling-related harm for people described as adults at risk. This is a more focused approach to the subject than one on vulnerable groups (who may include children). We focused our review on people with dementia, cognitive impairment (such as acquired head injury or learning disability) and/or other mental health problems affecting many individuals with care and support needs who are not able to protect themselves from harm. We did not limit this area to gambling that is regulated and so include risk of harm from scams and fake lotteries. We also sought to examine whether gambling addiction (or similar) is cited among ‘perpetrators’ of adult abuse or neglect as explanation or motivation. The following research questions were explored with a view to improving the understanding of the extent to which gambling is a safeguarding issue for those working in social care and for local authority adult services:

1. What is the evidence of gambling participation among adults at risk?

2. What is known about the impact of gambling participation for adults at risk?

3. Is there evidence that perpetrators of abuse against adults at risk are committing these acts or crimes to fund gambling addictions?

4. What is the evidence about how social work and/or adult safeguarding teams address gambling-related harm and risks?
Methodology

Initial searchers identified little literature relating to adult safeguarding and gambling. Therefore a broader search strategy was developed using the mnemonic PICo: Population, phenomenon of Interest, Context (Glasper & Rees, 2016). Table 1 outlines the search strategy together with the inclusion and exclusion criteria.

The search and screening phases of the review are shown in Figure 1. Literature which made reference to or identified dementia, cognitive impairment, learning disabilities and mental health problems as comorbidities of gambling addiction was not included in this review, as its main focus was on literature which examined people who fall

### Table 1: Search strategy and inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Population</th>
<th>Population Phenomenon of interest</th>
<th>Context</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
</table>
| ‘adult* at risk’ OR ‘at risk adult’ OR ‘dependent adult’ OR ‘vulnerable adult’ OR ‘vulnerable person’ OR ‘vulnerable population’ OR ‘vulnerable group’ OR ‘adult* in need of protection’ OR ‘adult* with disab’ OR ‘adult* with learning disab’ OR ‘person with dementia’ OR ‘dementia patient’ OR ‘person with an acquired head injury’ OR ‘older adult’ OR ‘vulnerable older adult’ | Gambling | ‘adult safeguarding’ OR ‘adult protection’ OR ‘adult protective service’ OR ‘social service’ OR ‘elder abuse’ OR ‘elder guardianship’ OR ‘safeguarding adult’ OR ‘social work’ OR ‘financial abuse’ OR ‘neglect’ OR ‘act* of omission’ OR ‘perpetrator*’ OR ‘abuser*’ | English language | Literature pre-2007
| | | | Wide-ranging including: academic articles OR reports; legislation; statutory guidance; professional press; books; book chapters; newsletters; briefing papers; industry statistics | Adolescent gambling |
into the current category of adults at risk, together with viewing gambling from a safeguarding, social work and/or social care perspective. Similarly, literature which focused on abuse or neglect but did not explicitly refer to adults at risk, safeguarding, social work or social care (for example, child protection) was not included in this review but has been included in the background where relevant.

Figure 1: Literature review flowchart based on a PRISMA flow diagram (Moher, Liberati, Tetzlaff & Altman, 2009)
Findings

Gambling-related harm and adults at risk

Literature on gambling-related harm provided insights into how such harm can be conceptualised, who might be considered as vulnerable to it, and how to identify people who may be experiencing gambling problems. Some data about adults at risk were identified (see below, collected by GamCare and the National Problem Gambling Clinic), but most of the articles were general and described people who were at risk of gambling-related harm – and if or how this status intersected with other social deprivation measures.

Langham et al. (2016) developed a taxonomy of gambling-related harm following a literature review, focus groups and interviews with stakeholders. Seven classifications of harm were identified: financial harm; relationship disruption, conflict or breakdown; emotional or psychological distress; detriments to health; cultural harm; and reduced performance at work or study. Furthermore, the authors identified harms which might occur and lead to a change in the lifecourse of an individual, with generational loss to an individual or harm passed between generations (eg homelessness, incarceration and removal of children by government agencies) (Langham et al., 2016). They observed that there was often a temporal or time point of significance in terms of the experience of harm – general harms, crisis and legacy.

Some literature found that certain populations might experience gambling-related harm more than the general public. Blaszczynski et al. (2014) suggested that those most at risk of developing problem gambling often have pre-existing vulnerabilities in information processing and are impulsive decision-makers, making poor and rash choices due to an interaction of cognitive and neurological factors. Browne et al. (2016) acknowledged that some people experiencing harm from gambling may have experienced harm from another adaptive behaviour due to pre-existing conditions such as complex trauma, brain injury, or mental health problems, although they noted that in the absence of gambling availability, a different behaviour may have been adopted (and may also exist in conjunction with gambling). They acknowledged that not everyone who has experienced complex trauma or has a mental illness develops a problem with gambling; nor does every person who experiences problems with gambling have a history of complex trauma or a diagnosis of a mental illness.

Some groups, such as people with intellectual or mental health disabilities, people with health problems (eg co-morbid or concurrent conditions), people in socioeconomically vulnerable communities, people who are socially isolated, people with cognitive impairments, seniors (older people), people on community services or corrective orders (through the criminal justice system), people with poor English skills and those who are emotionally fragile (say, due to grief) – may be particularly vulnerable to problems with gambling (Browne et al., 2016). Furthermore, this review noted that data collected from professionals involved in the provision of problem gambling treatment, ancillary counselling services, community education, primary health care, public policy, research and the provision or promotion of responsible gambling within venues revealed that gamblers with an acquired brain injury or cognitive impairment formed a growing client base for some professionals (Browne et al., 2016). Participants believed that the nature and restrictions of such conditions made them more vulnerable to developing problems with gambling (ibid). A treatment provider working with a number of clients with disabilities also stated that gambling as an entertainment activity could become a gateway to other detrimental health behaviours, such as smoking and alcohol abuse (ibid).

Additional factors related to general vulnerability raised within the literature concerned socio-spatial vulnerabilities. Welsh, Jones, Pykett and Whitehead (2014) conceptualised these vulnerabilities in relation to the setting in which an
individual or community experiences some form of harm. They conceptualised the ‘setting’ as the socio-spatial, socioeconomic and socio-cultural relations of those involved and in which the social practice, in this case gambling, takes place. They explored how particular spaces of vulnerability can lead individuals to succumb to the ‘buzz’ of gambling. They proposed that some communities might be vulnerable to gambling-related harm because the gambling industry saturates them with different kinds of opportunity for gambling (Welsh et al. 2014). Giving the example of an area in Tottenham, London, where there are extensive mental healthcare facilities, what they described as vulnerable adults living in care in the community (in terms of this review adults with care and support needs) and an unusually high number of houses in multiple occupation occupied by single men and vulnerable adults (not defined), the authors observed that connections are forged by the gambling industry and vulnerable groups of people located within particularly vulnerable neighbourhoods (Welsh et al. 2014). Therefore the authors argued for the need to consider the connection between problem gambling and social and spatial vulnerability, especially as gambling becomes normalised within particular vulnerable groups and within particular kinds of communities. The websites of two gambling support services such as GamCare and the National Problem Gambling Clinic indicate that information relevant to being an adult with care and support needs or being a carer may be collected during the referral process. GamCare collects data relating to ‘vulnerable adults’ within its online form which individuals use to register for online counselling (GamCare, 2016). Individuals completing the form are asked a series of questions including whether they have carer responsibilities for children or a vulnerable adult, and if they do, to provide their names and dates of birth; whether the children or vulnerable adults live with them; whether gambling has had an impact on the welfare of a child or a vulnerable adult; and if the individual requesting support has had any involvement with statutory services (GamCare, 2016). In addition, the National Problem Gambling Clinic collects data about current ill-health and engagement with other agencies within its referral forms, which are completed by individuals and/or providers (National Problem Gambling Clinic, 2016a) and significant others (National Problem Gambling Clinic, 2016b). The forms ask if the person being referred ‘has issues’ with regards to mental health (current ill-health requiring medication or intervention), physical illness (current ill-health requiring medication or intervention) drug use, homelessness, physical disability, social services and probation. We did not ascertain why these two gambling support services collect this particular data, or how they use such data when providing help, support, advice or treatment to gamblers, but this might be an avenue for further research.

Further discussion of individuals being required to self-declare problems with gambling was evident within discussions concerning approaches taken to provide responsible gambling information to individuals and approaches to harm minimisation. Harm minimisation ‘denotes bringing the severity and extent of harm to the lowest level … at the individual and societal level in ways that represents efficient use of resources dedicated’ to this task (Blaszczynski et al., 2014:16). Blaszczynski et al. (2014) identified three approaches to harm minimisation – product-based approaches, operations-based approaches and community-based approaches. They observed that the current approach to providing vulnerable persons with problem gambling information and guidance is largely reactive and therefore recommended that a proactive approach where problem gambling and referral information are provided to customers who appear to be exhibiting distress or signs of problem gambling would be complimentary and might enhance informed choice. These sentiments were echoed by Welsh et al. (2014), who considered that the term ‘vulnerable persons’, as used by the Gambling Commission, might be problematic in practice because guidance provided to problem gamblers about responsible gambling and harm minimisation is ‘reliant primarily on self-presentation or an assessment by staff of the mental state of a user of the premises’. They argued that the prevailing discourse places primary responsibility with the vulnerable person, with the gambling industry responsible (to the best of its ability) for protecting the problem gambler only once they are exposed or present themselves. Furthermore, measures to safeguard gamblers neglect the fact that problem gamblers are ‘not vulnerable to gambling as a future practice; they are already exploited and harmed by it, therefore the concept of vulnerability with regard to problem gambling is severely limited’ (Welsh et al. 2014: 165).
The identification by venue employees of customers who might be experiencing problems with gambling has been examined by Thomas, Delfabbro and Armstrong (2014). They developed a set of problem gambling behavioural indicators for use by gambling venue employees so as to help identify people who might be experiencing problems with electronic gambling machines (EGMs). They sought to validate a set of problem gambling behavioural indicators and found that the strongest indicators included the rarest behaviours (eg customer asks for credit or loans, displays visible deteriorations in personal appearance, conceals presence at venue, is rude to staff, or if friends or relatives contact the venue looking for the customer). Behaviours exhibited by problem gamblers were said to include looking sad and depressed, leaving the venue to find money, betting relatively large sums per spin, replaying wins or gambling through meal times. For men, additional indicators included avoiding contact with others, physically shaking while gambling, and gambling for long periods without a break. For women, additional indicators included avoiding the cashier and gambling intensely without reacting to what was going on around them.

In stage two of their research, the authors examined the practical validity of the gambling behavioural indicators by piloting them with staff working in the Australian state of Victoria’s electronic gaming machine (EGM) environment in Melbourne hotels. Feedback from experienced staff suggested that the measure facilitated quick and easy identification of problem gamblers, and for less experienced staff (less than two years’ EGM experience), the measure assisted in proactive identification of problem behaviours and increased confidence when managing customers (Thomas, Delfabbro & Armstrong, 2014). Most behaviours were considered easy to observe, although a small number were considered more difficult to assess, including the least common behaviours, which were also the strongest problem gambling indicators: those less obvious to staff without specific training (eg friends or relatives contacting venue to locate customers) and those requiring greater-than-normal customer attention or customer knowledge (eg observing a spending pattern increase). The observability of some behaviours was also location- or shift-dependent, and busy periods limited the observation of behaviours requiring sustained observation (eg spotting customers staying on to gamble after friends had left). Staff usually observed around 10 behaviours before responding with a follow-up action (eg a general chat before putting the customer under further observation), and staff actions were more likely to follow observation of multiple higher-severity behaviours than lower-severity behaviours (Thomas, Delfabbro & Armstrong, 2014).

This section has provided an insight into the range of harms which might be experienced by people, their family members and the broader community as a result of gambling participation. However, it is unknown which gambling-related harms adults at risk may experience or to what extent. It may be anticipated that adults at risk participate in gambling given that two gambling support services collect data about whether people who are referred to their services currently receive support from public services, are living with medical conditions, are parents, or have caring responsibilities; however, we do not know the results of such enquiries. The discussion of how people who may be experiencing gambling-related harm are identified focuses on the notion of the responsibility to self-declare any issues. However, the identification of social and spatial vulnerabilities as possible indicators of gambling-related problems highlights that there is a range of factors which may lead to someone being vulnerable to gambling-related harm. With regards to the visual identification of suspected
problem gamblers in venues by gambling industry employees, it appears that the use of behavioural indicators may be useful. Furthermore, given that the identification of problem gamblers is affected by location, shift patterns, busy periods and the amount of time a staff member is able to dedicate to observation, more research is needed to determine how to effectively monitor, identify and approach individuals who may be experiencing problems with their gambling. The principle ‘know your customer’ (KYC), which is applied in relation to due diligence (Banks, 2016), is applied to assist with the monitoring and identification of possible individuals at risk of harm, but if and how this works in practice are not discussed in the literature.

**Acquired brain injury/intellectual difficulty**

Acquired brain injury (ABI) can lead to impulse control disorders such as excessive gambling (Guercio, 2012). Guercio (2007) had earlier suggested that people with an acquired brain injury (ABI) might experience problems with gambling more than other people, following his assessment of the prevalence of problem gambling in participants with an ABI, which found a 25 per cent prevalence rate in a sample of 162 participants, compared to 1-2 per cent in general samples in the US. He also found a relationship between the site of the ABI, in that damage to the frontal lobe and basal portions of the brain was much more predictive of a higher South Oaks Gambling Screen score than damage to other areas of the brain. Guercio, Johnson and Dixon (2012) later concluded that people with an ABI also appear to be more likely to gamble than non-brain-injured people.

A different perspective concerning gambling participation by people with an ABI was obtained in research by the Central West Gippsland Primary Care Partnership in Australia (2013) that examined the views of family carers of people with an ABI or an intellectual disability (ID). Focus groups carried out with the carers explored five themes – enablers of community participation, barriers for community participation, risky behaviour, money and budgeting, and what can be done? Enablers of social communication participation included social connectedness, building self-esteem and having a sense of belonging – but the carers reported these aspects to be lacking in the lives of almost all of those whom they cared for or supported. Peer pressure was considered to be a risk that those with ABI or ID might face, with one carer reporting that peer pressure led someone with an ABI or ID to play pokie (slot) machines. Another carer reported that the person with an ABI or ID they supported was unaware of the difference between spending a small amount and a large amount on an item. Gambling was considered a problem by some carers because some individuals spent excessive amounts of money on raffles, placed bets on horse races but did not have the knowledge of when to stop, and played pokie machines. Money and budgeting formed another theme, as some carers expressed concerns about the person they supported not knowing the value of money and engaging in compulsive buying.

With regards to what can be done to address such problems, public education was seen as one way to improve the community’s perceptions of people with an ID or ABI. Better education for family members of people with an ID or ABI was also thought to help people understand what triggers their behaviour and learn strategies from professionals on how to deal with certain challenges. Education for gaming venue staff was also suggested in relation to self-exclusion for people with an ID or ABI and what types of employee behaviour would be classed as discrimination. The authors concluded that people with an ID or ABI often experience limited access to other recreational activities and social support which could lead to the development of problem gambling.

In summary, these three studies suggest that people with care and support needs with an ABI or ID might be more likely to participate in gambling than other adults, and aspects of their condition may lead them to experience problems with budgeting, spending, and maintaining control, all of which are relevant to gambling. The studies also
provide an insight into the perspective of carers, who advocate educating the public and gaming venue staff so as to help to understand triggers, how to manage people with ABI or ID, and that improving access to recreational activities and social support may minimise the risk of people with ABI or ID experiencing gambling-related harm.

**Learning disability/difficulty**

A survey of gambling habits of people with intellectual disabilities (in England, the term learning disability is used in law and in most services) conducted with 79 clients presenting with an intellectual disability clinic in Las Vegas, Nevada, US, found that, of the 53 individuals who had a mild range of intellectual disability, six were problem gamblers and one person who fell into the moderate range of intellectual disability was also a problem gambler. Other conditions experienced by these problem gamblers included major depression (five people), panic disorder/General Anxiety Disorder (two people), schizophrenia/schizoaffective disorder (two people) and ADHD (one person) (Kalinowski, 2007). These figures suggested to the researcher that problem gambling may be more common in individuals with intellectual disability than among the general population living in Nevada. However, the author suspected that the actual prevalence of problem gambling among people with ID may be underestimated. Some people were under guardianship, known gamblers might have declined to participate in the study and all of their participants were recipients of state-funded ID services, meaning they may have had less opportunity to gamble than others.

With regards to learning disabilities/learning difficulties, Wardle (2015) noted that there are no British-based studies examining the relationship between gambling behaviour and these conditions. While we also did not find any studies, our literature search did identify a discussion of whether the expansion of gambling opportunities as outlined within the Gambling Act 2005 could be ‘bad news’ for some people with a learning disability. Shelmerdine, Stannard & Kandernani (2007) visited a middle-aged man with autism and learning disability and his carer and reported this as a case study. They observed that the man talked constantly about his betting intentions. In contrast, his carer expressed concerns about his lack of interest in other activities, such as group outings or socialising, and reported that his addiction to gambling had led him to shoplift in order to feed his gambling habit. The authors suggested that people with a learning disability might be more vulnerable to the harmful effects of gambling, as they may be unable to recognise when their pastime is becoming a problem, or if they do, may be unaware of whom to turn to for help. This case led the authors to contact various gambling support groups in order to discuss the issues potentially faced by people with learning disabilities. They described being shocked to discover how little protection is available for this population (Shelmerdine et al., 2007). For example, they reported that Gamblers Anonymous did not allow carers to be involved in counselling sessions due to confidentiality rules, and the authors’ idea to set-up a special group was rejected (Shelmerdine et al., 2007). In response, they produced a pamphlet in a similar style to Books Beyond Words, a series of books which contain only pictures in order to inform people about everyday events, things which are going to happen, life decisions and things that have already happened. The aim was to help people with a learning disability to recognise problem gambling and obtain feedback from some gambling support groups. GamCare has expressed an interest in including this in their literature, but Gamblers Anonymous said this was not something the fellowship would take up (ibid).

The right to participate in gambling has also been raised in respect of people with learning disabilities. Shelmerdine et al. (2007) considered that there are difficulties associated with excluding this population from taking part in gambling. More recently, Liverpool Public Health Observatory (2014) found that some betting shop staff mentioned that vulnerable adults, such as those with learning disabilities, are not prevented from spending large amounts of money (Liverpool Public Health Observatory, 2014). This research also found that while 87 per cent of betting shop staff, who were asked questions by Licensing Officers during visits to 198 of 440 licensed betting offices located across the Liverpool city region, stated that there was a policy in place for vulnerable adults, 13 per cent did not, and most of the betting offices did not have a vulnerable adult barring register (Liverpool Public Health Observatory, 2014). These four studies have provided an insight into the prevalence of gambling by people who have learning disabilities/difficulties, although concerns were expressed in relation to the under-reporting of gambling by this group of people. Two studies
discussed gambling by people with learning disabilities/difficulties in the UK. One study outlined that some people with learning difficulties/disabilities may become preoccupied with gambling, commit criminal acts in order to fund their habit, and be unable to recognise when their participation is becoming problematic or unaware of where to seek help. The rights to participate in gambling and not exclude people with learning difficulties/disabilities were outlined, with a survey of betting shop staff reporting that vulnerable adults, such as those with learning difficulties/disabilities, are not prevented from spending large amounts of money. The existence of a vulnerable adult policy and of a vulnerable adult barring register was reported but there is little detail of their content.

Other disabilities

Physical disability is referred to in other literature, in addition to learning or intellectual disabilities. Two forms of gambling have been investigated in this respect – machine play and bingo. In one report of the gambling behaviour and experiences of individuals holding a loyalty card for Ladbrokes, William Hill or Paddy Power, 16 per cent of people who were unable to work because of illness or disability played machines in a bookmaker’s every day, compared to 7 per cent of individuals in paid employment. Furthermore, men with either the lowest levels of personal income or who were unemployed or unable to work because of long-term disability/sickness were more likely to be either a problem gambler or to have more problems with their machine play than others (Wardle, Excell, Ireland, Illi & Sharman, 2014).

UK research on problem gambling within licensed bingo premises found that older patrons, those with any long-term illness, health problem or disability (defined as a physical, sensory or other impairment) limiting their daily activities or employment visit bingo clubs most frequently, together with those who are not working for reasons other than unemployment (Wardle, Welch, Bollen, Kennedy & Gariban, 2016). This large telephone survey also investigated the reasons why people played bingo. Disabled people and other individuals who visit bingo clubs daily/almost daily cited reasons such as wanting to get out of the house, to avoid boredom/fill time, and to take their mind off other things. Bingo was considered by older patrons, patrons with a disability and patrons who attend daily/almost daily to provide social benefits, as they can be around other people and can feel safe even when they are on their own. Bingo was also considered to offer intellectual stimulation, particularly to individuals with a disability. Older patrons and patrons with a disability also described bingo as a way to save money, because the venues are warm and cheap, with tea and food on offer. In addition, patrons who are older or have disabilities considered bingo appealing because it is one of the few activities in which they can participate. Such research provides insight into the appeal of this particular form of gambling.

Use of benefit payments to fund gambling

Concerns have been raised about whether social security benefit payments, in general or specific to disability, should be used to fund gambling activities. Interview data obtained from people who have had problems with gambling contained a comment which suggested that one person had knowledge that some of their friends who were in receipt of benefits had withdrawn cash at midnight, when the money was paid into their account, and had then spent the money by 12:30am (Liverpool Public Health Observatory, 2014). Another question related to the use of public funds received to meet care and support needs was mentioned by service users (receiving social care support) who attended events across Scotland organised by the Mental Health Foundation and the Scottish Mental Health Cooperative. Some service users expressed anxiety about the extent to which they could spend personal budgets on ‘leisure’ activities, such as bingo, which was an important social activity to them but technically counted as gambling (Mental Health Foundation, 2013). There appeared to be no evidence about whether these fears were based on experience or general uncertainty about legitimate use of personal budgets/self-directed support, which needs to be approved by the local authority and excludes expenditure on alcohol, gambling, and debt repayments.

Homeless people

There is relatively more literature concerning the prevalence and impact of gambling participation among one group of people who may be adults at risk, namely individuals who are homeless. Primary data about homelessness and gambling were
gathered within seven studies. The prevalence of gambling among homeless people was investigated within four studies. In a comparative study of the causes of new episodes of homelessness among people aged 50 years and older in Australia and England, 28.8 per cent (n = 32) of respondents reported having problems with gambling in the Australian sample, compared to 5 per cent of respondents in the English sample (Rota-Bartelink & Lipmann, 2007). In the Australian sample, 52 care workers reported that some of their clients either had or were suspected of having gambling problems. Furthermore, men were significantly more likely than women to report having problems with gambling, and of those who reported having such problems, most (85 per cent) did not seek assistance. The authors concluded that problem gambling may be under-reported by older homeless people, and that funding should be directed into strategies designed to address gambling among this population.

Matheson, Devotta, Wendaferew & Pedersen (2014) examined the prevalence of problem and pathological gambling among clients of homeless service agencies in Toronto, Canada. The prevalence of lifetime problem gambling was 10 per cent, and that of pathological gambling was 25 per cent in this sample (Matheson et al., 2014). Sharman et al. (2014) conducted a study into the rates of problematic gambling in a sample of British homeless people. They recruited 456 individuals who were attending homeless services provided by Westminster local council. The rate of problem gambling within the sample was 11.6 per cent, and was even higher among the rough sleepers compared to hostel residents. While shop-based gambling activities included electronic roulette on a FOBT, slot machines were the most common forms of betting among the homeless problem gamblers. The authors suggested that the link between sleeping status, gambling and gambling type may be the shelter offered by high street gambling venues. For example, amusement arcades and bookmakers’ shops have extended opening hours, can offer very low-stake gambling, are warm, and provide free hot drinks and snacks. Wardle, Parke and Excell (2014) also observed that a bookmaker’s shop might be an appealing environment for homeless people who want to stay there for as long as possible.

Nower, Eyrich-Garg, Pollio & North (2015) investigated the prevalence of gambling disorder and comorbid psychiatric disorders in a homeless population in the US. African-American homeless people (n = 275) took part in structured interviews. The sample comprised 60 non-gamblers, 152 recreational gamblers and 63 problem gamblers. Lifetime rates of sub-clinical problem (46.2 per cent) and disordered (12 per cent) gambling were significantly higher than in the general population. Problem gamblers were more likely than non-problem gamblers to meet diagnostic criteria for antisocial personality disorder, post-traumatic stress disorder, bipolar disorder, and any psychiatric...
disorder, and more likely than non-gamblers to use illicit drugs or meet criteria for abuse/dependence for nicotine, alcohol, or any substance.

A later UK study conducted by Sharman, Dreyer, Clark and Bowden-Jones (2016) examined the extent to which problem gambling was a cause or consequence of homelessness. They recruited 72 participants from homeless centres in Westminster, London. Problem gambling was evident among just under a quarter (23.6 per cent) of the sample, of whom most (82 per cent) said that their gambling preceded their homelessness, while 17.6 per cent had experienced gambling problems after homelessness. Rough sleepers were more likely than hostel residents to be problem gamblers. Of the 26 participants who were classified as at-risk gamblers, six did not consider themselves as having experienced gambling problems, 16 disclosed gambling problems prior to becoming homeless, while four reported only experiencing gambling problems after becoming homeless. Furthermore, nine participants admitted committing an illegal act specifically to fund gambling, with five of these crimes involving theft (stealing, shoplifting and burglary). High rates of substance and alcohol dependence were not correlated with Problem Gambling Severity Index scores. Awareness of treatment options for gambling was significantly lower than for substance and alcohol misuse services. About three-quarters (76.9 per cent) of those who had participated in gambling in the last 12 months were aware of support services for gambling, compared to almost all (94.7 per cent) of the participants who consumed alcohol and almost all (95.7 per cent) of those who misused drugs. Access to gambling support had been undertaken by a quarter (26.9 per cent) of gamblers in the ‘some risk’ group, whereas nearly half (46.2 per cent) of participants with alcohol problems and over three-quarters (67.9 per cent) with drug problems had accessed treatment services.

Two further studies examined the experiences of people who were homeless and had gambling problems (Guilcher et al., 2016) and those providing support (Holdsworth & Tiyce, 2012). Holdsworth and Tiyce (2012) conducted in-depth interviews with 17 homeless people who were seeking assistance for housing and related problems, and 18 service providers (i.e. social workers, counsellors, and case workers). The study was conducted in the Northern Rivers region of New South Wales, described as one of Australia’s most disadvantaged areas. Both the service users and service providers recognised a connection between homelessness and gambling. One service provider emphasised that discussing matters such as finances and gambling was critically important, not only to uncover ‘hidden’ problems, but also to provide a fuller understanding of each person’s situation and how assistance might best be given. However, others noted that some service users were reluctant to disclose private information and rarely disclosed gambling problems. Another service provider observed that homeless people were only able to deal with one thing at a time, which meant that some become overwhelmed by accumulating problems that were difficult to untangle. Others remarked that homeless people can find it difficult to face up to their problems, especially gambling problems – some may deny that they have a problem or be unwilling to admit to their problems. These feelings could relate to issues of identity, self-esteem and honesty, as some staff believed that gambling behaviour was often consciously concealed. Stigma and shame, which shape and reinforce undesired identities, were viewed by the homeless people as embedded in interactions with staff. Homeless people claimed a need to keep their problem hidden from staff in order to protect their identity and self-worth so as not to be labelled or viewed in a negative light. Some felt that their behaviours and experiences were not understood or valued by those around them, and maintaining a strong sense of self-worth and integrity was described as being critical to coping with homelessness and other related problems, as these were often denied in other areas of their lives. Both homeless people and staff recognised that it was important for individuals to present to services as responsible, and staff expected that homeless people would demonstrate self-responsibility in their behaviours and ‘narratives of self’ in order to be eligible for assistance. Staff spoke of the difficulties they faced when making decisions concerning the allocation of extremely limited resources.

Interviews conducted with men who had experienced problem gambling and housing instability in another study in Toronto, Canada, sought their perception of and experiences with services. The concept of person-centred engagement was a main overarching theme (Guilcher et al., 2016). Person-centred engagement comprised empowerment and autonomy; empathy, compassion and sincerity; respectful communication; and tailored holistic life plans.
Recommendations for improving service provision included increasing general awareness of services for problem gambling, delivering integrated services via a one-stop-shop to help address people’s complex and multiple needs in one place, addressing mental health through psychotherapy and pharmacotherapy, providing timely access to prevention and recovery services, and enhancing life skills by peer support (ibid).

Evidence of the impact of gambling participation on housing security was found by the UK Gambling Commission (Gambling Commission, 2016g). In 2016, the regulator identified several serious failings on the part of Paddy Power Holdings Ltd in relation to keeping crime out of gambling and protecting vulnerable people from being harmed or exploited. For example, the gambling behaviour of Customer A was deemed to have possibly contributed to him losing jobs, becoming homeless and losing access to his children. Customer A usually used FOBTs at a branch of Paddy Power, and in mid-May 2014 shop staff became aware that he had five jobs to fund his gambling and that he had no excess funds, although he had indicated to staff that he was comfortable with his level of spending. A decision was taken by senior staff at Paddy Power to continue to monitor Customer A. Later in May 2014, a senior staff member advised shop staff to encourage Customer A to increase his visits and the time spent in the branch, although the shop manager recorded some discomfort about how to reconcile commercial and social responsibility considerations and concluded that staff would continue to monitor Customer A’s spending and provide good customer service in the hope that his spending would increase in the future, once he was in a more comfortable situation (ibid).

In summary, two themes emerged from the literature concerning homeless people. First, gambling might be an appealing activity for homeless people, perhaps because of the shelter offered by high-street gambling venues, as noted above in Sharman et al. (2014) and by Wardle, Parke and Excell (2014). Second, even infrequent gambling may cause problems for homeless people because it can become an activity beyond their disposable means (Griffiths, 2015), and for some, gambling may have contributed to the factors leading to homelessness (Sharman et al, 2016).

**Service implications for homeless people**

Because gambling may be considered an under-recognised (Sharman et al., 2016) or hidden problem (Holdsworth & Tiyce, 2012), some researchers have recommended screening for gambling problems should be undertaken by support services (Sharman et al., 2014; 2016; Nower et al., 2015; Matheson et al., 2014). The idea that other support services should screen for problem gambling was acknowledged in research conducted by Dowling et al. (2014), who explored the prevalence and patterns of family violence in a sample of treatment-seeking problem gamblers. Clients from 15 treatment services across 14 Australian agencies were systematically screened for problem gambling and family violence. The prevalence of family violence in the gambling sample was 27 per cent for victimisation, 22.9 per cent for perpetration of family violence, and 33.9 per cent for any form of family violence. Perpetrators of such violence included parents, current partners, former partners, siblings, children,
in-laws and extended family members. The same groups were also identified as victims of family violence (it is not known whether these might include people with care and support needs unable to protect themselves). The prevalence of problem gambling in family violence services in this study was 2.2 per cent, 4.3 per cent in alcohol and drug services, 2 per cent in mental health services and 10.6 per cent in financial counselling services. The rate of problem gambling in the financial counselling sample was 4.8 times higher than that in the family violence sample. However, as problem gambling is also closely related to alcohol and drug use problems and other mental health problems, it is possible that the rates of family violence observed in the problem gambling treatment sample may reflect an association of family violence with accompanying alcohol, substance use or mental health problems, rather than any specific association with gambling problems (ibid).

Another study confirmed that people who present to a support service (not for gambling) may have multiple problems: in the survey of 66 substance misuse service clients in Wales, 48 reported alcohol as a reason for accessing the services (Alcohol Concern, 2013). However, three quarters (75 per cent; n = 38) of those attending services because of alcohol problems had gambled within the last 12 months while a smaller number (16.7 per cent; n = 8) said that they had problems gambling, with half saying that their gambling increased when they drank more. Almost all respondents (94 per cent; n = 45) said that addiction services should consider providing a service for gambling addiction.

Possible links between suicidal ideation or attempts and addiction were explored in two studies. Manning et al. (2015) analysed the medical records of 2,187 patients in Singapore with drug, alcohol or gambling disorders entering an outpatient treatment service to explore differences in suicidal ideation and lifetime attempts between substance and gambling addictions. Rates of suicidal ideation (thoughts, and plan), but not lifetime attempts, were significantly higher among gambling than substance misuse patients. Comorbidity, debt, gender (being female) and being a ‘gambling patient’ were significant predictors of suicidal behaviours. The researchers stressed the importance of screening for suicidality, even in the absence of comorbidity, particularly among gambling disorder patients with debts. They recommended that suicide risk should be assessed periodically and referral to suicidal prevention interventions routinely offered to this group, whom they described as a vulnerable population. Concerns about suicide in relation to vulnerable people who gamble were also raised within a case study of posts made to a problem gambling forum website (Miller, Krasodomski-Jones & Smith, 2016). Forum users questioned why posts which encouraged another vulnerable person to place bets and commit suicide, and posts containing threats, were not reacted to rapidly or removed. Although some studies advocated screening for gambling problems, it is also acknowledged that people might be reluctant to disclose gambling problems or consciously conceal their gambling behaviour. Not surprisingly, people may want to protect their identity, self-worth, integrity and avoid being stigmatised by service providers (Holdsworth & Tiyce, 2012).

Gambling might be viewed as a less serious matter by some service providers when compared to other addictions such as alcohol or drug misuse. This is evidenced by service providers stipulating that homeless people with alcohol or drug problems must engage with treatment and support services as part of the accommodation agreement, while there is no requirement to access gambling treatment services (Sharman et al., 2016). These authors recommended that gambling should be considered when assessing the treatment and support needs of homeless people (Sherman et al., 2016). It has also been suggested that homelessness and gambling could be addressed together (Sharman et al., 2014), however, another study highlighted that homeless people may become overwhelmed if asked to deal with more than one problem at a time (Holdsworth & Tiyce, 2012). A general concern in relation to Sharman et al.’s (2014) research was voiced by Griffiths (2015) who argued that the findings might be used by anti-gambling lobby groups to serve their own political agendas, without taking into account the many other issues outside of (and additional to) problem gambling that homeless individuals face (eg alcohol and/or drug dependence, psychotic illness, depression).

In relation to help-seeking behaviours, service users in one study reported that being understood, feeling valued (Holdsworth & Tiyce, 2012), being made aware of services for problem gambling, being told where to go to seek help, being able to access integrated services and person-centred engagement were important (Guilcher et al., 2016). As noted, some service providers acknowledged that they faced difficulties when making decisions...
concerning the allocation of what were often considered extremely limited resources and recognised the importance of service users presenting to services as responsible (Holdsworth & Tiyce, 2012).

Finally, given that gambling can potentially impact upon individuals' housing security, job security and family relationships, it is important to consider the effectiveness of monitoring customer behaviour and interactions with customers by gambling operators. In the Paddy Power case described above, it is evident that while customer A's behaviour was monitored and interactions did take place, there appeared to be a lack of recordkeeping that would indicate whether the customer was signposted to sources of help. The gambling operator seemingly permitted the customer to continue spending and their compliance with the social responsibility code was questioned.

Older people

Literature concerning older people (generally defined as retired and/or over 60/65 years of age) tended to mention possible age-related dementia, cognitive impairment, and mental health problems as being risk factors for problem gambling, but in other reports older people are referred to more generally.

Tse et al. (2012) reviewed 75 empirical studies including data on the distribution and determinants of problem gambling (PG), pathological gambling disorder (PGD) and the outcomes of gambling internationally. They analysed participation rates for gambling, prevalence rates of disordered gambling, motivation for initially beginning to gamble, risk and protective factors for disordered gambling, and negative and positive health outcomes from gambling. The authors recommended that future studies focus on the wellbeing of older adults who gamble, research methods, and take into account older people’s inspirations and adjustment to the ageing process in the 21st century.

The prevalence of older people participating in gambling activities in the US was explored in a study by Lichtenberg, Martin and Anderson (2009). The authors conducted a population based-study of over 1,000 older urban adults and found that the level of ‘at-risk’ gambling was 10 per cent overall, ranging from 14 per cent for those who visited a casino a few times a year to 20 per cent for those who visited a casino on a monthly basis. Correlates of at-risk gambling were also identified and included increased physical and mental health disability, a smaller and less-satisfying social network, and less access to transportation and money (Lichtenberg et al., 2009). The authors presented two case studies to illustrate what they perceived to be some of the common characteristics of older problem gamblers.

In the first case study, an older woman lost control over her gambling behaviour, leading her to stop paying her bills and rent, which led to her moving to a homeless shelter and ill health. In the second case study, the older person was described as ‘going to the casino after she received her social security check at the beginning of the month’. This female gambler stopped paying her bills, borrowed money from her children under false pretences, and was evicted from a senior citizen housing complex. She therefore had to move in with her daughter, who then took over her finances and insisted that she seek counselling for her problem gambling. Both case studies raise the possible inter-relations of financial vulnerability, comorbidity, and the onset of gambling problems. Financial vulnerability may prompt gambling if older adults consider gambling to be a way to make money, an outcome of gambling, or a combination of the two. Comorbidity might be a problem because gambling can be associated with mental health problems and physical disability, with reduced mobility. Furthermore, the onset of problem gambling
later in life may lead to self-neglect and financial problems. 

Among older people, there are distinct types of gambling participation. These are cited in three studies reporting the views and experiences of professionals working with older people. From the perspective of six counsellors trained in gambling addiction, Bjelde, Chromy & Pankow (2008) conducted a qualitative study to explore the social factors surrounding casino gambling among older adults both nationally and in the state of North Dakota, US. Four participants were licensed addiction counsellors, one was a licensed professional counsellor and one a licensed social worker. Counsellors identified several factors which they thought impacted older gamblers in particular, including casino marketing and machine gambling within casinos. Other factors noted were the progression from gambling being social to asocial; gambling to relieve emotional pain such as loneliness, loss and boredom; the quick progression to gambling addiction; the lack of discussion or recognition of mental health problems among older adults; limited services and distance from services; and depression as a comorbid factor.

Parekh and Morano (2009) investigated the risk factors associated with problematic gambling during workshops with older adults, both by conducting interviews with a sample of older adults and by conducting separate interviews with service providers. An elder abuse case worker (in the English context, this would be adult safeguarding) confirmed that many older adult gamblers were in arrears with their rent, played the lotto, or were involved in a pyramid scheme (an unsustainable business which rewards people for enrolling others into a business that offers a non-existent or worthless product) (ActionFraud, no date). A senior housing case manager reported encountering clients with high rent arrears because they had visited the casino ‘too often’ over the previous few months. Professionals’ knowledge of the relationship of gambling to other financial problems seemed limited as they seldom asked their clients specifically about gambling. The authors advised that social workers who administer any gambling survey to older adults must do this sensitively. Confidentiality is an important concern for many older people; they therefore recommended that social workers need to understand that, although gambling might be socially acceptable, the idea of an older adult having a gambling problem can be stigmatising. Nonetheless, they advised social workers to ask about gambling behaviours, in acknowledgment that some older people’s settings may provide trips to local casinos as part of an activity programme. This research also reported the risk that some residents might take advantage of their peers with physical or cognitive impairments – for example, during ‘friendly’ games of poker.

Stansbury, Beecher, Schumacher, Martin and Clute (2015) investigated professional perspectives on casino gambling by older adult clients. The authors sent a questionnaire to 150 social service agencies in Washington State, US. A response rate of 58 per cent was achieved. They found that the most prevalent reasons cited for older adults visiting casinos were for entertainment and the desire to win money. Many respondents felt that their clients were aware of the risks of casino visits, although 29.5 per cent (n = 26) reported that their clients were largely unaware of them. Furthermore, several respondents reported that cognitive impairments, dementia, or memory problems could account for this lack of awareness, others attributed the lack of awareness to the perception that casino gambling was merely entertainment. A minority (15.4 per cent; n =14) of respondents indicated that an older person had approached them with a concern about gambling and 11.4 per cent (n = 10) reported that a co-worker had approached them with concerns about an older adult’s gambling. Almost all of the respondents reported that they had not received any training regarding problem gambling although 44.3 per cent (n = 39) were not interested in additional training opportunities. Reasons for this included the opinion that the training was irrelevant to their service, casino visits were infrequent, clients were closely monitored by
staff and/or family, and clients had not exhibited any problem gambling. Those who reported some interest in receiving some or additional training thought that specific training about how to spot problem gambling and treatment interventions would be effective.

Kerber, Schlenker & Hickey (2011) recommended that nurses should be aware of older adults’ vulnerability to gambling problems because of the increase in gambling opportunities. They remarked that gambling problems might be difficult to detect and those in a position of trust may unknowingly send someone with a gambling problem on a casino trip. The authors also recommended that nurses should educate and assess their older clients with mental illness for gambling problems because nurses need to differentiate the altered cognitions seen in pathological gambling from other conditions such as depression and dementia. They noted that gambling may impact older clients by increasing impairment, damaging their ability to function socially and financially, and negatively affecting their physical and mental health.

Evidence concerning the knowledge of and attitudes towards gambling of future social workers was gathered by Ly Butel (2009), who surveyed a sample of 42 US Master’s of social work students (MSW) students about what they termed ‘pathological gambling’ among older adults. Five students reported experiences of working with older adults who were problem gamblers. With regards to how knowledgeable they felt about the phenomenon of problem gambling among older adults, nearly 70 per cent (n = 29) indicated low levels of knowledge. Three case vignettes were designed to analyse participants’ attitudes towards the gambling behaviour of older adults. Case vignette 1 focused on a caregiver (family carer) spending money on gambling; 74 per cent (n = 31) of the students rated the behaviour as severely problematic or close to severely problematic, while 26 per cent (n = 11) rated the behaviour of the caregiver as not at all a problematic or close to this. Case vignette 2 focused on an older adult receiving social benefits and engaging in betting at a casino, the older adult stating that he only bets ‘what I can afford to lose’ and pleading for the social worker to not discuss this with his family members. Over 70 per cent (n = 30) of the respondents rated the behaviour as severely problematic or close to severely problematic. Case vignette 3 focused on the behaviour of an older adult who plays poker and blackjack socially but doesn’t keep track of her wins and losses and sometimes dips into her savings to cover her losses. In this case, 65 per cent (n = 27) of respondents rated this gambling behaviour as severely problematic or close to severely problematic. Analysis of qualitative data in relation to how they would describe pathological gambling yielded six themes – spending beyond means, impulse control/addiction, impact on basic human needs, duration/frequency of gambling behaviour, psychosocial ramifications, and lack of insight/judgement. This sample of social work students was thought to lack clinical knowledge to differentiate between recreational gambling and a gambler with problematic or pathological tendencies. The authors concluded that students were not being prepared for this area of practice with their older clients and recommended that gambling should be included within their curriculum.

Primary data from older people who either participate in gambling or have been impacted by someone else’s gambling behaviour were collected in two studies. Data collected via semi-structured interviews with older women in the UK provided an insight into the motivations for gambling and patterns of gambling behaviour (Pattinson & Parke 2016), reflecting the growing interest in female gambling overall. One of the participants in this study was a widow who had depression and was a full-time carer of her son, who had Huntington’s disease. This participant reported that gambling on EGMs was a pleasurable distraction from her caring responsibilities. However, she described spending more than she could afford when feeling depressed. Three core themes emerged from the data overall – gambling filling voids, providing emotional escape, and the risk of overspending. Gambling could be a reason to get dressed, an opportunity to visit a welcoming and safe environment. With regard to emotional escape, gambling could provide opportunities for participants to get away from negative age-related experiences, including increased loneliness after retirement and bereavement, declining physical health, and demanding caring roles. The participants perceived that many of these age-related events were inevitable, hence rather than seeking to reduce or alleviate the stressors, they chose to temporarily escape such experiences. Gambling could evoke a positive state in a setting where they could seek support from their peers. Overspending occurred in some instances, although participants stated that they budgeted
and set a monetary sum that they could afford to lose before they began to gamble. The participants acknowledged that the situational characteristics of gambling venues enticed them to spend, and that there was a lack of responsible gambling awareness. Raising awareness of ‘disordered gambling’ and how to gamble responsibly was therefore deemed important for this population (Pattinson & Parke, 2016). Others have noted the increase in marketing of gambling to older people through offers of transport, free food and drink, accessible venues, and other encouragements (Garrett 2014; Ziettlow 2014), as well as the attraction of a clientele who may participate in gambling during the daytime.

The impact of gambling on older people’s family was discussed within the evaluation of Your Money Matters, a free, confidential and impartial money advice service for older people in the UK, run by Help the Aged (now Age UK), in partnership with Barclays Bank, from 2006 to 2009. Brazier, Frumkin, Litster & Ward (2009) conducted 87 interviews with individuals who had consulted Your Money Matters over the phone and in person. One case study illustrated how participation in gambling by someone living with dementia can have serious consequences. ‘Brenda’ experienced financial problems as her husband became seriously depressed, was diagnosed with dementia and then participated in gambling. She discovered that her husband had accumulated debts in excess of £25,000, which included gambling debts, credit cards and loans. Brenda had no previous experience in managing money, and therefore found it difficult to deal with banks and other financial institutions. Her health suffered as a result. She sought advice from a Your Money Matters adviser, who helped her to get matters under control (Brazier et al., 2009). This particular case study highlights the hidden nature of gambling problems and potential dangers of participating in gambling when judgement may be impaired and declining.

Several themes emerged within the literature concerning older people. First, there may be particular risk factors associated with some of this population when gambling, such as financial vulnerability (lack of experience in managing money), life events leading to isolation or caring responsibilities, the risk of dementia or other conditions affecting mental capacity or impairing cognitive ability that may be slow to emerge. Such vulnerabilities may impact upon individuals’ ability to recoup losses and their understanding of the risks associated with gambling. Second, it appears that for some service providers (particularly those in certain settings or cultures), gambling is part of the range of social activities desired by, or on offer to, older people, so it is important that they are informed about the risks associated with it. For those with impaired capacity or at risk of gambling-related harm, carers, care providers and other people in positions of trust may be able to monitor behaviour or ask older adults questions to help identify whether someone is experiencing gambling-related harm. Third, it is apparent that gambling is an activity in which carers might also participate, and they should therefore be informed of the potential risks. Fourth, legal frameworks in England and Wales covering mental capacity and best interests decision-making may be considered with respect to individuals, so that the risks of gambling participation leading to harm may be managed.

Gambling participation among ‘perpetrators’ of abuse

Some literature suggests that those carrying out acts of abuse or omission, who may be called ‘perpetrators’ of adult abuse, undertake this activity or commit such crimes in order to fund their gambling behaviour. Elder abuse to fund gambling and substance misuse habits, for instance, may be undertaken by paid careworkers or by family and acquaintances (Manthorpe 2015).

Evidence of abusers’ gambling participation emerged within the UK Study of Abuse and Neglect of Older People (O’Keefe et al., 2007), a major prevalence study of community-dwelling older people. The study found that 2.6 per cent of people aged 66 and over reported that they had experienced mistreatment involving a family member, close friend or care worker during the past year, and the overall prevalence increased to 4 per cent when the one-year prevalence of mistreatment was broadened to include incidents involving neighbours and acquaintances. Prevalence rates for the individual types of mistreatment were neglect (1.1 per cent), financial (0.7 per cent), psychological (0.4 per cent), physical (0.4 per cent) and sexual (0.2 per cent). The findings suggest that risk factors for financial abuse included living alone, those in receipt of services, those in bad or very bad health, older men, and women who were divorced, separated or lonely. Pertinent to this present review, the perpetrators of financial abuse were...
reported (by the older people) to have a range of personal problems including relationship problems (30 per cent), alcohol use (30 per cent), financial problems (30 per cent), gambling problems (23 per cent) and drug use (8 per cent).

Additional evidence of thefts from ‘vulnerable adults’ (using the general definition of the term) was found by the Gambling Commission, which identified a number of serious historical weaknesses in the anti-money laundering and social responsibility controls used by Gala Coral group Ltd t/a Coral Racing Limited and Coral Interactive (Gibraltar) Limited to mitigate the risk of money laundering and problem gambling (Gambling Commission, 2016f). Law enforcement agents notified the Gambling Commission of a conviction for theft of a customer of Gala Coral Group, who had been sentenced to several years’ imprisonment after pleading guilty to stealing £800,000 from a vulnerable adult. The police examined the individual’s bank records and concluded that the thefts had been used to fund the customer’s gambling, with the majority of this gambling being conducted with Gala Coral Group’s businesses. The Gambling Commission found that Gala Coral Group had conducted an inadequate investigation into the customer’s source of funds, did not make effective use of the customer’s account and play history to reliably assess the customer as a social responsibility risk, over-relied on uncorroborated information, did not effectively utilise open source information, did not submit a Suspicious Activity Report in a timely fashion and over-relied on information gathered through hospitality events. Nonetheless, there had been indicators in the customer’s online and in-store play, including an increase in the number of bets, the value of bets and time spent gambling. However, Gala Coral Group did not assess the customer from a social responsibility perspective, despite being in possession of information relating to their betting patterns, and there were no recorded interactions with the customer. This case raises questions whether the monitoring of individuals’ gambling behaviour is effective in helping gambling operators to identify indicators of problem gambling, and whether gambling operators are using interactions in order to manage risk.

Larger-scale financial abuse was reported within a Safeguarding Adults Case Review (SACR) published by Gloucestershire Safeguarding Adults Board (2014). The SACR outlines incidents of financial abuse of service users (all of whom would likely fall into the category of adults at risk) in a ‘supported living’ home. A care worker had been taking service users’ ATM cards and using them to withdraw cash in order to play bingo or fruit machines. It was unknown how much
money was stolen from the victims, or over what period of time, because of poor bookkeeping by the service provider. The perpetrator was charged with three counts of ‘fraud by abuse of position’ and imprisoned for eight months.

Numeracy problems might also be a risk factor for abuse. Numeracy is ‘usually conceptualised as the capacity to understand and manipulate mathematical concepts’, and is considered to be important in a broad range of decision-making contexts (Wood, Liu, Hanoch & Estevez-Cores, 2016). Wood et al. (2016) administered surveys to 201 independent, community-dwelling adults aged 60 and older who resided in the Greater Los Angeles Area of the US. Risk of financial elder exploitation was assessed using the Older Adult Financial Exploitation Measure (OAFEM), a 79-item, client self-report measure that has been psychometrically validated in a sample of abused older adults which covers six domains of financial exploitation: theft and scams, abuse of trust, financial entitlements, coercion, signs of possible abuse, and risk factors. The authors found that lower numeracy was related to higher scores on the OAFEM, consistent with higher risk for financial exploitation. Furthermore, self-reported physical and mental health problems, being male, and being young were also related to increased risk.

Mass-market fraud – or ‘Jessica Scam Syndrome’ – where fraud is carried out via post, telephone, text message and online affects adults at risk, among others. Jessica Scam Syndrome is the term often used in UK crime prevention circles to describe a chronic fraud victim who denies or refuses to accept that they are being defrauded – for example, because of mental health problems, loneliness or gambling addiction (George, Graham & Lennard, 2014). Relatives and carers can find it very difficult to intervene, and the Think Jessica charity has called for the syndrome to be recognised as a condition whereby the victims can be separated from the criminals by redirecting the victim’s mail to a trusted person and changing their phone number. It advocates that counselling and support should be provided to help overcome social isolation.

International literature also outlines incidents of fraud and abuse in relation to gambling. A survey about fraud and misconduct in Australia and New Zealand was sent to 2,140 private and public-sector organisations. Responses were received from 214 organisations. Respondents were asked to consider fraud occurring in their organisation during the period 1 February 2008 to 31 January 2010. Fraud was defined as ‘any dishonest activity causing actual or potential financial loss to any person or entity including theft of monies or other property by employees or persons external to the entity and where deception is used at any time immediately before or immediately following the activity’ (KPMG, 2010: 27). The authors found that gambling was the most common motivator for fraud in 2008, however, this fell to being the third most prevalent motivator in the 2010 survey, being cited as the primary motivator in just 2 per cent of detected fraud. The average loss to this sample of public and private-sector organisations that was associated with gambling reduced substantially, from $1.1 million in 2008 to $175,456 in 2010 (KPMG, 2010).

Other Australian research investigated levels of gambling-motivated fraud between 1998-2007 (Warfield, 2008), 2008-2010 (Warfield, 2011) and 2011-2016 (Warfield, 2016). Over $450 million was stolen via gambling-motivated fraud between 1998 and 2016 (Warfield, 2008; 2011; 2016). Case studies outlined within the reports provide an insight into incidences of gambling-related fraud that involve people who might be considered in need of care and support and unable to protect themselves. For example, a carer used an ATM card linked to the savings account of an 81-year-old person with dementia. The carer put $430,000 in poker machines and stole $30,000 from the person with dementia, who subsequently had five
strokes after the theft was discovered (Warfield & Associates, 2008). Another person was imprisoned for six years following a conviction for the financial fraud of 65 intellectually impaired clients over a 12-month period (Warfield & Associates, 2008). A further carer forged or altered cheques and transferred money through telephone and internet banking in order to obtain $950,000 (Warfield, 2016). In these examples, it is not reported whether the carers were family members or paid care workers. Known examples of staff members who committed gambling-related crime included one person who defrauded a registered community housing provider of $3.8 million (Warfield, 2016). A financial adviser who had complete control over a 94-year-old client’s finances stole $925,000 from her (Warfield & Associates, 2016). This report calculated that between 2005 and 2016 a total of $584,918 was obtained via gambling-motivated fraud from care receivers, who in UK terminology would very likely be seen as adults at risk. Analysis of court records revealed that although reasons were not provided for the frauds in most cases, factors that emerged included past or present traumas or some life-impacting experience such as death of a close family member, rape, physical abuse, marriage breakdown or personal financial crisis (Warfield, 2008; 2011; 2016). High levels of depression were also reported among many of the perpetrators (Warfield, 2008; 2011; 2016). Drawing on elder abuse research, a further study of calls to a telephone helpline in Australia found that, of the 455 calls received, 18.5 per cent of perpetrators were reported to have a substance misuse problem or gambling addiction (Joosten, Dow and Blakey, 2015).

Such literature illustrates the potential for gambling to impact on older people, perhaps due to age-related vulnerabilities, including being less numerate, experiencing cognitive decline, impaired mobility, increased care needs, isolation or loneliness, and increasing reliance on caregivers. Furthermore, the literature illustrates the potential for gambling to impact on care providers due to incidents of theft or fraud by employees, and reputational damage as a result of subsequent investigations. The literature also highlights the need to consider whether monitoring of gambling behaviour and interactions with customers are effective in managing the risks associated with gambling, particularly in relation to the prevention of crimes committed against adults at risk.

**Potential dilemmas when dealing with incidences of gambling-related theft**

In Australia, Patford & Tranent (2013) surveyed human service practitioners working in specialist roles concerning gambling, students undertaking tertiary programmes in relevant professional disciplines, and practitioners based in agencies likely to attract clients with gambling problems (eg family counselling, mental health, domestic violence and substance abuse agencies). This was in order to examine the dilemmas associated with preserving confidentiality when working with clients who may be harming a third party as a result of gambling-related theft. Surveys were completed by 178 practitioners, who included social workers, psychologists, lawyers, financial counsellors, personal/relationship counsellors, a physician, venue support workers, agency managers, youth workers, nurses, community workers and teachers. The findings highlighted areas of uncertainty and disagreement with regard to participants’ understanding of their legal and ethical obligations concerning confidentiality and disclosure when a client reported involvement in gambling-related theft. For example, most practitioners correctly (in the jurisdiction of Australia) understood that confidentiality is not absolute in either law or ethics, and that some professionals overestimated their profession’s legal obligation to disclose. Practitioners expressed less certainty about their legal and ethical obligations when clients posed non-physical rather than physical risks to third parties, and had mixed reactions to demands for written case records. Practitioners’ opinions diverged on their legal and/or ethical obligations. There may therefore be scope for discussion about disclosure and confidentiality in specific situations. However, larger thefts, either from a partner or from an employer, were more likely to be disclosed by practitioners than smaller ones (ibid). The study highlighted how different practitioners from different disciplines are likely to deal with gambling-related theft, and revealed areas of uncertainty and disagreement between practitioners, which may need to be addressed.
Social work

One definition of the social work profession is:

a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (International Federation of Social Workers, 2014).

The UK British Association of Social Workers’ (BASW) Code of Ethics (BASW, 2014) outlines four values: human rights, social justice, professional integrity and ethical principles. It also outlines 17 ethical-practice principles which social workers should apply to their practice, including assessing and managing risk; acting with the informed consent of service users, unless required by law to protect that person or another from risk of serious harm; providing and sharing information; empowering people; contributing to the continuous improvement of professional practice; maintaining confidentiality; and maintaining clear and accurate records. These values and ethical-practice principles may provide a framework in which social workers are able to consider their responses to and interactions with adults at risk who are experiencing gambling-related harm as a consequence of participating in gambling or as a consequence of a carer or someone in a position of trust carrying out abuse, neglect, or acts of omission because of their gambling behaviour.

Social work and gambling

Several publications discuss the case for social workers being involved with the management of gambling problems. The main argument for why social workers should be involved in managing gambling risks centres on the fact that many social workers engage with adults at risk regularly, and specifically in safeguarding services. Rogers (2013) identified that young people; those who experience unemployment, poor health, poverty and insecure housing; those who have few educational qualifications; people from ethnic minority groups; and women are potentially susceptible to addictions in general, including gambling problems. He argued that gambling problems should be on the ‘radar’ of social work because the risk factors associated with gambling are also associated with the reasons why people make contact with social services (Rogers, 2013). A similar view was expressed by Engel, Bechtold, Kim and Mulvaney (2012), who observed that because of the relationship between gambling and social problems, social workers are likely to encounter, knowingly or unknowingly, clients with gambling-related problems. King Pike and Tamburro (2013), in their discussion of gambling, also recommended that social workers should screen routinely for gambling problems because problem gambling is frequently associated with many mental health diagnoses. Furthermore, if problem or disordered gambling is identified, social workers will need to explore further the specific nature of clients’ problem or disordered gambling as an essential aspect of a comprehensive assessment. The authors argued that social workers are uniquely situated to identify and intervene with clients involved in problem or disordered gambling.

Despite being well-placed to identify gambling-related problems, Rogers (2013) acknowledged that, at present, UK social work has little involvement in the identification of problem gamblers and referrals for help, but suggested that social workers may be able to develop practice in this area. However, he noted little specific coverage of the subject within any of the 79 social work training programmes surveyed, and argued that this should be remedied to improve social workers’ awareness and enable them to identify, refer and support individuals and their families. He recommended that the Social Care Institute for Excellence (SCIE) should produce information and training materials for the wider social care workforce, that research relating to social work and gambling problems be commissioned by the National Institute of Health Research (NIHR) School for Social Care Research, and that local authorities should consider problem gambling when developing their public health strategies.

The theme of training social workers was also addressed by Engel, Bechtold, Kim and Mulvaney (2012). They conducted a survey of the programme directors or deans of 197 accredited MSW programmes in the US, to examine the extent to which content on pathological and problem gambling is included in the curricula.
Of the 86 responses 33 (38.4 per cent) of the respondents reported that their schools included gambling-related content in their MSW curriculum, with one respondent highlighting that their school had a course (module) devoted to gambling. The main courses in which gambling-related content were located were within addictions courses (72.7 per cent), followed by practice courses that were neither specifically addictions-focused nor mental health-focused (24.2 per cent), and mental health courses (12.1 per cent). The most common forms of content covered in the courses were the relationship of gambling to other forms of addiction (93.5 per cent), the criteria to diagnose problem gambling (90.3 per cent), and the relationship between addiction and mental health (71 per cent). Other content included the characteristics of people most at risk for gambling-related problems, methods to assess pathological and problem gambling, and treatment strategies.

Most (53) respondents reported that their programmes did not include content on pathological gambling or gambling-related problems. Reasons provided were that this was a low priority for the school (39.1 per cent), that they lacked expertise in this area (28.3 per cent), that there was no interest in gambling-related problems (28.3 per cent), that they had addiction-related content (although gambling was not included) (19.6 per cent), that it was not focus of the programme (8.7 per cent), that it was taught elsewhere (6.5 per cent), as well as other reasons (6.5 per cent). Of the 34 schools that had no didactic content on gambling in the graduate curriculum some ran continuing education programmes in which two schools had a session focused on gambling, and three other schools had plans for such sessions. Of the 25 schools that included gambling content and had a continuing education programme, nine had conducted gambling-focused sessions, and one reported planning to do so. Engel et al. (2012) concluded that gambling as a problem has a low profile partly because of the low numbers of people (social work clients) who actively seek help specifically for their gambling and the lack of expertise or knowledge about assessing problem or pathological gambling in social work. The lack of funding for research may be also another reason why faculties lack expertise about gambling-related problems, as there is little to attract current social work educators, researchers, or doctoral students to the field. However, because increased opportunities and accessibility to gambling may lead to increased numbers of people affected by problem gambling, schools of social work could prepare their graduates to address this problem. The authors recommended that students should be taught about the characteristics of people with pathological or problem gambling diagnoses, that problem gambling is a co-occurring problem with substance abuse and/or mental health conditions, the diagnostic criteria, broad treatment strategies, and the related social and economic consequences.

Wider education in the care sector

More generally, Rogers (2013) noted that Skills for Care (the sector skills council in England) had completed a consultation on new National Occupational Standards for gambling-related harm, following recognition that the broader health and social care workforce needs greater awareness of this issue. Prior to this, a National Occupational Standard had been developed in relation to gambling, which potentially applies to those working in the gambling industry, as well as people working as primary healthcare workers, debt/money advisers, welfare benefits advisers, housing advisers, local authority staff, social workers, police/community support officers, teachers, education workers, youth workers, working with young people, occupational health workers, hospitality, leisure, sports coaches, probation staff, custodial care staff, helpline workers, HR staff, volunteer co-ordinators, and community voluntary workers (Skills for Justice, 2012). This particular National Occupational Standard was designed to help workers recognise when a presenting problem may be linked to gambling-related harm, and assist them to identify and signpost to alternative organisations providing information, support and/or interventions for clients (ie service user, patient, caller, employee, people in custody, student, or anyone affected by gambling-related harm) (Skills for Justice, 2012). It is currently unknown to what extent the workforce is aware of the National Occupational Standard and if it possesses the knowledge and understanding needed to meet the performance criteria.

Human services provision and practice

Problem gamblers may access one or several of a range of human service agencies. A survey of executive directors of all mental health, family counselling, drug and alcohol, and faith-based,
addiction-related organisations in one area in the US was conducted to determine whether such services are prepared to engage in prevention and treatment efforts for gambling-related problems prior to the opening of a casino (Engel, Rosen, Weaver & Soska, 2010). Of the 248 human service agencies within the one US county, 137 responded to the survey (Engel et al., 2010). The different roles undertaken by these agencies indicated the wide range of human services provision in the US:

- 23 had sent staff to training sessions or provided in-house training.
- 19 screened for problem or pathological gambling, with agencies providing mental health and/or substance abuse services being the most likely to screen or ask questions about problem gambling.
- Eight provided treatment, with all of them being providers of mental health and/or substance abuse services. However, six respondents felt that although their agency provided treatment, staff members did not have adequate training to treat gambling-related problems.
- 35 reported that their agencies referred clients to other providers for treatment of problem gambling.
- Six reported having certified problem gambling counsellors on staff, all of which were within agencies that provided mental health and/or substance abuse support.
- 79 did not engage in training, screening, treatment and/or referral. Reasons why they did not engage with these activities included gambling-related training not matching client needs, lack of knowledge of training programmes, lack of financial resources to send staff to training, and being uninterested in training. Similarly for lack of screening of problem gambling, this was due to problem gambling not being an issue for their clients, a lack of familiarity with screening instruments, lack of appropriately trained staff, and lack of staff time. In relation to treatment, about half of those who did not offer treatment reported that problem gambling was not an issue for the agency. Other reasons included a lack of appropriately trained staff, unfamiliarity with treatment modalities, and lack of staff time. In relation to referral, over half of the agencies reported that gambling-related problems were not an issue, and that they were unfamiliar with agencies providing treatment; lack of staff time was also a reason.
- Only 12 said that their agency was involved with client or community education about gambling-related problems.

Engel et al. (2010) concluded that there was little capacity-building or activity related to problem gambling within human service agencies in the one county studied. Few agencies were taking steps to educate their staff, few agencies screened for or treated problem gambling, and most agencies did not refer clients to treatment providers. The researchers also found that many providers did not perceive problem gambling as affecting their clients, however, given the link between problem gambling and other social problems, Engel et al. (2010) observed that such agencies might be able to play a role in identifying problem gamblers and referring them to treatment providers. Limited knowledge about referral agencies for problem gambling might be addressed by publicising treatment providers. The lack of screening or treatment services within substance use and mental health agencies surprised the researchers, but they acknowledged historic funding patterns that had generally placed all addictions treatment in substance abuse treatment agencies, and that the level of public funding could be seen as insufficient to stimulate agencies’ interest in this area of work. The lack of interest in gambling-related problems seemed related to views that these problems did not affect many of their clients, as well as a lack of trained staff. However, given that problem gamblers may present with a mental health or addiction problem, it may be that gambling is present but not identified or reported. Engel et al. (2010) recommended that agencies should explore whether problem gambling does not affect their clients. They also proposed that state and local government funds should be available for staff training in both screening and treatment. In relation to the specific purpose of this study (consultation about a casino), Engel et al. (2010) concluded that little attention was being given by the services system and government officials to the potential consequences of opening a new casino in relation to the increased need for education, screening, referral, treatment and training regarding problem gambling.

The impact of gambling on vulnerable people was addressed by Momper (2010), who focused on the implications of gambling among people from
American Indian communities for social work research and practice. She noted that gaming has become widespread in American Indian communities, with 225 tribes in 28 states opening some form of gambling, generating $25.7 billion in gaming revenue in 2006. Because American Indians are thought to be at increased risk for problem or pathological gambling, Momper (2010) advocated that social work researchers investigate the social impact of disordered gambling on individuals and families, although social work practitioners should be aware that gambling is not necessarily viewed as negative behaviour among American Indians, and that treatment programmes should distinguish between disordered gambling and sacred and social gambling of the past. Moreover, social workers should be aware of the potential for American Indians receiving substance abuse or mental health treatment to have a gambling problem, and should therefore conduct routine gambling screening. She suggested that social workers should be trained to identify, assess and provide services aimed at treating problem and pathological gambling. They should be aware of the historical relationship between the federal government and American Indian communities, and how this influences perceptions of American Indian gambling. For example, there is a concern that government intervention might prohibit gaming, thereby eliminating the gains from gambling that have been made by American Indians in education, economic development, health care, police and fire protection, infrastructure and housing (Momper, 2010).

The attitudes of social workers towards problem drinking, gambling and eating were gathered by Egerer (2013) in a study which examined the perspectives of Finnish and French social workers using the Reception Analytical Group Interview (RAGI) technique. This technique uses film clips as interview stimuli in a focus group situation. The social workers watched three film clips demonstrating loss of control, neglect of duty and cue-dependency/relapse (i.e. stimuli which individuals encounter in an environment and subsequently trigger gambling-related behaviours [Rose, Field, Franken, Munfanò, 2013]) for the three addictions. Of the 27 French social workers, 10 worked within health and disability services, seven in general social work, and the rest in other areas. Of the 31 Finnish social workers, 12 worked in adult social work, four in family services, three in childcare, and the rest in various other contexts. In both Finland and France, social workers are not responsible for treating addictions, and none had special training in addiction treatment. The Finnish social workers focused on the harm gambling places on family members and discussed limiting the available money for gambling in an attempt to prevent problem gambling. They offered the view that society is too liberal and individualised, leading to
people being left alone without any help. In relation to recovery, the Finnish social workers emphasised that willpower is important for problem gamblers, and that those who engage in problem gambling may be engaging in a wrong (maladaptive) form of coping, as a way of filling one’s life with something positive. The Finnish social workers thought that neglect of family problems can be an indicator of problem gambling. For them, problem gamblers are perhaps also led into their predicament because consumer freedom and individual autonomy have rendered each person responsible for their own fate; the Finnish social workers therefore saw individuals as responsible for their own recovery.

In contrast, the French social workers thought that gambling was a social issue, with those people around the problem gambler perhaps encouraging them to continue with this behaviour. The French social workers thought that the media portrays a positive image of gambling and does not inform people about the risks of gambling in the same way as is now done in relation to tobacco and alcohol. They also considered that entry to gambling environments was too easy. The French social workers put their hope in society and prevention while viewing their profession as being in a position to help, but not having an obligation to get involved. This research highlighted the potential for practitioners in different jurisdictions and cultures to hold different views about gambling and who is responsible for harm and recovery.

Discussion of gambling in relation to social work is not confined to safeguarding of adults at risk. Rowe and Hassall (2011) mentioned gambling as a risk factor in relation to child neglect. They reported that social work practitioners have noted four impacts of problem gambling – emotional unavailability; failure to ensure physical safety; financial stress, which could lead to material neglect; and emotional unavailability of the gambler’s spouse. Furthermore, practitioners might focus their attention on the adult client, which, because they are time-poor, might lead them to pay insufficient attention to child neglect. In addition, the reduction of gambling outlets in poor neighbourhoods might be an effective strategy to attend to correlates of neglect. The Royal College of Nursing also made reference to gambling in its guidance for nurses on safeguarding children and young people. Nurses are advised to consider that gambling problems among parents might indicate that their child could be vulnerable (Royal College of Nursing, 2014).

These studies highlight that an increase of gambling opportunities within a community may require capacity-building by human services agencies. Understanding social workers’ and other professionals’ attitudes towards gambling may reveal how they view their professional role and responsibilities for supporting gamblers and harm minimisation.

Local partnership working

The Local Government Association’s (2013) briefing for councillors on problem gambling noted that individuals, or their families or carers, rarely contact health or social care services with problem gambling as their presenting condition. It also noted that problem gambling can emerge in different ways, including physical and mental health problems, as well as social care and financial ones. The Local Government Association observed that individual impacts on problem gamblers and their families have a cumulative effect on the health and wellbeing of the wider community and society, with the briefing document urging local government to work, through its partners on Health and Wellbeing Boards, to develop a coherent approach to problem gambling, especially focusing prevention work on potential high-risk groups. In addition, it recommended that local NHS Clinical Commissioning Groups should be encouraged to raise awareness of problem gambling among primary care professionals and work with local government to signpost people to local and national support services. Mental health service providers were advised to consider how they can better identify problem gambling and provide access to specialist support. Local audit, clinical and public research and evaluation of interventions across health and social care partnerships were described as having the potential to support the national evidence base and develop the business case for intervention. Licensing, planning, trading standards and council scrutiny processes were identified as needing to be involved in bringing together public bodies and betting companies to establish the nature and extent of problems in local areas and to ask questions about service outcomes. This document provided an insight into which organisations might be well placed to tackle gambling-related harm and emphasised that partnership and collaborative working are needed in order to help tackle gambling-related harm within local communities.
This scoping review aimed to improve understanding of gambling-related harm for people described as adults at risk by outlining the relevant evidence base. Four research questions were explored: What is the evidence of gambling participation among adults at risk? What is known about the impact of gambling participation for adults at risk? Is there evidence that perpetrators of abuse against adults at risk are committing these acts or crimes to fund gambling addictions? and What is the evidence about how social work and/or adult safeguarding teams manage gambling-related harm? The findings are discussed below.

**Research question one: What is the evidence of gambling participation among adults at risk?**

There is some evidence of gambling participation among adults at risk. This is evidenced within studies which highlight that gambling is undertaken by people with an acquired brain injury, those who are homeless, those with cognitive impairment, those with intellectual disability/disability, those with other disabilities and among older people and their carers. We have found no data indicating the prevalence of gambling by adults at risk, or any account of which forms of gambling might be particularly problematic for adults at risk. Some organisations do collect data pertaining to this group – for example, GamCare and the National Problem Gambling Clinic. However, we do not know why these two gambling support services collect this specific data or how they use it when providing help, support, advice or treatment to gamblers. The 2012 Health Survey for England did collect data about gambling participation and being in receipt of informal social care (adults aged 16+) and social care among adults aged 65 or over. It may therefore be worthwhile conducting a secondary analysis of the data to examine the prevalence of gambling among these individuals, though it should be noted that this survey data is becoming dated.

The task of determining the prevalence of gambling participation by adults at risk may well be difficult because it is reliant on individuals either self-declaring their gambling habits or on the identification of individuals’ gambling participation by third parties – for example, by staff working in gambling venues, or by carers, social workers, counsellors, and other treatment providers. Individuals might be unwilling to report their gambling habits because they think that their level of gambling participation is normal, lack confidence, feel unable to face their problems, think that they may be stigmatised, feel shame, are concerned about confidentiality and/or are unable or unwilling to trust other people. Furthermore, people involved in the identification need to have received sufficient training so as to identify adults at risk and the behavioural indicators which may suggest problem or at-risk gambling behaviour and then to take action. Research concerning behavioural indicators of problematic gambling might be useful to consider when informing industry employees of the signs to look out for within gambling environments. However, care must be taken to ensure that certain behaviours (eg a person physically shaking while gambling) which might be indicative of problem gambling are not confused with the visual symptoms of health conditions (eg Parkinson’s Disease). This therefore relies on staff being interested in receiving training and increasing their knowledge about adults at risk and gambling, in order to raise awareness of the associated risks, identify individuals who may experience gambling-related harm, monitor their gambling participation, intervene, and signpost to appropriate support organisations. As well as necessitating employer commitment, this also relies on staff being able to follow policies and procedures, and having the time and resources to carry out assessments. And, of course, it needs face to face encounters.

The rights of adults at risk to participate in gambling – and mitigating the ability to safeguard this population – were also discussed in relation to whether adults at risk are able to understand
the potential danger associated with their activity. Gambling operators cannot discriminate against adults at risk and exclude them from participating in gambling as a group. However, there was some evidence in the literature relating to policies about vulnerable adults and a barring register being in place within betting shops, which may be worth exploring. More information is needed about how vulnerable adults are monitored by gambling operators, why such policies are in place and how they are applied. This raises the question of if and how information is provided to vulnerable people about what gambling is and the risks of gambling-related harm. Some adults at risk may take longer to learn new things and need information to be provided to them verbally, visually and/or in written form. Their learning style and communication preferences should therefore be taken into consideration when designing and disseminating responsible gambling information.

With this in mind, the literature suggests that there is potential to focus on preventing gambling-related harm using a proactive approach. An insight into the motivations for adults at risk participating in gambling was provided within some studies. These included being subjected to peer pressure and becoming preoccupied with gambling in order to socialise, to escape from their everyday problems, to feel safe/secure, to obtain intellectual stimulation, to save money on heating and food, to seek shelter, to cope with age-related events (e.g., unemployment, bereavement, isolation), to be distracted and to fill voids. There were also reports that some individuals use their benefit payments to fund a gambling habit, worsening their quality of life in the process. Consequently, the aims of tackling social isolation, which have been highlighted by the Campaign to End Loneliness (among others), and efforts to help people in financial difficulty, might note the risks of gambling more often.

Evidence of participation in gambling contributing to a loss of wellbeing was contained within a statement produced by the Gambling Commission on Paddy Power’s failure to observe effective social responsibility controls. This statement contained references to the gambling operator monitoring an individual’s gambling behaviour and interacting with the individual. However, such social responsibility measures were seemingly ineffective in this case, as the individual became homeless, unemployed and experienced family breakdown. The effectiveness and appropriateness of behaviour monitoring and interactions with adults at risk could therefore be investigated in order to ascertain which behaviours are monitored and for how long. How are decisions made in relation to the optimal time for interactions to take place, and how is responsible gambling information disseminated and signposting to support services provided? In addition, how are decisions made in relation to self-exclusion and/or the gambling operator preventing adults at risk from participating in gambling. Such investigations should also include remote gambling, where there is no opportunity for gambling operators to interact face-to-face with gamblers. The asocial and anonymous nature of remote gambling also raises concerns about decision-making capacity, as individuals are often required to state that they have capacity to enter into and adhere to the terms and conditions associated with an online gambling account.

Research question two: What is known about the impact of gambling participation for adults at risk?

Examples of gambling-related harm were obtained from accounts related to certain vulnerable groups, particularly from the homeless population. However, there is no evidence of a systematic account dealing with the extent to which adults at risk experience gambling-related harm or whether they may experience different harms to those individuals who are not identified as adults at risk or similar. The types of gambling-related harm which adults at risk experience included involvement in criminal activities, high expenditure, withdrawal from social life, unemployment, family/relationship breakdown, financial difficulties, ill health, being unsure of when to stop gambling, unable to exert control over their gambling participation and housing security/homelessness. Hence the taxonomy of gambling-related harm as proposed by Langham et al. (2016) might be useful when determining the impact of gambling for adults at risk and considering whether adults at risk may experience unique harms. This is also relevant when examining the harms experienced by significant others as a result of problem-gambling. There was case report evidence to suggest that participation in gambling can be hidden, and friends, relatives and carers can become responsible for liaising with creditors and financial institutions in situations where the mental capacity of the gambler has deteriorated.
substantially. We did not find data related to gambling and proxy decision-makers, such as people who have been confirmed as having lasting power of attorney under the Mental Capacity Act 2005.

Awareness of gambling support and treatment services appeared to be low, even among professionals. Uptake of the same was also low and concerns were raised about how resources are allocated. This suggests that efforts may need to be made to raise awareness about services, encourage people to engage in help-seeking behaviours, and ensure that there are services in place to support adults at risk who experience gambling-related harm. In addition, more research is needed to determine the effectiveness of self-exclusion, time-out facilities, monitoring of behaviour and customer interactions for adults at risk.

**Research question three: Is there evidence that perpetrators of abuse against adults at risk are committing these acts or crimes to fund gambling addictions?**

There is some evidence to suggest the desire to gamble may lead some people to abuse, neglect and/or commit thefts against adults at risk. Evidence from UK victims of financial abuse that some perpetrators of abuse and/or neglect had gambling problems is reported within media accounts and within reviews of procedures implemented by safeguarding agencies and gambling operators. Recordkeeping, the monitoring of customers’ gambling behaviour, and interactions between gambling operators and their customers were identified as areas for improvement that could mitigate the risk of gambling-related harm. Furthermore, a study investigating the dilemmas associated with responding to incidents of gambling-related harm revealed how different practitioners/stakeholders are likely to deal with such incidents and highlighted areas of uncertainty or disagreement around the disclosure of information and their professional responsibilities. More research is therefore needed to understand how to prevent adults at risk becoming victims of neglect and/or abuse when gambling is a risk factor. More research is also needed to determine how stakeholders deal with gambling-related safeguarding issues and the effectiveness of interventions.

**Research question four: What is the evidence about how social work and/or adult safeguarding teams manage gambling-related harm?**

The case for social workers, other professionals, service providers and other stakeholders managing gambling-related harm was put forward within the literature. There is a notion that certain professionals could be involved in the identification of adults at risk who may be experiencing gambling-related harm via screening, referring or signposting individuals to support services and providing support. However, it is unclear whether social work or other professionals are equipped with the skills, tools, knowledge, capacity and resources in safeguarding adults at risk from gambling-related harm. There might be a lack of coverage of gambling in UK social work programmes and training, and in other professional training programmes. There might also be a lack of inclination to include gambling in the education and training of social workers because gambling is seen as a low priority, attracts little interest, and because of a view that there are only relatively few individuals who will seek help for their gambling problems.

Knowledge of how gambling-related harm is addressed by local authorities overall, and social workers or safeguarding teams in particular, is limited. It appears that data held by adult safeguarding teams are not used to inform local risk indices or local risk assessments which form part of the licensing process. In addition, there appears to be a lack of information relating to policies and practices which are followed by the gambling industry in relation to adults at risk. It is not known whether social workers in the UK view gambling-related problems as an area of practice that should be a part of their role, or what practices and procedures are followed and effective in managing gambling-related safeguarding concerns. Furthermore, the extent to which social workers, treatment providers, local authority staff and healthcare professionals work in partnership to support adults at risk who experience gambling-related harm is uncertain.
References


Department for Culture, Media and Sport (2016b). Review of gaming machines and social responsibility measures: Call for evidence. London: TSO.


