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Gambling related harm among active electronic gaming machine players within a social determinants of health framework

Retina Rimal
University of Auckland
Robin-Marie Shepherd
New Zealand skills and Education college
Louise Elizabeth Curley
University of Auckland
Frederick Sundram
f.sundram@auckland.ac.nz

University of Auckland

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Abstract

Background

Electronic gaming machines (EGMs) are disproportionately associated with gambling-related harm, yet qualitative research exploring these harms from the perspectives of active EGM users remains limited. Understanding how harm is experienced and sustained is critical for informing population-level public health responses.

Methods

A qualitative study was conducted using semi-structured, in-depth interviews with twelve regular EGM users in New Zealand. Participants were recruited through purposive sampling and were required to have engaged in EGM gambling at least weekly in the past 60 days. Interviews were audio-recorded, transcribed verbatim, and analysed using the framework method to enable systematic comparison across cases. Analysis was guided by a social determinants of health lens.

Results

Six interrelated themes were identified: social and environmental influences, behavioural and psychological reinforcement, emotional and mental health impacts, financial harm and broader life consequences, barriers to help-seeking, and perspectives on harm minimisation. Participants described how the accessibility of EGMs, immersive venue environments, and reinforcing structural machine features interacted with emotional vulnerability and social context to sustain prolonged gambling. Harms extended beyond financial loss to include relationship disruption, psychological distress, and reduced wellbeing. Help-seeking was often constrained by stigma, limited awareness of services, and a reliance on self-regulation strategies that frequently deteriorated over time.

Conclusions

Findings highlight the limitations of individual-focused harm minimisation approaches and demonstrate the need for population-level strategies addressing the structural and commercial determinants of gambling harm. Strengthening regulation, reducing accessibility, and improving public awareness may more effectively mitigate EGM-related harm and associated inequities.

Background

Gambling is a widely regulated leisure activity in New Zealand, with approximately 64% of adults participating in some form of gambling each year (Ministry of Health, 2025). A substantial proportion of national gambling expenditure (37%) comes from electronic gaming machines (EGMs; also referred as

slot machines, video lottery terminals, and pokies) outside casinos (Department of Internal Affairs, 2025). Correspondingly, EGMs remain the leading mode of gambling among people accessing harm-reduction and intervention services, with 54% of presentations citing EGMs as their primary form of gambling (Ministry of Health, 2025) and countries like Australia (Hing et al., 2021).

Continuous forms of gambling such as EGMs are well-established as particularly harmful (Browne et al., 2023; Marionneau et al., 2022; Schüll, 2012). Their design incorporates structural characteristics including audio-visual reinforcement, near-miss features, rapid betting cycles, and losses disguised as wins (LDWs) that intensify engagement and encourage prolonged expenditure (Livingstone, 2017). The geographic distribution of gambling opportunities can significantly influence the risk associated with certain forms of gambling. For instance, while casino table games are typically confined to central business districts in major cities, EGMs are far more widely distributed across New Zealand (Cowlishaw et al., 2025). Approximately 63% of non-casino gambling venues, such as pubs, clubs, and legalised betting organisations hosting EGMs are in areas classified as having medium to very high levels of deprivation. Furthermore, over half of all non-casino gambling venues gambling expenditure is generated from machines situated in the most deprived communities (Department of Internal Affairs, 2024). This uneven distribution of EGMs intensifies the risk of financial and social harm for already vulnerable populations.

The negative impacts of gambling are well documented, with gambling recognised as a public health issue (Langham et al., 2016). Harms extend across health, economic, social, cultural, and personal domains; although most pronounced among people experiencing problem gambling, they occur across a continuum of risk (Browne et al., 2023; Langham et al., 2016; Blaszczynski, 2009). These harms ripple outward, affecting families, friends, workplaces, and communities (Langham et al., 2016). Consequences include financial hardship, relationship conflict, psychological distress, poorer physical and mental health, reduced participation in study or employment, and criminal offending. The broader societal burden includes healthcare costs, productivity loss, and increased demand for social services (Fell et al., 2025). Research suggests that one in five New Zealand adults (22%) are affected at some point in their lives by their own gambling or someone else's gambling (Ministry of Health, 2025).

New Zealand is among the few countries that has adopted a public health approach to gambling harm. This approach emphasises multi-sector collaboration, integrating prevention, early intervention, treatment, research, and community engagement to address gambling harm at a population level (Clune et al., 2024; Hawk et al., 2017). Integrating gambling harm within such public health frameworks is particularly critical for EGMs, given their strong association with harm and the commercial practices that perpetuate it (Marionneau et al., 2022; Miller et al., 2018).

A growing body of international and New Zealand research continues to link EGMs to substantial harm due to structural features such as rapid play, near misses, and LDWs (Livingstone, 2017; Blaszczynski, 2013). Evidence shows that EGM accessibility particularly in areas of high deprivation correlates with increased harm, including financial hardship, mental health issues, and social disruption (Russell et al.,

2023; Marionneau et al., 2022). Policy evaluations suggest that restricting operating hours and reducing machine numbers can reduce harm, but policy implementation is inconsistent and often constrained by industry influence (Benedetti et al., 2025; Marionneau et al., 2022). Harm-reduction tools such as pre-commitment and self-regulation strategies show promise but have mixed uptake (Hing et al., 2024). This individual-focused orientation has led to intervention approaches centred primarily on personal behaviour and responsibility rather than the broader systems that shape gambling harm (Ukhova et al., 2024).

Few studies have examined gambling harm through the lens of public health determinants using qualitative insights from EGM players (Miller et al., 2018; Marko et al., 2022). This study examines how active EGM players understand and make sense of gambling-related harm within their everyday lives, with particular attention to the social and structural conditions that shape these experiences. Situated within a social determinant of health framework, the analysis focuses on how emotional vulnerability, machine design, venue environments, and accessibility intersect to reinforce continued gambling and cumulative harm.

Method

Study design and theoretical framework

This qualitative study was informed by Crotty's (1998) research framework, encompassing epistemology, theoretical perspective, methodology, and methods. An interpretivist epistemological stance was adopted, recognising that knowledge is co-constructed through participants' subjective experiences. A phenomenological theoretical perspective guided exploration of lived experiences of EGM gambling, while a social determinants of health framework informed interpretation of how broader structural, environmental, and social factors shape gambling behaviour and harm.

Research team and reflexivity

Interviews were conducted by [insert researcher name/role], who has experience in public health and qualitative research. The research team engaged in ongoing reflexive discussions throughout the study to consider how their backgrounds, assumptions, and professional perspectives may influence data collection, interpretation, and analysis. Efforts were made to remain grounded in participants' accounts while critically examining emerging interpretations.

Participant recruitment and sampling

A purposive sampling strategy was used to recruit participants with current experience of EGM gambling. Eligibility criteria included being aged 18 years or older, fluent in English, and having engaged

in EGM gambling at least once a week in the preceding 60 days. Participants were recruited through [add recruitment method: e.g., community networks, online advertisements, gambling harm services].

Sampling aimed to capture diversity in age, gender, and ethnicity to reflect a range of lived experiences. Recruitment continued until sufficient depth of data was achieved and no substantially new themes were emerging, indicating data saturation.

Data collection

Data was collected through semi-structured, in-depth interviews conducted between [insert dates]. Interviews lasted approximately 30 to 60 minutes and were conducted face-to-face.

An interview guide was used to explore participants' experiences of EGM gambling, perceptions of harm, behavioural patterns, and views on harm minimisation strategies, while allowing flexibility to follow emerging topics.

All interviews were audio-recorded with consent and transcribed verbatim. Transcripts were checked against recordings for accuracy and returned to participants for member checking to confirm the credibility and completeness of their accounts.

Data analysis

Data was analysed using the framework method, a systematic approach suitable for applied qualitative health research. Initial coding was conducted using NVivo 12 (QSR International Pty Ltd., 2018). Codes were developed inductively from the data and iteratively refined through team discussion to produce an analytical framework.

Once the framework was established, all transcripts were re-coded, and data were charted into a matrix to facilitate comparison within and across cases. Themes were generated by identifying patterns, relationships, and contrasts across participants' accounts and were interpreted through a social determinants of health lens.

Rigour and trustworthiness

Several strategies were employed to enhance rigour. Credibility was supported through member checking and verbatim transcription. Analytical rigour was strengthened through systematic coding, iterative team discussions, and transparent use of the framework method. Reflexivity was maintained throughout to account for potential researcher influence. The use of a structured analytic approach enabled clear links between data and interpretations, supporting dependability and confirmability.

Ethics approval

Ethics approval was obtained from Human Participants and received institutional ethics approval from the University of Auckland Human Participants Ethics Committee (Reference No: 018674). All participants provided informed consent prior to participation, and confidentiality was maintained throughout the study.

Results

A total of 12 (male = 8; female = 4) participants were interviewed for this study. The age ranged from 21 to 69 (mean age = 48; SD = 17.4). Over half of the participants identified as belonging to the New Zealand European ethnic group, two participants were Pacific, two Asian participants and one Māori participant. Most participants reported daily EGM use in the 30 days prior to interview (see Table 1).

Table 1
Sociodemographic profile of participants (names changed to protect their identities)

Names	Age	Gender	Ethnicity	Employment
P1	36	Male	Pacific	Employed
P2	69	Male	NZ European	Retired
P3	67	Female	NZ European	Retired
P4	32	Female	Pacific	Employed
P5	28	Male	NZ European	Employed
P6	25	Male	Asian	Student
P7	48	Male	Māori	Employed
P8	68	Male	NZ European	Retired
P9	21	Female	NZ European	Unemployed
P10	58	Male	NZ European	Employed
P11	52	Male	NZ European	Employed
P12	43	Female	Asian	Employed

Overview of themes

Six interrelated themes were identified, 1) social and environmental influences, 2) Psychological and behavioural patterns, 3) Emotional and mental health impacts, 4) Financial harm and other life consequences, 5) Barriers to help seeking, and 6) Perspectives on harm minimisation. Results are presented through an integrated analytical lens combining phenomenological insights with a social determinants of health perspective. While themes reflect participants' lived experiences of EGM

gambling, their interpretation highlights how these experiences are shaped by broader social, environmental, and structural conditions (see Fig. 1).

1. Social and environmental influences

Participants described how gambling was shaped by their social environments, relationships, EGM design and atmosphere of EGM venues. For some, gambling provided a sense of connection and a place to interact with others:

“I go to play for a social interaction with people. I feel like I am in control most of the times say if I win, I go home. So that is the reason I continue to gamble.” – P3

For others, the venue created a space for solitude, even when surrounded by people:

“I am a social person but I don’t socialise when I gamble. I tend to socialise when betting on the horses or at TAB but when I am on the machines its more solitary.” – P2

Some participants preferred to remain unnoticed, describing gambling spaces as private and intentionally isolating:

“The machines are incredibly private and I hated having people around. One thing I resented most was sharing one machine, they took too much space and loud and I didn’t want to be disturbed and I resented that.” – P11

“I just go to play, I do take note of who is around me and I do say hello but I don’t get into conversation with anyone, and I am not there to make friends.” – P10

Across participants, the common experience was the convenience and accessibility of venues, which made EGM gambling an easy and routine activity.

“Well, I enjoy RSAs you can have a beer to socialise and go on those machines while TABs are just handy.” – P8

2. Gambling behaviour shaped by structural influences

Participants described a range of behavioural patterns, including gambling as a way to cope with stress, habit formation, and perceptions about how machines operate. Gambling was frequently described as a way to escape from everyday problems:

“I guess it was the excitement at the beginning and then slowly to escape from many other problems in my life. Now I see that, I drowned my problems in gambling. While I played pokies, I forgot my other problems.” – P4

The escape from reality often intertwined with a progressive loss of control, where initial intentions to limit spending or time rapidly deteriorated once play began. Participants highlighted the structural

characteristics of EGM such as rapid play cycles, sensory stimulation, and the absence of environmental cues were frequently cited as reinforcing these patterns

“Nobody makes money from gambling, and it was never about money, but just playing the machines, the lights and buzzes and sound and zoned out. There is no window, no clocks and you can just hide in these venues for as long as you want to.” – P11

Several participants also described cognitive distortions consistent with the gambler’s fallacy, such as attributing meaning to machine numbers, believing certain machines were “due” to pay out, or perceiving patterns in random outcomes.

“I look at the number of each machine and I usually go for the number with 6 I have won quite a few jackpots over my time and they have usually been with the numbers from my birthday like 6 is the date and 12 is the month.” – P10

“I feel like a lot of people don’t understand the machines. When I go into the venue, I walk around and when I feel like the machine hasn’t paid out I will sit on that machine. I also have some lucky machines that pay out than others you know” – P8

Participants described a recurring cycle of relapse, where periods of reduced gambling or abstinence were followed by renewed engagement, often triggered by emotional vulnerability, boredom, or the anticipation of excitement. These interrelated psychological drivers illustrate how machine design, emotional coping, and behavioural reinforcement operate collectively to sustain harmful gambling trajectories.

“I was gamble free for couple of months until I had free time one Monday and went to pub and lost about $800. Then I took a quick loan and tried to win the money back that [is] how I went back into gambling.” – P4

3. Financial harms and life consequences

Participants described significant financial harms arising from their gambling, ranging from acute losses to long-term financial instability. Several recounted losing substantial amounts in a single session, with some spending thousands of dollars in one day, while others experienced severe downstream consequences such as homelessness and debt.

“Well I lost everything to gambling, I didn’t have any money, only possession I had was my keyboard. I was homeless and slept on the bench, I have literally lost everything and been in debt.” – P2

“I have taken money that wasn't mine from my family and my work has suffered. I start out lately by saying, I can stick to a small amount of money, but it never sticks to that. I have taken money off my partners credit card and even gotten loan behind my partner’s back.” – P4

These financial strains often contributed to wider social and relational harms, including distancing from family and the breakdown of intimate relationships.

“Gambling had a huge impact on my first marriage I just distanced myself from my family when I had little twin girls” – P10

“I was skipping work lying to my family and friends to gamble. I have a loving partner and I deceived him too.” – P4

4. Emotional and mental health impacts

Participants described emotional and mental health impacts associated with their gambling, often characterised by cycles of shame, guilt, and self-blame. Many reflected on the emotional distress that followed episodes of losing control, describing intense guilt about the consequences of their behaviour for themselves and their families.

“a lot of people who gamble have a lot of stories of lying and shameful stuff and not being able to control that is also a huge shame for me.” – P7

“The escaping from reality and I always drank when I gambled so the two went together and I enjoyed at the time but then I regretted it when I lost all my money or ran out of money.” – P1

Participants highlighted gambling contributed to significant anxiety and depression, with daily mood fluctuations closely tied to wins and losses.

“I am usually depressed after gambling sessions. When I get home after gambling I usually have so much to drink I just go to bed and the depression does not hit till the next morning.” – P10

“The experiences I had especially financial consequences. I think that is a big reason for my anxiety” – P2

For some, the emotional burden escalated to severe distress, including suicidal thoughts linked to financial harm and the cumulative effects of long-term gambling.

“When I was in debt from gambling, I have had fleeting thoughts of suicide I never had the strengths to carry on through it.” – P2.

5. Barriers to help seeking

Participants described a range of coping and help-seeking behaviours aimed at managing or reducing their gambling, but these strategies were often undermined by environmental triggers, emotional distress, and insufficient system support. Some attempted to control their gambling through budgeting and limiting access to money, often with mixed results. People shared budgeting attempts as one

participant shared “I put a little bit of money aside and I don’t touch it for my addictions; you have to know when to stop and you can manage to play with that each day.” – P10

Others reflected that despite strong intentions to set limits, these efforts frequently deteriorated once gambling commenced. Alongside these attempts at personal control, several participants sought formal support through counselling, group therapy, or helplines.

“I was gamble free for couple of months after my wife gave me an ultimatum until I had free time one Monday and went to pub and lost about $800, however I am back getting help” – P4.

Self-regulation also took the form of internal strategies to manage urges, with one participant noting

“I believe it’s the case of me helping myself. It trying to control my urges of gamble myself. I try to think about all the things I could do with this gambling money and most of the times these are the thoughts that has stopped me.” – P5

However, not all participants felt confident accessing external support, with some expressing uncertainty or discomfort about where to seek help.

“I didn’t feel comfortable enough to call helpline and I didn’t know where to go for help.” – P1

Experiences with formal treatment settings also varied; for some, structured programmes provided temporary stability but limited long-term benefit. Reflecting on time in a residential programme, one participant shared, “I didn’t drink or gamble when I was in the treatment but after leaving the place I didn’t find it helpful at all. I still thought about gambling all the time once I came back home I just fell back to old habits.” – P7

6. Perspectives on harm minimisation

Participants proposed several harm-minimisation strategies informed by their lived experiences of gambling and attempts to reduce harm. Many emphasised the importance of reducing access and availability to electronic gaming machines, suggesting limits on the number of venues and machines, or restricting them to casinos.

“If I had not been allowed to access venues easily may be that would have stopped me in the first place. And they are everywhere so reducing the number of venues and numbers.” – P5

“the machines are designed to lure you into the cycle of addiction so if there were no machines, so I was in Malaysia for 2 years with my current partner who is Malaysian I didn’t gamble at all and I was okay so I guess getting rid of the machines.” – P10

Participants also highlighted the need to improve public knowledge and awareness of gambling harm, arguing that early education could prevent people from being drawn into harmful patterns of play

“When I first started I didn’t think gambling can create such harm I just thought it was entertaining and I saw scared how it sort of pulled me in so I guess it should be government’s job to make people aware how harmful gambling can be.” – P6

“There should be anti-gambling campaigns targeting younger population using social media could be one and proper training for the venue staff I feel like they don’t care.” – P7

In addition, participants identified significant gaps in host responsibility, noting that staff monitoring was inconsistent and often unavailable during the times when vulnerable gamblers were most at risk.

“There is also host responsibility staff about 4 people who work 8 – 5 Monday to Friday. You know there aren’t anybody at 3 am in a Sunday morning while little marry has been there since midday Friday and you know I feel like it’s not important for them, also it is a business there to make money.” – P11

Participants shared disliking and often ignoring the pop-up messages, one participant “I hated the pop-up messages, you know I didn’t want to know how long I have been there and how much I have spent, don’t need to know that, I mean I would know it when had run out of money and I had to go to cash machine again.” – P8

Discussion

This study examined gambling-related harm among active electronic gaming machine (EGM) players, focusing on how experiences are shaped by broader social, environmental, and structural conditions. Drawing on a phenomenological approach and a social determinants of health framework, the findings show that harm is not solely driven by individual behaviour but emerges through the interaction of product design, venue accessibility, and socio-economic context. Participants’ accounts highlight how these factors collectively sustain gambling-related harm in everyday life. The widespread availability of EGMs, in combination with venue design features and participants’ personal circumstances, supported ongoing engagement even when harms were recognised.

Participants described behavioural processes such as escapism, diminished control, and cognitive distortions that reinforced continued play and contributed to cumulative harm. Rather than occurring in isolation, these mechanisms interacted with structural features of EGMs and venue environments to sustain prolonged gambling involvement. Harms were experienced across financial, relational, emotional, and mental health domains, underscoring the multifaceted and compounding nature of gambling-related harm as it unfolds within everyday life. Together, these findings extend existing research by shifting attention from discrete gambling outcomes to the processes through which harm accrues and becomes entrenched among active players.

The study also offers important implications for gambling harm prevention and policy. Participants’ accounts challenge individualised framings of gambling harm by demonstrating that active EGM players frequently locate responsibility within product design, venue practices, and regulatory environments

rather than solely in personal behaviour or self-control. Structurally driven harm was not only recognised by participants but often normalised as an expected feature of EGM gambling, particularly in contexts of high accessibility and limited external safeguards. By illustrating how harm is negotiated and sustained outside treatment settings, this study strengthens the case for population-level prevention strategies and regulatory interventions that address the social and commercial determinants of gambling harm rather than relying predominantly on individual self-regulation.

From a policy perspective, awareness-raising initiatives remain essential in public health strategies, improving understanding of gambling risks and consequences. Participants commonly reported low awareness of EGM harm and held misconceptions such as believing machines would eventually pay out or that certain actions could influence outcomes. These observations reflect broader literature emphasising the importance of product-focused and diverse awareness campaigns rather than uniform, one-size-fits-all approaches (Wardle et al., 2019; Milia et al., 2025). Misunderstandings were further compounded by structural machine features such as rapid play cycles, reinforcement mechanisms, and losses disguised as wins (Murch, Ferrari & Clark, 2024). These characteristics contribute to overestimating wins and prolonging play (Barton et al., 2017; Myles et al., 2023). Evidence suggests prohibiting positive audiovisual feedback for net-negative trials, including LDWs, could reduce immersion and associated harm (Livingstone et al., 2019; Murch & Clark, 2021; Myles et al., 2023;).

Participants also emphasised EGM accessibility and availability were major contributor to gambling onset, persistence and relapse. Research consistently shows that EGMs are disproportionately concentrated in socioeconomically deprived communities, contributing to heightened harm and widening inequity (Department of Internal Affairs, 2024; Russell et al., 2023). While New Zealand's sinking-lid policies, absolute caps, and per-capita caps have reduced the number of EGMs and venues over time (Ministry of Health, 2021), some evidence shows machine reductions alone may not significantly affect expenditure unless numbers are reduced below demand (South Australian Centre for Economic Studies, 2005; Lund et al., 2009). The experience of Western Australia provides a salient example: restricting EGMs to a single casino has resulted in substantially lower EGM participation and fewer gambling-related problems compared with other Australian states (Russell et al., 2023).

The placement of EGMs in venues outside casinos also places considerable responsibility on frontline venue staff to identify and respond to gamblers showing signs of harm. Participants in this study perceived staff to have limited awareness and noted that monitoring was inconsistent, especially during high-risk times. This observation is consistent with wider research demonstrating that although staff can identify behavioural indicators of harm, host-responsibility practices are often unevenly implemented and insufficiently applied (Riley et al., 2024). Participants suggested the need for reframing staff roles, for example, encouraging staff to provide evidence-based harm-minimisation advice to all gamblers, rather than only to those already showing signs of harm. In addition, participants recommended limiting venue opening hours and modifying gambling products, so they are less harmful.

Consistent with participants' views, evaluations of harm-reduction policy demonstrate that limiting the availability of EGMs, regulating venue environments, and increasing early public awareness can meaningfully reduce gambling-related harm, although implementation remains uneven and is often constrained by commercial interests (Marionneau et al., 2022; Benedetti et al., 2025). When gambling is legally permitted, responsibility for preventing harm extends beyond gamblers and gambling providers to include legislators and regulators who authorise gambling and set the conditions under which it operates (Ukhova et al., 2024). There is also a broader need to reshape the discourse surrounding gambling by focusing on harmful products, industry practices, and the consequences of liberalisation (van Schalkwyk, 2021).

Overall, these findings demonstrate that gambling-related harm among active EGM users cannot be understood solely as a matter of individual choice or behaviour. Instead, harm is produced through the interaction of product design, venue environments, and broader contextual influences that shape how gambling is experienced in everyday life. Participants' accounts illustrate how these conditions not only enable continued engagement but also contribute to the normalisation of harm over time. This shifts the focus from individual responsibility toward the environments and systems that sustain risk. Addressing EGM-related harm therefore requires upstream, population-level interventions that reduce exposure, reshape gambling environments, and strengthen regulatory responses.

Strength and limitations

A key strength of this study is its focus on a single, high-harm form of gambling, electronic gaming machines, allowing for an in-depth exploration of how specific product features, venue environments, and social contexts shape gambling behaviour and harm. By recruiting active EGM players, rather than relying solely on treatment-seeking or clinically defined problem gamblers, the study captures experiences of harm as they occur within everyday gambling practices. This approach provides insight into how gambling-related harm emerges, is sustained, and often becomes normalised prior to formal help-seeking, extending existing qualitative literature that predominantly focuses on help-seeking populations. Using Crotty's (1998) framework supported an in-depth exploration of how multiple factors interact to shape EGM gambling behaviour. The qualitative design and use of semi-structured, in-depth interviews enabled participants to articulate their experiences in their own terms, supporting a rich, contextually grounded analysis (Liamputtong, 2019). Applying a social determinant of health framework strengthened the analytical contribution by situating individual narratives within broader structural, environmental, and regulatory contexts known to influence gambling harm. Rigour was enhanced through systematic analysis using the framework method, iterative team discussions during coding, and member checking to support the credibility and interpretive integrity of the findings.

Several limitations should be considered when interpreting the results. As a qualitative study with a relatively small, purposively selected sample, the findings are not intended to be statistically generalisable. However, the aim was not representativeness but depth of understanding and analytical insight into processes shaping gambling-related harm. The cross-sectional design also limits the ability

to directly examine changes over time; therefore, references to the emergence or persistence of harm reflect participants' retrospective accounts rather than longitudinal measurement. Future research using longitudinal or mixed-methods designs could build on these findings to more explicitly examine transitions in gambling behaviour across the risk continuum.

In addition, participants were recruited from a specific national and regulatory context, which may influence the transferability of findings to other jurisdictions with different gambling environments. Nevertheless, the structural and experiential themes identified, particularly those relating to accessibility, product design, and the limitations of individualised harm-minimisation approaches are consistent with international evidence and may resonate in comparable settings. Taken together, these strengths and limitations highlight the study's contribution as providing nuanced, experiential insight into the processes through which EGM-related harm is produced and sustained, while appropriately bounding the scope of its claims.

Conclusions

This study highlights how gambling-related harm among active electronic gaming machine (EGM) players is shaped by social environments, structural features of gambling products, and broader determinants of health. Participants' accounts show that harm accumulates across financial, relational, emotional, and mental health domains and is often normalised within highly accessible and immersive gambling contexts. The findings underscore the limitations of individualised harm-reduction approaches and reinforce the need for population-level strategies that address systemic drivers of harm. Strengthening regulation, enhancing early and product-specific awareness initiatives, and reducing the availability of EGMs particularly through limits on machine numbers or restricting them to casino settings may collectively reduce gambling-related harm and better support communities most affected by EGM gambling.

Declarations

Ethical approval and accordance

Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee (Reference No: 018674).

The study was conducted in accordance with relevant institutional guidelines and regulations governing research involving human participants.

Consent to participate

All participants provided written informed consent prior to participation after receiving an explanation of the study procedures and reviewing the participant information sheet.

Consent to publish

Not applicable.

Author Contribution

Retina Rimal: Conceptualisation, Methodology, Investigation, Formal analysis, Writing – original draft.Robin-Marie Shepherd: Methodology, Formal analysis, Writing – review and editing.Louise Elizabeth Curley: Methodology, Formal analysis, Writing – review and editing.Frederick Sundram: Methodology, Formal analysis, Supervision, Writing – review and editing.

Data Availability

The data that support the findings of this study are not publicly available due to the sensitive nature of qualitative data collected under conditions of confidentiality and ethical approval. Data may be made available from the corresponding author upon reasonable request and subject to appropriate ethical and confidentiality considerations.

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Figures

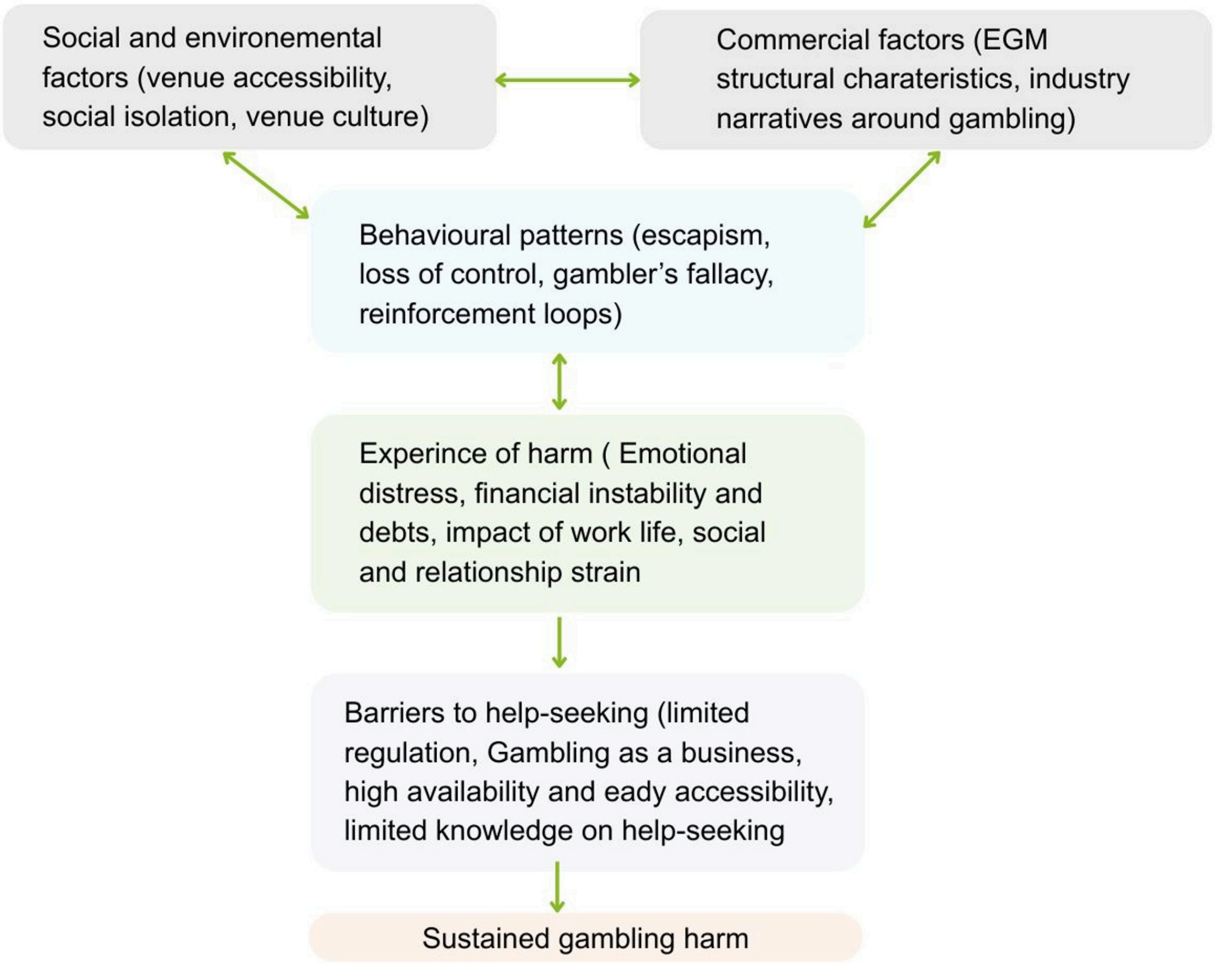


Figure 1

Interconnected pathways to EGM gambling harm