Gambling among adults from Black, Asian and Minority Ethnic communities: a secondary data analysis of the Gambling Treatment and Support study

On behalf of GambleAware

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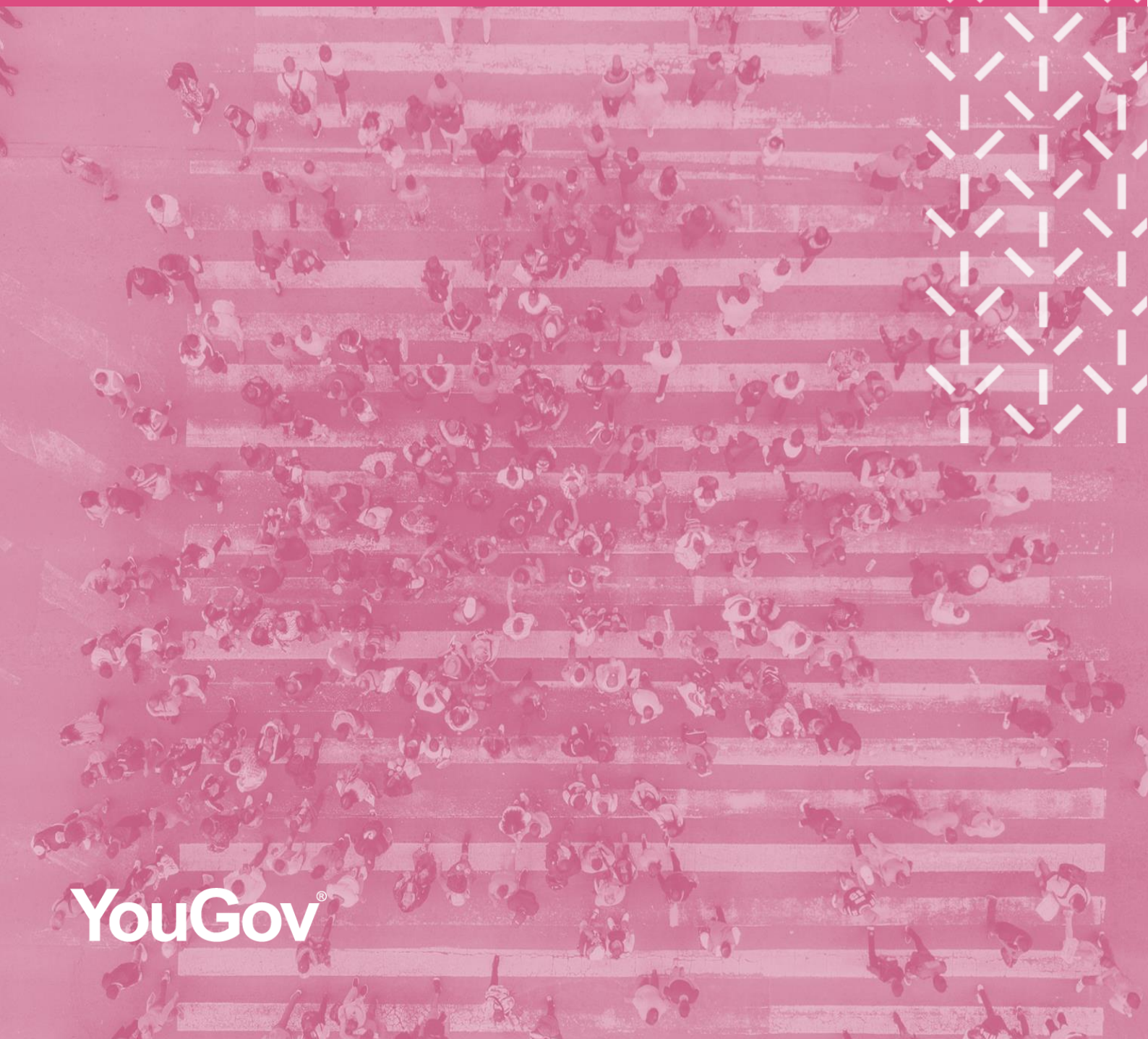

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1 Key findings

The gambling landscape among ethnic minority communities

Overall, one in five (20%) adults from Black, Asian and Minority Ethnic (BAME) communities scored one or higher on the Problem Gambling Severity Index (PGSI) scale (see section 2.4 for more detail), higher than the proportion of white adults (12%) with a PGSI score of 1+. This comprises eight percent who were classified as a low-risk gambler (a PGSI score of 1-2); six percent who were classed as a moderate-risk gambler (a PGSI score of 3-7) and seven percent who were classified as a problem gambler (a PGSI score of 8+).

Respondents from Black African (including mixed Black African and white) (27%), Pakistani (25%) and Indian (24%) backgrounds were most likely to fall into the PGSI 1+ category. Those from a Pakistani background were particularly likely to be classified as problem gamblers with a PGSI score of 8+ (12%).

The profile of gamblers and affected others from ethnic minority communities

There are some interesting differences in gambling participation among subgroups from BAME communities. Black African gamblers (including those of mixed heritage) are more likely than Black Caribbean gamblers to have participated in various activities, including football betting, other sports betting, and fruit or slot machines. Pakistani gamblers, who have the highest PGSI scores among the subgroups, were the group most likely to have participated in casino gambling (11%).

Demographic patterns among adults from BAME communities mirror those seen in the overall adult population, as discussed in the 'Gambling Treatment and Support' report[1], with men and younger adults more likely to be classified as gamblers experiencing harm from their gambling. Reflecting the findings above, gamblers from BAME communities with a PGSI score of 1+ are more likely to be of a Black African (including mixed heritage), Indian or Pakistani heritage compared to the overall population from BAME communities. Problem gamblers from BAME communities are particularly likely to be Pakistani.

[1] 'Gambling Treatment and Support' (YouGov, 2020): https://about.gambleaware.org/media/2185/gambling-treatment-and-support.pdf

Overall, nine percent of respondents from BAME communities qualified as affected others. This was higher than the proportion seen among white adults (7%) and may reflect the higher incidence of gambling with some level harm seen among adults from BAME communities. Among gamblers from BAME communities, the proportion qualifying as an affected other increases with PGSI score, showing a relationship between an individual's own gambling and their experiencing of issues related to others' gambling.

Treatment usage and demand

Among gamblers from BAME communities with a PGSI score of 1+, three in ten (31%) reported having used either treatment alone, or a combination of treatment, support and advice, to cut down on their gambling in the last 12 months. This compares with just 15% of white 1+ gamblers who had sought treatment, support or advice. This pattern is particularly pronounced among gamblers with higher PGSI scores, who are experiencing higher levels of harm from their gambling. Seven in ten (71%) problem gamblers from BAME communities report having used some form of treatment and support, compared to under half (46%) of white gamblers.

Demand for treatment and support/advice mirrors usage, with higher rates among gamblers from BAME communities with higher PGSI scores. There is a higher demand among gamblers from BAME communities in comparison to their white counterparts (31% vs. 15%); a greater proportion of problem gamblers from BAME communities reporting this (75% vs. 49%) drives this difference.

Gamblers from BAME communities with a PGSI score of 1+ were more likely than their white counterparts to say that awareness of channels would motivate them to seek treatment, support or advice, in particular, knowing that they could get help by phone (11% vs. 4%). This is particularly the case for problem gamblers from BAME communities (25%) and highlights the importance of increasing awareness of different available channels.

2 Introduction

This report presents the findings of a study to explore the usage of, and demand for, treatment and support services among gamblers and those affected by another's gambling. The report focuses specifically on gamblers from Black, Asian and Minority Ethnic (BAME) communities. In addition to describing their usage of and demand for treatment and support, the report presents detailed demographic and behavioural profiles of gamblers and those affected by another's gambling. The research was conducted by YouGov on behalf of GambleAware.

2.1 Background

GambleAware Treatment and Support study

The latest data published by the Gambling Commission[2] on the number of problem gamblers and those at-risk of problem gambling is much higher than the proportion of problem gamblers that accessed GambleAware-funded treatment services in 2016-17[3]. This large discrepancy between the number of people currently receiving treatment and the number of people estimated to be in need of treatment because they have been classified as problem, moderate or low risk gamblers on the Problem Gambling Severity Index (PGSI) scale (see section 2.4 for more detail) suggests that there may be an issue with either the demand for services and/or the supply of treatment services.

[2] 'Gambling participation in 2016: behaviour, awareness and attitudes' (Gambling Commission, 2016): https://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2016-behaviour-awareness-and-attitudes.pdf

[3] 'Gambling Treatment Services Needs Assessment Report' (ACT Recovery, 2019: page 38): https://about.gambleaware.org/media/2184/gambling-treatment-services-needs-assessment-report.pdf

As a result of this, in 2018 GambleAware commissioned a research initiative to examine gaps and needs that exist within all forms of treatment services for gamblers experiencing problems and those affected by gambling related harm. This initially consisted of two programmes of research. The National Centre of Social Research (NatCen) reviewed and produced evidence about gambling related harms and pathways to support among the general UK population, whilst ACT Recovery focused on the harms and risks among vulnerable populations and evaluated specific clinical treatment services and pathways into these for those who had accessed Gamble Aware funded treatment services.

Following this, GambleAware commissioned YouGov to undertake a two-stage study to 1) identify gamblers with a PGSI score of 1+ (gamblers experiencing some level of harm from their gambling) in the sample, as well as affected others, and their overall usage of and demand for treatment, advice or support, and 2) explore the views and experiences of gamblers and affected others regarding seeking treatment/support, motivations and barriers.

GambleAware wished to estimate the proportion of the gambling population that has received, and that wants to receive, any form of treatment or support in relation to their gambling, and to explore the geographical distribution of this demand across Great Britain. The aims of the research were to enable better targeting of support, identify current capacity issues, and support the strategic development of future treatment services and ultimately help reduce gambling-related harm.

Additionally, the study was intended to investigate affected others (those who have been negatively affected by another's gambling), delving into the characteristics of this group, as well as enhancing understanding of behaviour, needs, and impacts experienced among this group. Current prevalence estimates do not take into consideration the effects that gambling can have on those other than the gambler. More recent thinking has focused on measuring gambling-related harms, and it is now understood that harms may affect not only the individual gambler but also their family, friends, communities and broader society.

Ethnic minority communities: gamblers and affected others

Overall findings from the study were reported in the 'Gambling Treatment and Support' report[4]. Initial findings suggested that gambling behaviour, impacts and usage of treatment and support may vary by ethnic group. This is also supported by a wider evidence base, such as NatCen's 2016 analysis of gambling behaviour in Great Britain[5]. To explore this in more detail, a further analysis of the data was commissioned to focus specifically on gamblers from BAME communities. The scope of this analysis goes beyond treatment and support needs, to explore in depth the demographic and behavioural profiles of this group.

This analysis will contribute to a broader scoping exercise to inform potential prevention campaigns and interventions specifically addressed at gamblers from BAME communities, as well as building an evidence base and richer understanding of the demographic profiling and treatment and support needs of gamblers from BAME communities. This report details the findings pertaining to people from BAME communities as gamblers and, where possible, as 'affected others' (reporting of 'affected others' is limited due to sample size limitations).

It should be noted, however, that whilst we are able to explore commonalities and variations in responses by ethnicity, the primary research objectives of the Gambling Treatment and Support study did not include a specific focus on the relationship between an individual's gambling behaviours and their ethnic background. Therefore, this study should be seen as a starting point, providing indications of areas where further consideration could be given to the role of ethnicity in preventing and reducing gambling harms, rather than a conclusive or exhaustive exploration of these issues. The focus of this specific piece of analysis is to highlight differences between ethnic groups, rather than explore or explain the reasons for these.

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[4] 'Gambling Treatment and Support' (YouGov, 2020):: https://about.gambleaware.org/media/2185/gambling-treatment-and-support.pdf

[5] 'Gambling behaviour in Great Britain' (Natcen, 2016): https://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2016.pdf

2.2 Method

A notable challenge with this study was to reach a large enough sample of the general population to produce robust data on the geographical distribution of the target populations, while also reaching adequate numbers of gamblers and those affected by another's gambling to interview in more detail about their experiences. To meet this challenge, we utilised a two-phase approach.

The purpose of the Phase 1 study was to identify gamblers experiencing some level of harm from their gambling (a score of 1+ on the PGSI scale) in the sample, as well as for affected others, and the overall usage of and demand for treatment, advice or support among these groups.

For Phase 2 we conducted a separate study which targeted gamblers experiencing some level of harm (a score of 1+ on the PGSI scale) and affected others only, with the objective of exploring their views and experiences in more detail, including experiences of seeking treatment/support, motivations and barriers. Further details of both phases are provided below.

Phase 1 (nationally representative)

The Phase 1 fieldwork was carried out between 24th September and 13th October 2019. Interviews were conducted online using YouGov's online research panel. In total, 12,161 adults in Great Britain were surveyed, including 1,383 respondents from BAME communities. Results have been weighted to be representative of the GB adult population according to age, gender, region, socio-economic group and ethnic group.

Table 1. Phase 1 sample breakdown (nationally representative)

Category	BAME		White	
	Unweighted n	Weighted n	Unweighted n	Weighted n
Total	1,383	1,549	10,778	10,612
Men	658	763	5,313	5,137
Women	725	786	5,465	5,475
18-34	630	709	2,832	2,823
35-54	533	594	3,545	3,675
55+	220	246	4,401	4,114
North East	23	27	443	473
North West	122	131	1,285	1,234
Yorkshire and the Humber	102	109	957	924
East Midlands	94	97	854	814
West Midlands	167	179	938	920
East of England	102	108	1,102	1,058
London	518	619	973	1,025
South East	152	162	1546	1,547
South West	46	51	1,075	1,026
Wales	22	24	599	576
Scotland	35	42	1,006	1,016

Phase 2 (targeted sample)

Phase 2 comprises a targeted survey of gamblers experiencing some level of harm (a PGSI score of 1+), and 'affected others' (anyone who feels they have been affected by another's gambling). Respondents could qualify as both a gambler and an affected other, if relevant.

It was permitted (but not required) for respondents to take part in both Phase 1 and Phase 2. Some respondents for Phase 2 were recruited via their participation in the Phase 1 survey, while others were identified via screening of YouGov's wider panel. In total, 3,001 gamblers and affected others, including 279 respondents from BAME communities, were interviewed online between 23rd October and 12th November 2019.

The Phase 2 data was weighted to match the group of PGSI 1+ gamblers and affected others found in Phase 1, according to age, gender, ethnic group, social grade, region, gambler/affected other status and PGSI score category. The rationale for this was that the Phase 1 study, being nationally representative, provides more authoritative information on the overall characteristics of this audience, in comparison to Phase 2's targeted sampling approach.

Table 2. Phase 2 sample breakdown (PGSI 1+ gamblers and affected others)

Category	BAME		White	
	Unweighted n	Weighted n	Unweighted n	Weighted n
Total	279	311	2,711	2,679
Men	151	174	1,436	1,497
Women	128	137	1,275	1,182
18-34	141	179	758	882
35-54	111	108	1,122	1,043
55+	27	24	831	753
North East	5	5	146	121
North West	24	30	323	362
Yorkshire and the Humber	20	20	284	288
East Midlands	20	25	189	199
West Midlands	41	48	190	233
East of England	18	16	272	247
London	88	106	292	304
South East	30	29	383	369
South West	10	12	229	215
Wales	9	8	134	115
Scotland	14	13	269	227
Gambler only	166	213	1,362	1,640
Affected other only	70	65	967	802
Gambler and affected other	43	32	382	237

2.3 Ethnicity definition and groupings

The data in this report is analysed by ethnic group, with broad comparisons made between respondents from BAME communities and those from white backgrounds, in addition to highlighting differences and similarities among specific ethnic subgroups. It has been recognised that the term 'BAME' implies a homogeneity between ethnic subgroups and is therefore contentious and difficult in nature. However, in the context of this report, it allows for broad comparisons to be made, with the BAME category broken down further where possible. Ethnicity is among the demographic data that YouGov already holds on its panellists, meaning that it was not asked in the GambleAware survey. Respondents' ethnicity is self-reported using the question below. This is asked to be consistent with Census definitions to ensure that data collected is comparable to other datasets.

The question is single code, meaning that respondents have to choose a best fit description of their ethnicity, rather than being able to fully self-define. The categories used to analyse responses by ethnicity are constructs for the purpose of quantitative analysis and groupings are outlined in the table below. The overall BAME grouping encompasses the following ethnic groups outlined in the table below: Mixed/Multiple ethnic groups, Asian/Asian British, Black/ African/Caribbean/Black British and other ethnic group.

Table 3. Ethnicity breakdown

What ethnic group best describes you? *Please select one option only.*	Census classification	Grouping used in reporting
White and Black Caribbean	Mixed/Multiple ethnic groups	Black (inc mixed white / Black)
White and Black African	Mixed/Multiple ethnic groups	Black (inc mixed white / Black)
African	Black/ African/Caribbean/Black British	Black (inc mixed white / Black)
Caribbean	Black/ African/Caribbean/Black British	Black (inc mixed white / Black)
Any other Black / African / Caribbean background	Black/ African/Caribbean/Black British	Black (inc mixed white / Black)
White and Asian	Mixed/Multiple ethnic groups	Asian (inc mixed white / Asian)
Indian	Asian/Asian British	Asian (inc mixed white / Asian)

Pakistani	Asian/Asian British	Asian (inc mixed white / Asian)
Bangladeshi	Asian/Asian British	Asian (inc mixed white / Asian)
Chinese	Asian/Asian British	Asian (inc mixed white / Asian)
Any other Asian background	Asian/Asian British	Asian (inc mixed white / Asian)
Any other Mixed / Multiple ethnic background	Mixed/Multiple ethnic groups	Other Mixed / Other
Arab	Other ethnic group	Other Mixed / Other
Any other ethnic group	Other ethnic group	Other Mixed / Other

Consideration was given to the different possible ways of reporting on ethnic subgroups, in the context of the sample sizes and with an understanding that any approach would have some limitations.

It has been recognised that using 'mixed' as a category can be problematic since it conflates varied ethnic subgroups who will have different needs and experiences. In the case of this report, this would have resulted in combining, for example, those of white and Black heritage with those of white and Asian heritage. Yet it has been argued that the experiences of people of 'mixed' ethnicity may not differ significantly from those of the relevant mono-racial minorities[6].

As an alternative, we considered the idea of combining those of mixed heritage with the relevant minority ethnic group (e.g. 'mixed Black African and white' with 'Black African'). An advantage of this approach is that it ensures that base sizes are large enough to draw meaningful comparisons from and avoids using an overall 'mixed' category which would conflate individuals from quite distinct backgrounds as described above.

We recognise that this approach has limitations since the relevant respondents self-identified as 'mixed', as opposed to selecting other categories that were available to them. In fact, any combining of categories necessarily conflates individuals who may have different needs and experiences.

[6] 'Mixed Heritage – Identity, Policy and Practice' (The Runnymede Trust, 2006): https://www.runnymedetrust.org/uploads/file/Perspectives-MixedHeritageFinal.pdf

Following consideration, in recognition of the fact that an overall 'mixed' category would present significant issues, and due to significant benefits of having larger base sizes to analyse, a decision was made to present findings for each minority ethnic background, including those of mixed heritage. A future piece of research with a larger sample size would allow for findings to be reported on at a more detailed level.

The analysis by ethnic group in this report should not be taken to imply or demonstrate anything inherently different about individuals based on their ethnicity. Instead, ethnicity should be considered a proxy for underlying drivers rather than an explanation in and of itself.

2.4 Standardised tools and classifications

The following standardised tools and classifications were included in the survey and analysis process:

Problem Gambling Severity Index (PGSI)

The study utilised the full (9-item) Problem Gambling Severity Index (PGSI) to measure levels of gambling behaviour which may cause harm to the gambler. The PGSI[7] consists of nine items ranging from 'chasing losses' to 'gambling causing health problems' to 'feeling guilty about gambling'. Each item is assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores: never = 0; sometimes = 1; most of the time = 2; almost always = 3.

When scores to each item are summed, a total score ranging from 0 to 27 is possible. A PGSI score of 8 or more represents a problem gambler. This is the threshold recommended by the developers of the PGSI and the threshold used in this and previous reports.

[7] 'Gambling behaviour in Great Britain' (NatCen, 2016): http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2016.pdf

The 9 items are listed below:

- Have you bet more than you could really afford to lose?
- Have you needed to gamble with larger amounts of money to get the same excitement?
- When you gambled, did you go back another day to try and win back the money you lost?
- Have you borrowed money or sold anything to get money to gamble?
- Have you felt that you might have a problem with gambling?
- Has gambling caused you any mental health problems, including stress or anxiety?
- Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
- Has your gambling caused any financial problems for you or your household?
- Have you felt guilty about the way you gamble or what happens when you gamble?

Respondents were placed into the following categories, according to their score on the PGSI measure. The report often refers to gamblers with a score of 1+; this term encompasses low-risk (PGSI score 1-2), moderate-risk (3-7) and problem (8+) gamblers.

Throughout the report, gamblers with a PGSI score of 8+ are referred to as 'problem gamblers'.

Table 4. PGSI score categories

Category	PGSI score
Non-problem gambler	0
Low-risk (gamblers who experience a low level of problems with few or no identified negative consequences)	1-2
Moderate-risk (gamblers who experience a moderate level of problems leading to some negative consequences)	3-7
Problem gambler (gamblers who gamble with negative consequences and a possible loss of control)	8+

Social Grade

Social grade is a classification system that is based on occupation. Developed by the National Readership Survey (NRS), it has been the research industry's source of social-economic classification for over 50 years. The categories can be found below. For analysis purposes, these have been grouped together into ABC1 and C2DE; comparisons between these groups have been made throughout the report. The brackets 'ABC1' and 'C2DE' are commonly used to describe the 'middle class' and 'working class' respectively.

Table 5. NRS Social Grade categories

		% of population (NRS Jan- Dec 2016)
A	Higher managerial, administrative and professional	4
B	Intermediate managerial, administrative and professional	23
C1	Supervisory, clerical and junior managerial, administrative and professional	28
C2	Skilled manual workers	20
D	Semi-skilled and unskilled manual workers	15
E	State pensioners, casual and lowest grade workers, unemployed with state benefits only	10

Alcohol Use Disorder Identification Test – Consumption (AUDIT-C)

The Alcohol Use Disorder Identification Test – Consumption provides a composite measure of alcohol consumption levels, incorporating: frequency of drinking, units consumed on a typical occasion, and frequency of drinking six units or more (for women) or eight units or more (for men). These three questions each carry a score of 0-4, depending on the answer given. This gives each individual an AUDIT-C score between 0 and 12. Scores have been grouped as shown in the table below.

Table 6. AUDIT-C categories

Category	AUDIT-C score
Low risk	0-4
Increasing risk	5-7
Higher risk	8-12

Kessler Psychological Distress Scale (K10)

The Kessler Psychological Distress Scale (K10) is a measure of psychological distress. The K10 scale involves 10 questions about emotional states each with a five-level response scale. The measure is intended to be used as a brief screen to identify levels of distress. Each item is scored from one 'none of the time' to five 'all of the time'. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

For analysis purposes we have classified respondents as '10-19' (likely to be well) and '20 or higher' (likely to have some level of distress).

Treatment, support and advice

Throughout the report, when discussing the types of treatment, support and advice that people could receive in order to help cut down their gambling, we refer to 'formal treatment services' and 'less formal sources of advice and support'. Formal treatment services are shown in pink on the charts throughout the report and include a range of professional services including mental health services (e.g. counsellor, therapist), specialist face-to-face treatment service for gambling and other addiction services (e.g. drug or alcohol). Less formal sources of advice and support are shown in purple on the charts and include friends and family members, websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare) and spouses/partners, amongst others. The table below gives the full breakdown of sources.

Table 7. Sources of treatment, support and advice

Source	Treatment, support and advice type
GP	Treatment
Mental health services (e.g. counsellor, therapist)	Treatment
Social worker, youth worker or support worker	Treatment
Specialist treatment service for gambling (e.g. National Gambling Treatment Service)	Treatment
Other addiction service (e.g. drug or alcohol)	Treatment
Online therapy for gambling e.g. CBT	Treatment
Face to face therapy for gambling	Treatment
A support group (e.g. Gamblers Anonymous)	Support and advice
Your spouse/partner	Support and advice
Friends or family members	Support and advice
Your employer	Support and advice
Books, leaflets or other printed materials	Support and advice
Websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare)	Support and advice
Online forum or group	Support and advice
A telephone helpline (e.g. National Gambling Helpline)	Support and advice
Self-help apps or other self-help tools (e.g. self-exclusion, blocking software and blocking bank transactions)	Support and advice

2.4 Notes for interpretation

The findings throughout are presented in the form of percentages, and all differences highlighted between subgroups are statistically significant at an alpha level of 0.05 unless otherwise indicated. In the charts, significant differences are indicated in red (significantly lower) and green (significantly higher). Where percentages do not sum up to 100, this may be due to rounding, the exclusion of 'don't know' and 'prefer not to say' responses, or because respondents could give multiple answers.

3 The gambling landscape for people from ethnic minority communities

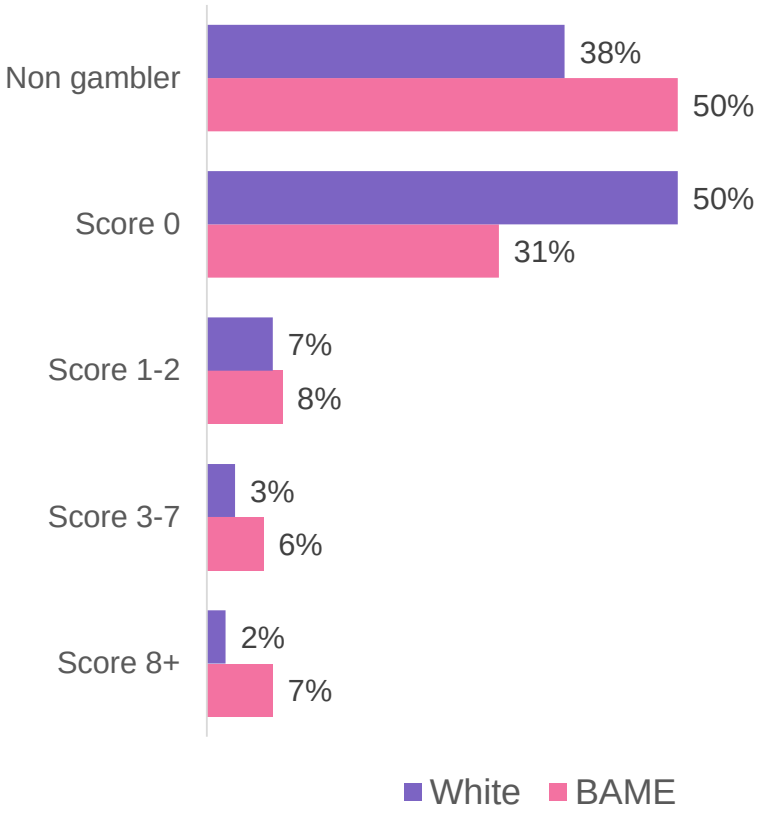
3.1 Extent of harmful gambling

In order to know the size of the population wanting any form of treatment or support, it was first necessary to calculate PGSI scores to know the proportion of the population experiencing gambling related harms. Placing respondents into these categories also allows for comparisons between each group. As set out in Section 2.4, the study utilised the full (9-item) PGSI to measure levels of gambling behaviour which may cause harm to the gambler, with respondents placed into the following categories according to their score:

- Non-problem gambler (PGSI score of 0)
- Low-risk gambler (PGSI score of 1-2; gamblers who experience a low level of problems with few or no identified negative consequences)
- Moderate-risk gambler (PGSI score of 3-7; gamblers who experience a moderate level of problems leading to some negative consequences)
- Problem gamblers (PGSI score of 8 or more; gamblers who gamble with negative consequences and a possible loss of control)

Overall, a fifth (20%) of adults from BAME communities surveyed scored one or higher on the PGSI scale, in comparison with 12% of white adults. Eight percent were classified as a low-risk gambler (a score of 1-2); six percent as a moderate-risk gambler (a score of 3-7) and seven percent as a problem gambler (a score of eight or higher). The difference by ethnic group is most notable among the 'problem gambler' category: the seven percent of adults from BAME communities placed into this category contrasts with just two percent of white adults. A different pattern is evident among each group: white adults are decreasingly likely to be in each ascending PGSI category, whereas the proportion of adults from BAME communities classified as problem gamblers is actually higher than those classified as moderate-risk.

Figure 1: PGSI category – by ethnic group



It is important to note that a higher PGSI score does not inherently denote more frequent or riskier gambling, compared to a lower score. Since some of the items on the PGSI scale relate to emotions such as guilt, and mental health effects such as stress and anxiety, it is perfectly possible for one individual to score higher than another, based not on gambling more, but on their own response to their gambling behaviour. It is possible that cultural or religious context may influence responses such as guilt or anxiety in relation to gambling.

Demographic patterns among adults from BAME communities mirror those seen in the overall adult population, as discussed in the 'Gambling Treatment and Support' report, with men and younger adults more likely to be classified as gamblers experiencing some level of harm (a score of 1+). A quarter (24%) of men from BAME communities recorded a PGSI score of 1+, significantly higher than the proportion seen among women from BAME communities (15%) or among white men (16%). Most notably, nine percent of men from BAME communities were classified as a problem gambler compared with three percent of white men. Among women from BAME communities, 15% recorded a score of 1+, in comparison with nine percent of white women, and five percent were classified as a problem gambler (compared with one percent of white women).

A fifth (21%) of 18-34 year olds from BAME communities, and the same proportion of 35-54s, recorded a PGSI score of 1+, falling to 14% of adults from BAME communities aged 55 or older. While the proportion classified as a PGSI 1+ gambler was the same among the younger and middle age groups, 18-34s were more likely to be classified as a problem gambler, with a score of 8+ (9% compared with 6% of 35-54s, and just 2% of those aged 55+). While younger adults from BAME communities were more likely to be classified as PGSI 1+ gamblers, they were also more likely to be non-gamblers than those in the older age cohorts (59% vs 43% and 37% of 35-54s and 55+ respectively). The same pattern is evident among white adults.

Adults from BAME communities in C2DE social grades were not significantly more likely to be classified as gamblers experiencing some level of harm (a score of 1+) than those in ABC1 social grades (21% vs. 19%). This is in contrast to white adults, among whom the difference is significant (14% of C2DE white adults compared with 11% of ABC1), although it is worth noting that the smaller sample size for respondents from BAME communities means that a greater percentage point difference is needed in order for any difference to be statistically significant.

Table 8 shows the breakdown of PGSI categories among demographic groups within the sample from BAME communities. For reference, the following table shows the equivalent data among white adults.

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Table 8: PGSI score categories among adults from BAME communities – by gender, age, and social grade

	All BAME adults (n=1383)	Men (n=658)	Women (n=725)	ABC1 (n=847)	C2DE (n=536)	18-34 (n=630)	35-54 (n=533)	55+ (n=220)
Non-gambler	50%	45%	54%	50%	49%	59%	43%	37%
Non-problem gambler (score 0)	31%	30%	31%	31%	30%	20%	36%	49%
Low-risk gambler (score 1-2)	8%	8%	7%	6%	9%	7%	9%	7%
Moderate-risk gambler (score 3-7)	6%	8%	4%	5%	6%	5%	7%	5%
Problem gambler (score 8+)	7%	9%	5%	7%	6%	9%	6%	2%
All gamblers with a score of 1+	20%	24%	15%	19%	21%	21%	21%	14%

Table 9: PGSI score categories among white adults – by gender, age, and social grade

	All White adults (10,778)	Men (5,313)	Women (5,465)	ABC1 (5,688)	C2DE (5,090)	18-34 (2,832)	35-54 (3,545)	55+ (4,401)
Non-gambler	38%	35%	40%	39%	36%	45%	31%	38%
Non-problem gambler (score 0)	50%	49%	51%	50%	50%	37%	54%	55%
Low-risk gambler (score 1-2)	7%	9%	5%	7%	7%	9%	8%	5%
Moderate-risk gambler (score 3-7)	3%	4%	2%	2%	4%	4%	4%	2%
Problem gambler (score 8+)	2%	3%	1%	2%	3%	4%	3%	0%
All gamblers with a score of 1+	12%	16%	9%	11%	14%	18%	15%	7%

There is considerable variation among individual ethnic groups from BAME communities. As shown in Table 10, over a quarter (27%) of Black African respondents were classified as a PGSI 1+ gambler; significantly higher than the proportion seen among Black Caribbean respondents (18%). By contrast, those of Black Caribbean heritage were more likely to be classified as non-problem gamblers with a PGSI score of 0 (43% vs. 32% of Black African adults).

Respondents from Pakistani and Indian backgrounds were also more likely than other groups to fall into the PGSI 1+ category (25% and 24% respectively). However, while this overall proportion is similar, there was significant variation between these two groups: 12% of Pakistani adults were classified as problem gamblers, compared with seven percent of Indian adults. By contrast, Indian respondents were more likely to be found in the low risk (score 1-2) category (11% vs. 7% of Pakistani respondents). It is notable that, among Pakistani adults, the proportion classified as PGSI 1+ gamblers (25%) is greater than that falling into the non-problem gambler category (16%), a pattern which cannot be seen among any other group.

Table 10: PGSI score categories among adults from BAME communities - by specific ethnic group

	Black African (inc mixed) (n=162)	Black Caribbean (inc mixed) (n=171)	Indian (n=283)	Pakistani (n=166)	Other Asian (n=233)	Mixed White and Asian (n=131)	Other mixed / Other (n=248)
Non-gambler	41%	39%	47%	59%	54%	45%	53%
Non-problem gambler (score 0)	32%	43%	29%	16%	28%	38%	35%
Low-risk gambler (score 1-2)	8%	10%	11%	7%	6%	5%	4%
Moderate-risk gambler (score 3-7)	10%	4%	6%	5%	6%	2%	4%
Problem gambler (score 8+)	9%	4%	7%	12%	7%	10%	3%
All 1+ gamblers	27%	18%	24%	25%	18%	18%	12%

3.2 Extent of affected others

Gambling is a widespread issue that can have a profoundly negative impact, not just on those gambling, but on those close to them. 'Affected others' are people that know someone who has had a problem with gambling (either currently, or in their past) and feel they have personally experienced negative effects as a result of a person's/people's gambling behaviour. This could include family members, friends and work colleagues, amongst others, with the negative effects ranging from financial to emotional or practical impacts.

Overall, nine percent of respondents from BAME communities qualified as affected others. This was higher than the proportion seen among white adults (7%) and may reflect the higher incidence of gambling with some level harm seen among adults from BAME communities. Since individuals will generally (although not always) have family members of the same ethnic group, a relationship between the number of gamblers experiencing harm and the number of affected others in the same ethnic group is to be expected.

Among adults overall and white adults, a pattern can be seen whereby women are more likely than men to be classified as an affected other, reflecting the fact that more men are classified as gamblers experiencing some level of harm. Among adults from BAME communities the same pattern appears to exist, however the difference is not statistically significant (10% BAME women; 8% BAME men). There is little variation by age, or by social grade.

Table 11: Affected other status among adults from BAME communities – by age, gender and social grade

	All BAME adults (n=1,383)	Men (n=658)	Women (n=725)	ABC1 (n=847)	C2DE (n=536)	18-34 (n=630)	35-54 (n=533)	55+ (n=220)
Proportion who qualify as an affected other	9%	8%	10%	9%	10%	8%	10%	10%

There was also little variation between specific ethnic groups in the proportion qualifying as an affected other. While certain groups were more likely to be classified as gamblers experiencing some level of harm (a PGSI score of 1+), this is not reflected in significant differences between ethnic groups when considering affected other status.

Table 12: Affected other status among adults from BAME communities – by specific ethnic group

	Black African (inc mixed) (n=162)	Black Caribbean (inc mixed) (n=171)	Indian (n=283)	Pakistani (n=166)	Other Asian (n=233)	Mixed White and Asian (n=131)	Other mixed / Other (n=248)
Proportion who qualify as an affected other	10%	8%	6%	10%	10%	12%	11%

Relationship between gambling status and affected others status

Among gamblers from BAME communities, the proportion qualifying as an affected other increases with PGSI score, showing a relationship between an individual's own gambling and the likelihood of experiencing of issues related to others' gambling. For example, one in five (21%) problem gamblers from BAME communities also identified as being an affected other, compared with just seven percent of gamblers with a PGSI score of 0, or eight percent of non-gamblers. This same pattern can be seen among white adults and the overall population and alludes to the complexity of disordered gambling.

Table 13: Affected other status among adults from BAME communities – by gambling status

	All BAME adults (1,383)	Non gambler (670)	PGSI score				
			0 (432)	1-2 (105)	3-7 (77)	8+ (99)	1+ (281)
Proportion who qualify as an affected other	8%	8%	7%	8%	15%	21%	14%

3.3 A behavioural summary of gamblers from ethnic minority communities

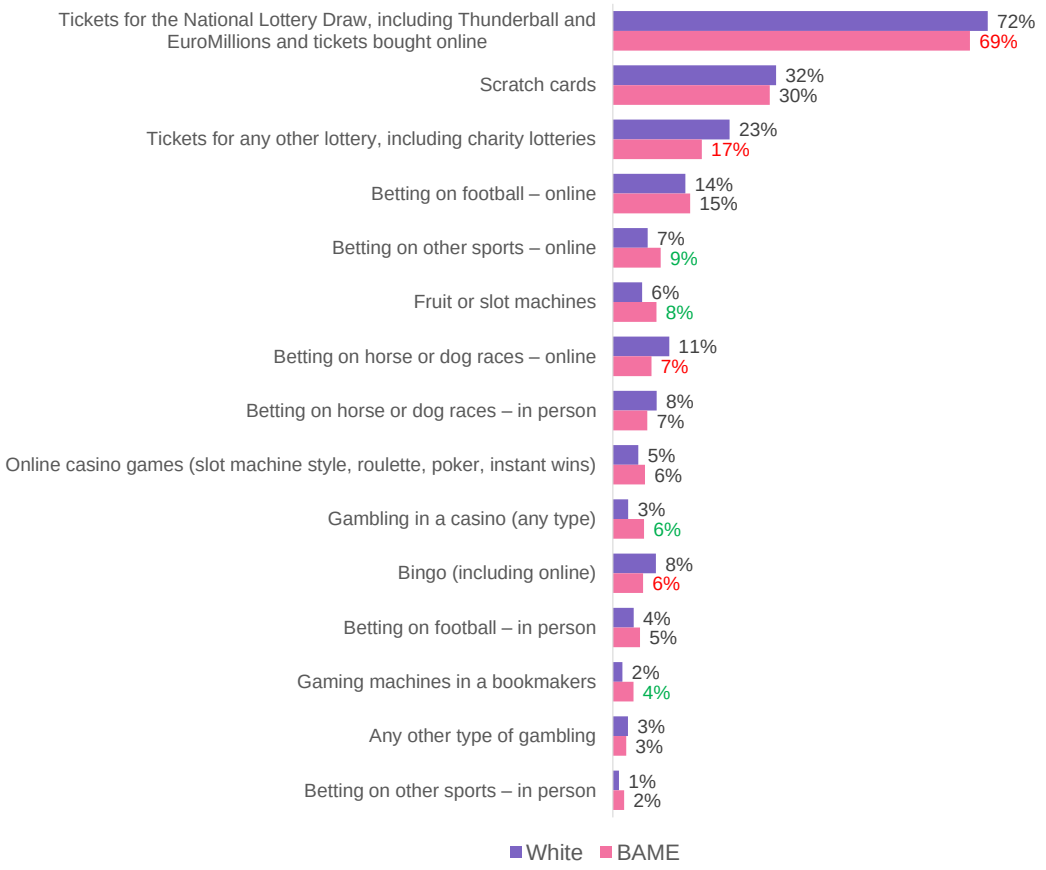
This section discusses gambling behaviour among gamblers from BAME communities, exploring contrasts and similarities to white gamblers and between specific BAME ethnic subgroups. It also provides further demographic and contextual detail on the gambling population from BAME communities. Due to sample size limitations, findings in this section are presented for all gamblers from BAME communities (i.e. including those with a PGSI score of 0), as well as for gamblers from BAME communities with a PGSI score of 1+ where appropriate.

Gambling participation

Gamblers from BAME communities are more likely to have participated in various gambling activities in the last 12 months than their white counterparts, including gambling in a casino, fruit and slot machines, betting on other sports (aside from football, horse and dog racing), and gaming machines at a bookmakers.

By contrast, gamblers from BAME communities are less likely than white gamblers to have participated in the National Lottery or other lotteries. Scratchcard participation is similar among both gamblers from BAME communities and white gamblers.

Figure 2: Gambling participation in last 12 months among white gamblers and those from BAME communities



Base: all gamblers from BAME communities (n=713); all white gamblers (n=6,702)

There is significant variation in activities participated in between individual groups from BAME communities, which may provide some useful context to the variation in PGSI scores reported in Chapter 3. Black African gamblers are more likely than Black Caribbean gamblers to have participated in various activities, including football betting, other sports betting, and fruit or slot machines. Notably, seven percent of Black African gamblers participated in casino gambling in the last 12 months, compared with just one percent of Black Caribbean gamblers.

The only activity in which those of Black Caribbean heritage are more likely to have participated is scratchcards, which were played by 43% of Black Caribbean gamblers compared with 34% Black African gamblers (they are indicatively more likely to have participated in the National Lottery but the difference is not significant). As such, Black Caribbean gamblers present a pattern which is more similar to that seen among white gamblers, whereas Black African gamblers show a more distinct pattern.

Pakistani gamblers, who as discussed earlier had the highest PGSI scores among the subgroups, were the group most likely to have participated in casino gambling (11%). This proportion is significantly lower among gamblers of Indian heritage (5%), although it rises to nine percent among those of other Asian backgrounds (including Bangladeshi and Chinese). Pakistani gamblers are also the group most likely to have used gaming machines in a bookmakers (9%).

Table 14: Gambling participation in last 12 months, by ethnic group among gamblers from BAME communities

	Black African (inc mixed) (n=99)	Black Caribbean (inc mixed) (n=104)	Indian (n=129)	Pakistani (n=66)	Other Asian (n=107)	Mixed White and Asian (n=72)	Other mixed / Other (n=119)
Tickets for National Lottery / Thunderball / EuroMillions	64%	74%	70%	63%	64%	66%	76%
Scratch cards	34%	43%	29%	34%	22%	27%	24%
Tickets for any other lottery, inc charity	20%	19%	18%	19%	11%	9%	19%
Betting on football – online	27%	12%	11%	15%	18%	16%	8%
Betting on other sports – online	15%	5%	9%	7%	10%	5%	8%
Fruit or slot machines	13%	5%	8%	12%	8%	3%	8%
Betting on horse or dog races – online	12%	8%	8%	7%	8%	8%	3%
Betting on horse or dog races – in person	8%	10%	7%	3%	5%	7%	8%
Bingo (inc online)	11%	7%	6%	6%	2%	4%	5%
Gambling in a casino (any type)	7%	1%	5%	11%	9%	6%	5%
Online casino games	12%	7%	5%	3%	5%	6%	5%
Betting on football – in person	11%	6%	3%	6%	6%	2%	2%
Gaming machines in a bookmakers	6%	1%	4%	9%	3%	4%	3%
Betting on other sports – in person	7%	0%	1%	5%	3%	3%	0%
Any other type of gambling	2%	3%	4%	3%	1%	5%	2%

3.4 A demographic summary of gamblers from ethnic minority communities

Gender

Gamblers from BAME communities with a PGSI score of 1+ were significantly more likely to be male than the overall population from BAME communities: three in five (60%) were male, compared with approximately half (49%) of adults from BAME communities overall. This is also the case for white gamblers: just over three in five (63%) were male, higher than the proportion (48%) in the overall white population.

There is a clear relationship between gender and levels of gambling harm. Among problem gamblers from BAME communities, around two in three (65%) were male. This was also the case among white problem gamblers, with the same proportion (66%) falling into this category.

Table 15: Gender by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All adults	All gamblers	PGSI 1+	PGSI 8+
	(n=1,383)	(n=713)	(n=281)	(n=99)	(n=10,778)	(n=6,702)	(n=1,324)	(n=232)
Male	49%	54%	60%	65%	48%	50%	63%	66%
Female	51%	46%	40%	35%	52%	50%	37%	34%

Age

Gamblers from BAME communities with a PGSI score of 1+ have a fairly similar age profile to the overall population from BAME communities: 48% were aged 18-34, compared with 46% of adults from BAME communities overall, and just 11% were aged 55+, compared with 16% of all adults from BAME communities. By contrast, among white respondents there is a bigger difference between gamblers and the population overall: 37% white gamblers with a PGSI score of 1+ were aged 18-34, compared to 27% of white adults overall.

There is a strong relationship between age and levels of gambling harm. Among problem gamblers from BAME communities, three in five (62%) were aged 18-34, much higher than the proportion (46%) of adults from BAME communities overall falling into this age category. This is also the case for white problem gamblers: half (51%) were 18-34, compared to around a quarter (27%) of white adults overall.

Table 16: Age group by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All	All gamblers	PGSI 1+	PGSI 8+
	(n=1,383)	(n=713)	(n=281)	(n=99)	(n=10,778)	(n=6,702)	(n=1,324)	(n=232)
18-34	46%	37%	48%	62%	27%	23%	37%	51%
35-54	38%	43%	41%	33%	35%	38%	41%	42%
55+	16%	20%	11%	5%	39%	38%	21%	6%

Ethnic group

Gamblers from BAME communities with a PGSI score of 1+ are more likely to be of a Black African, Indian or Pakistani ethnic background compared to the overall population from BAME communities. Seventeen percent of gamblers from BAME communities with a PGSI score of 1+ are from a Black African background (compared to 12% overall), 22% are Indian (compared to 18% overall) and 15% are Pakistani (compared to 12% overall).

Problem gamblers from BAME communities are particularly likely to be Pakistani. One in five (22%) gamblers from BAME communities are Pakistani compared to 12% of the overall population from BAME communities.

Table 17: Ethnic group by PGSI category, among gamblers from BAME communities

	All adults	All gamblers	PGSI score				
			0	1-2	3-7	8+	All 1+
	(n=1,383)	(n=713)	(n=432)	(n=105)	(n=77)	(n=99)	(n=281)
Black African (inc mixed)	12%	14%	13%	14%	21%	16%	17%
Black Caribbean (inc mixed	11%	13%	15%	15%	8%	6%	10%
NET: Black (inc mixed)	*26%*	*30%*	*31%*	*33%*	*32%*	*25%*	*30%*
Indian	18%	19%	17%	27%	19%	19%	22%
Pakistani	12%	10%	6%	11%	`11%	22%	15%
Other Asian	20%	18%	18%	16%	20%	19%	18%
Mixed White and Asian	3%	3%	4%	2%	1%	4%	3%
NET: Asian (inc mixed)	*53%*	*50%*	*45%*	*56%*	*51%*	*64%*	*57%*
Other mixed / Other	21%	20%	24%	11%	17%	11%	13%

Religion

Gamblers from BAME communities with a PGSI score of 1+ in the sample were significantly more likely to be religious than the overall population from BAME communities surveyed: seven in ten (72%) had a faith, higher than the proportion of people from BAME communities overall (62%). This pattern is not present among white gamblers: a comparable proportion of white gamblers with a PGSI score of 1+ and the overall white sample are religious. In general, people from BAME communities are more likely than their white counterparts to be religious.

There is a clear relationship between religion and levels of gambling harm among gamblers from BAME communities. Among problem gamblers from BAME communities, the vast majority (86%) are religious, higher than the proportion of people from BAME communities overall in the sample (62%). The pattern among respondents from BAME communities is driven by differences among the ethnic subgroups. A relatively high proportion of problem gamblers identify as Muslim; this is likely driven by the fact Pakistani gamblers are more likely to have higher PGSI scores than the other ethnic subgroups. This is also the case for the 'Other Christian' category. The higher proportion of problem gamblers being classified as this is driven by Black African gamblers identifying as having a Christian faith other than Church of England or Catholic.

Table 18: Religion by PGSI category, among gamblers from BAME communities

	All adults	All gamblers	PGSI score				
			0	1-2	3-7	8+	All 1+
	(n=1,288)	(n=676)	(n=412)	(n=96)	(n=73)	(n=95)	(n=264)
No faith	38%	38%	45%	39%	29%	14%	28%
Church of England	6%	8%	7%	16%	7%	6%	10%
Catholic	8%	10%	9%	8%	11%	12%	10%
Other Christian	10%	9%	7%	6%	10%	20%	12%
Muslim	20%	14%	11%	11%	25%	24%	19%
Hindu	8%	10%	9%	10%	10%	13%	11%
Other faiths	11%	11%	12%	10%	7%	11%	10%
Net: Faith	62%	62%	55%	61%	71%	86%	72%

Region

Table 19 shows the proportion of gamblers residing in different regions in Great Britain. The regional distribution of both gamblers from BAME communities and white gamblers was broadly comparable to the overall distribution of the respective population.

The only particular difference among adults from BAME communities is in the West Midlands. Problem gamblers from BAME communities are more likely to live here (17%, compared with 12% of the broader population from BAME communities). White problem gamblers are more likely to reside in London (14%, compared to 10% of the overall white population) or the North East (7%, compared with 4%).

Table 19: Region by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All	All gamblers	PGSI 1+	PGSI 8+
	(n=1,383)	(n=713)	(n=281)	(n=99)	(n=10,778)	(n=6,702)	(n=1,324)	(n=232)
N. East	2%	2%	2%	3%	4%	5%	5%	7%
N. West	8%	8%	8%	9%	12%	12%	14%	11%
Yorkshire/ Humber	7%	7%	9%	9%	9%	9%	11%	12%
E. Midlands	6%	8%	9%	7%	8%	8%	6%	7%
W. Midlands	12%	12%	14%	17%	9%	9%	9%	11%
East	7%	8%	5%	1%	10%	10%	8%	7%
London	40%	37%	37%	37%	10%	9%	11%	14%
S. East	10%	10%	7%	8%	15%	15%	14%	11%
S. West	3%	3%	4%	4%	10%	9%	8%	6%
Wales	2%	1%	1%	2%	5%	5%	4%	5%
Scotland	3%	3%	4%	1%	10%	10%	9%	9%

Working status

Gamblers from BAME communities were more likely than the broader sample from BAME communities to be in employment. Seven in ten (71%) gamblers from BAME communities with a score of 1+ were employed, compared with 64% of adults from BAME communities in the broader sample. This likely correlates with their age: the problem gambling population from BAME communities (PGSI score 8+) was younger and the younger age groups are more likely to be employed than those aged 55+. In line with this, gamblers from BAME communities who scored PGSI 1+ were less likely to be retired: 6% of gamblers from BAME communities with a PGSI score of 1+ gamblers were retired compared with 9% of adults from BAME communities in the broader sample. The same patterns can be seen among white adults. Among white gamblers scoring PGSI 1+, 70% were employed, compared with 57% of the broader white sample.

Table 20: Working status by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All	All gamblers	PGSI 1+	PGSI 8+
	(n=1,329)	(n=690)	(n=267)	(n=93)	(n=10,473)	(n=6,522)	(n=1,276)	(n=218)
Working	64%	69%	71%	71%	57%	61%	70%	73%
Full time student	10%	6%	9%	11%	5%	3%	5%	7%
Retired	9%	11%	6%	7%	25%	24%	11%	4%
Unemployed	7%	6%	7%	7%	4%	4%	6%	10%
Other not working	16%	14%	14%	11%	12%	12%	14%	17%

Marital status

Gamblers from BAME communities with a PGSI 1+ score are most likely to currently be in a relationship, more specifically, married or with a civil partner (44%). This is higher than the broader sample from BAME communities of whom 38% are married. Similarly, they are less likely to have never married (37%) compared with 43% of the broader sample from BAME communities.

This differs from white gamblers with a PGSI score of 1+ who are more likely than the broader white sample to have never married (39% vs. 30%) and are less likely to be married or with a civil partner (32% vs. 43% of white adults overall). White problem gamblers are particularly likely to have never married.

Table 21: Marital/relationship status by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All	All gamblers	PGSI 1+	PGSI 8+
	(n=1,377)	(n=712)	(n=281)	(n=99)	(n=10,748)	(n=6,689)	(n=1,318)	(n=232)
Living as married	11%	14%	11%	14%	14%	15%	17%	19%
Married / civil partner-ship	38%	40%	44%	43%	43%	44%	32%	30%
Never married	43%	37%	37%	37%	30%	27%	39%	42%
Separated / divorced	6%	7%	8%	7%	8%	9%	8%	8%
Widowed	2%	1%	<1%	-	5%	4%	3%	1%
Net: In relation-ship	50%	55%	55%	56%	57%	60%	50%	49%
Net: Not in relation-ship	50%	45%	45%	44%	43%	40%	50%	51%

Children in the household

Gamblers from BAME communities with a PGSI score of 1+ are more likely than the broader sample from BAME communities to have responsibility for children (aged under 18) in the household. Two in five (43%) adults from BAME communities with a PGSI score of 1+ had responsibility for children in the household, compared to three in ten (31%) adults from BAME communities in the broader sample. This is also the case among white gamblers: a quarter (25%) of white PGSI 1+ gamblers are responsible for children in the household, higher than the proportion (18%) of white adults in the broader sample.

Problem gamblers are particularly likely to have responsibility for children in the household. Over half (56%) of problem gamblers from BAME communities report this (compared with 31% of the broader sample from BAME communities) and 38% of white problem gamblers report the same (compared with 18%).

Table 22: Children under 18 in household by ethnic group and PGSI category

	BAME				White			
	All adults	All gamblers	PGSI 1+	PGSI 8+	All	All gamblers	PGSI 1+	PGSI 8+
	(n=1,252)	(n=662)	(n=257)	(n=87)	(n=10,435)	(n=6,524)	(n=1,273)	(n=213)
Any	31%	35%	43%	56%	18%	20%	25%	38%
None	69%	65%	57%	44%	82%	80%	75%	62%

The high proportion of gamblers from BAME communities with children can be partly explained by age (PGSI 1+ gamblers from BAME communities are concentrated in the younger-middle age years, which are broadly also the ages in which people are likely to have dependent children), but this factor alone does not fully explain the pattern. Even within a given age group, there is a relationship between higher PGSI scores and having dependent children. For example, among all 18-34s from BAME communities, 22% said that they had dependent children, but this rises to 39% among PGSI 1+ gamblers in the same age group. The same pattern can also be seen among white 18-34 year olds. The reasons for this could be an area for further exploration.

Co-existing long term health conditions

Approximately half (49%) of gamblers from BAME communities with a PGSI score of 1+ have been diagnosed with a co-existing long term health condition (e.g. arthritis, cancer, heart disease, mental health conditions). This is comparable to the proportion (50%) of white gamblers than have been, which is interesting in the context that 1+ gamblers from BAME communities are younger overall than their white counterparts and might therefore be expected to experience fewer such conditions. However, there is evidence to show that minority ethnic groups are more likely to experience health inequalities, which could play a role in this[8].

The proportion with co-existing conditions increases with PGSI score category. Among problem gamblers from BAME communities, 65% had a diagnosis of a co-existing condition, compared with 59% of moderate risk gamblers (score 3-7) and 33% of low risk gamblers (score 1-2). The same pattern can be seen among white gamblers.

Table 23: Co-existing long-term health conditions by ethnic group and PGSI category (1+ gamblers only)

	BAME				White			
	PGSI score				PGSI score			
	1-2	3-7	8+	All 1+	1-2	3-7	8+	All 1+
	(n=60)	(n=53)	(n=88)	(n=201)	(n=649)	(n=611)	(n=455)	(n=1,715)
Any	33%	59%	65%	49%	48%	51%	56%	50%
None	67%	41%	35%	51%	52%	49%	44%	50%

Alcohol use

There is an interesting link between alcohol consumption and gambling. The AUDIT-C measure identifies at-risk drinkers, categorising people into low risk, including non-drinkers (a score of 0-4), increasing risk (a score of 5-7) and higher risk (a score of 8-12).

[8] 'Tackling health inequalities for minority ethnic groups: challenges and opportunities' (Race Equality Foundation, 2007): https://raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief6.pdf

The majority (65%) of gamblers from BAME communities with a PGSI score of 1+ are drinking at low risk levels or not at all (AUDIT-C score under 5), whilst one in ten (11%) are higher risk drinkers (AUDIT-C score 8-12). White gamblers with a PGSI score of 1+ are more likely to be classified as higher risk drinkers, with two in five (21%) falling into this group. This is not surprising given that around a fifth of the sample from BAME communities were Muslim, a faith that generally prohibits alcohol consumption.

AUDIT-C scores increased with PGSI score in our sample, highlighting the complex link between gambling and other addictive behaviours. Among problem gamblers from BAME communities, a fifth (22%) were considered higher risk drinkers, compared with around just two percent of those in the PGSI 1-2 category. For gamblers with a PGSI score of 1+ who are white, this pattern is not apparent. The same proportion of problem gamblers and low-risk gamblers are drinking at higher risk levels (21% and 20% respectively).

Table 24: AUDIT-C score category – by ethnic group and PGSI category (1+ gamblers)

	BAME				White			
	PGSI score				PGSI score			
	1-2	3-7	8+	All 1+	1-2	3-7	8+	All 1+
	(n=62)	(n=55)	(n=92)	(n=209)	(n=659)	(n=621)	(n=464)	(n=1,744)
Low risk (under 5)	79%	73%	41%	65%	53%	51%	43%	51%
Increasing risk (5-7)	20%	14%	37%	25%	27%	28%	34%	29%
Higher risk (8-12)	2%	13%	22%	11%	20%	21%	23%	21%

Psychological distress

The K-10 psychological distress scale is widely used to measure distress, which can be used to identify those in need of assessment for anxiety and depression. Among gamblers from BAME communities with a score of PGSI of 1+, 59% had a K-10 psychological distress score of 20+, similar to the proportion (57%) of white gamblers that did.

There is a clear relationship between psychological distress and PGSI score category. Among problem gamblers from BAME communities, the vast majority (91%) were experiencing higher levels of distress (a K-10 score of 20+), compared with just one in three (35%) of those in the 1-2 category. This pattern was also evident for white problem gamblers: 83% were experiencing higher levels of distress, compared with 49% of those with a PGSI score of 1-2.

Table 25: K-10 psychological distress score - by ethnic group and PGSI category (1+ gamblers only)

	BAME				White			
	1-2	3-7	8+	All 1+	1-2	3-7	8+	All 1+
	(n=62)	(n=55)	(n=92)	(n=209)	(n=659)	(n=621)	(n=464)	(n=1,744)
Under 20	65%	38%	9%	41%	51%	43%	17%	43%
Over 20	35%	62%	91%	59%	49%	57%	83%	57%

4 Gamblers' from ethnic minority communities use of treatment and support

This chapter will discuss engagement of treatment, advice and support by gamblers from BAME communities experiencing some level of harm (a PGSI score of 1+), drawing comparisons with white gamblers. Results reported throughout this section are based on those with a PGSI score of 1+ only.

4.1 Usage of treatment and support in the last 12 months

The table below summarises usage of treatment services and informal support and advice, among gamblers from BAME communities and white gamblers experiencing some level of harm, over the last 12 months. These proportions are taken from the Phase 1 study. Gamblers from BAME communities with a PGSI score of 1+ were more likely than their white counterparts to have used some form of treatment (such as mental health services, their GP, or specialist face-to-face treatment) to help them to cut down the amount they gamble in the last 12 months (24% vs. 9%). They were also more likely to have used any form of informal support or advice (such as from family and friends, support groups, websites or books) (23% vs. 11%). Taking both of these figures into account, three in ten (31%) gamblers from BAME communities report having used some form of treatment and/or support/advice in the last 12 months, higher than the proportion of white gamblers (14%) that have done so. A third (33%) of Black African gamblers say they have used some form of treatment and/or support/advice in the past 12 months, comparable to the proportion (31%) of Asian gamblers that have.

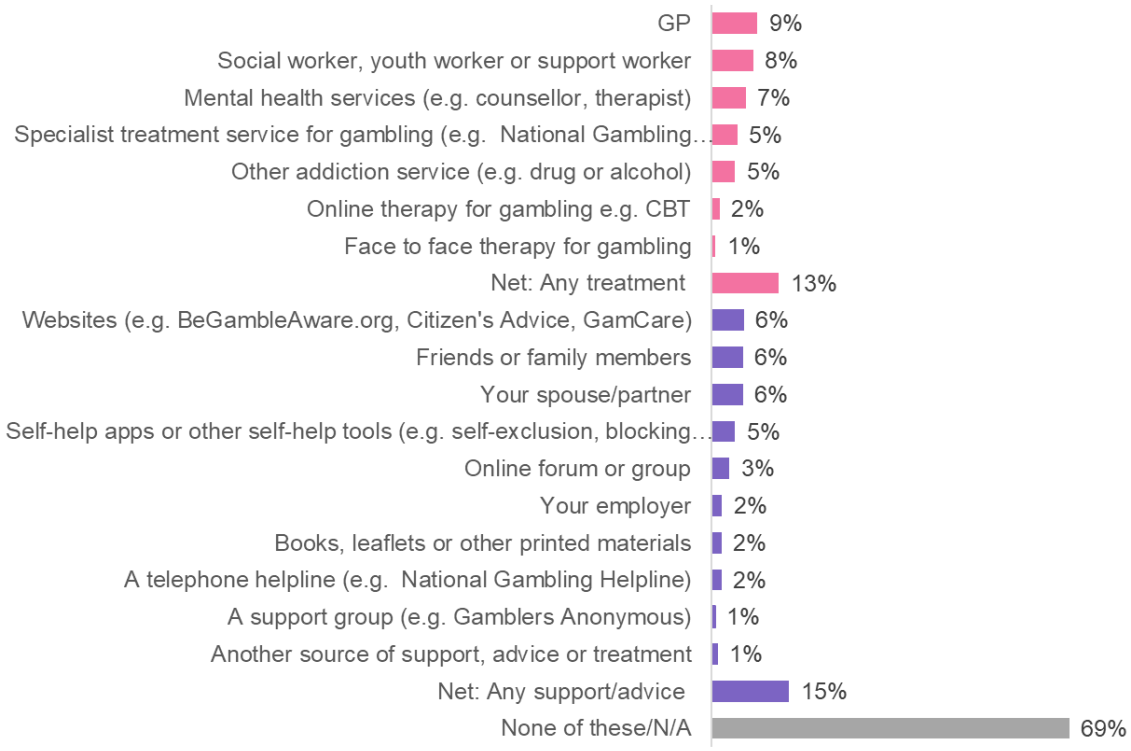
This pattern is particularly pronounced among gamblers with higher PGSI scores, who are experiencing higher levels of harm from their gambling. Seven in ten (71%) problem gamblers from BAME communities report having used some form of treatment and support, compared to under half (46%) of white gamblers. Specifically, over half (59%) report having used some form of treatment in the last 12 months (compared to 36% of white 8+ gamblers) and half (51%) have used some form of support or advice (compared to 34% of white 8+ gamblers).

Table 26. Usage of treatment and support/advice among PGSI 1+ gamblers – by ethnic group and PGSI score category

	All BAME 1+ gamblers (281)	All white 1+ gamblers (1,324)	BAME 1-2 (105)	White 1-2 (771)	BAME 3-7 (77)	White 3-7 (321)	BAME 8+ (99)	White 8+ (232)
Used any treatment	24%	9%	0%	2%	15%	8%	59%	36%
Used any support/advice	23%	11%	1%	2%	17%	14%	51%	34%
Used any treatment/ support/advice	31%	14%	1%	3%	24%	15%	71%	46%
Have not used any	69%	86%	99%	97%	76%	85%	29%	54%

The Phase 2 study further explored the usage of treatment, advice and support among gamblers from BAME communities with a PGSI score of 1+. Among professional treatment services, gamblers from BAME communities were most likely to say they have accessed a GP (9%), a social worker, youth worker or support worker (8%) or mental health services (e.g. counsellor, therapist) (7%). The most common informal sources of support and advice included websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare), friends or family members or a spouse or partner (all 6%).

Figure 3. Usage of treatment/support/advice by gamblers from BAME communities in the last 12 months



Base: all gamblers from BAME communities with a PGSI score of 1+ (n=218)

Gamblers with a PGSI score of 1+ from BAME communities were more likely than their white counterparts to have used many of the sources of treatment, support and advice shown in figure 3. They were more likely to have used almost all of the professional treatment services, such as GPs (9% vs. 3% of white 1+ gamblers), social workers, youth workers or support workers (8% vs. 3%) and mental health services (7% vs. 3%). They were also more likely to say that they had used a specialist treatment service for gambling (e.g. National Gambling Treatment Service) (5% vs. 2%). Among problem gamblers, usage of certain professional treatment services is particularly high. They were more likely to have spoken to a social worker, youth worker or support worker (23% vs. 13% of white problem gamblers) or a GP (19% vs. 9%). Among the informal sources of support, gamblers from BAME communities were more likely to have visited a website (6% vs. 3%) or an online forum or group (3% vs. 1%). The table below shows the comparisons among gamblers from BAME communities and white gamblers with PGSI scores of 1+.

Table 27. Sources of treatment, support and advice by ethnic group

Source	PGSI score of 1+	
	BAME (n=281)	White (n=1,324)
GP	9%	3%
Social worker, youth worker or support worker	8%	3%
Mental health services (e.g. counsellor, therapist)	7%	3%
Specialist treatment service for gambling (e.g. National Gambling Treatment Service)	5%	2%
Other addiction service (e.g. drug or alcohol)	5%	1%
Online therapy for gambling e.g. CBT	2%	1%
Face to face therapy for gambling	1%	1%
Websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare)	6%	3%
Friends or family members	6%	4%
Your spouse/partner	6%	3%
Self-help apps or other self-help tools (e.g. self-exclusion, blocking software and blocking bank transactions)	5%	2%
Online forum or group	3%	1%
Your employer	2%	2%
Books, leaflets or other printed materials	2%	1%
A telephone helpline (e.g. National Gambling Helpline)	2%	1%
A support group (e.g. Gamblers Anonymous))	1%	1%
Another source of support, advice or treatment	1%	0%

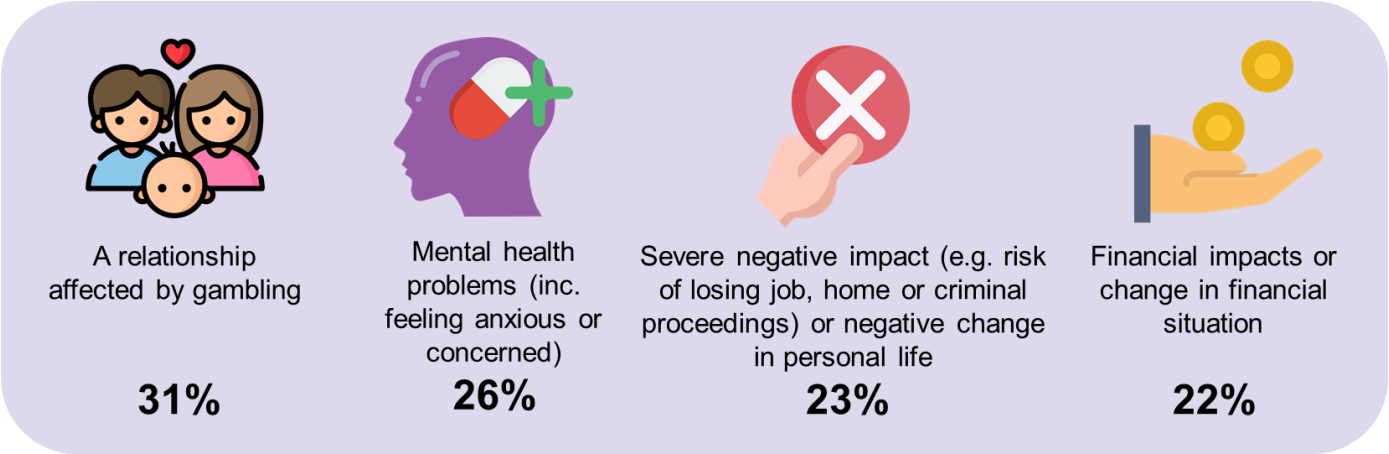
Gamblers from BAME communities in social grades ABC1 were more likely than those in social grades C2DE to report having spoken to friends or family members (9% vs. 2%), used websites (9% vs. 3%) or visited an online forum or group (5% vs. 1%) in an attempt to cut down their gambling. There were no differences in the sources of treatment, advice or support used to cut down their gambling among white ACB1 and C2DE gamblers.

Gamblers from BAME communities with responsibility for children in the household were more likely than those without to say they have used any form of treatment, advice or support to cut down their gambling (40% vs. 22%). This includes both formal forms of treatment or support (32% vs. 16%) and informal types (29% vs. 18%). This is mostly a result of them being more likely to say they have accessed treatment from a specialist treatment service for gambling (9% vs. 3%) or speaking to their spouse or partner (12% vs. 2%). This is also the case among white gamblers with a PGSI score of 1+. Two in ten (21%) white gamblers with children in the household said they had used any form of treatment, advice or support to cut down their gambling, compared to one in ten (10%) of those without. Having children in the household was more common among those with higher PGSI scores, even when adjusted for age. One hypothesis is that having dependents at home could increase the severity of the situation for gamblers from BAME communities, with a greater need to seek treatment, advice or support in order to support not only themselves but their family as well, however more research would be needed to confirm this.

4.2 Reasons for seeking treatment/support

Gamblers from BAME communities with a PGSI score of 1+ who say they have sought treatment, support or advice tended to be motivated to do so by the gambling affecting their relationships or family (31%), or mental health problems including feelings of anxiety or concern over their gambling (26%). Notably, just over a fifth (23%) were motivated by severe negative impacts from their gambling (such as the risk of losing their job or home, or the threat of criminal proceedings), or by a negative change in their personal life such as bereavement or relationship breakdown. An equivalent proportion (22%) cited financial impacts or a change in financial situation.

Figure 4. Factors that prompted gamblers from BAME communities to seek treatment/support/advice



Base: All gamblers from BAME communities with a PGSI score of 1+ who sought treatment/advice/support (n=93)

Gamblers from BAME communities were more likely than white gamblers who say they have sought treatment, support or advice to say they were motivated to do so due to being at risk of losing their job/employment (14% vs. 7%) or physical illness or injury (12% vs. 6%). By contrast, white gamblers were more likely to cite threat of criminal proceedings (6% vs. 1% BAME).

5 Gamblers' from ethnic minority communities demand for treatment and support

This chapter will discuss the current demand for treatment, advice and support by gamblers from BAME communities experiencing some level of harm (a PGSI score of 1+), drawing comparisons with white gamblers. Results reported throughout this section are based on those with a PGSI score of 1+ only.

5.1 Current demand for treatment and support

The table below summarises the current demand for treatment services and informal support and advice, by gamblers from BAME communities experiencing some level of harm (a PGSI score of 1+). These proportions are taken from the Phase 1 study. Mirroring current usage, overall, three in ten (31%) gamblers from BAME communities said they currently want some form of treatment, advice or support. Four percent had not accessed any form of treatment, advice or support before in the last 12 months but had a demand for it, whilst 27% had accessed some support before but would like more. A quarter (26%) of gamblers from BAME communities expressed a desire for any form of treatment from professional sources and slightly less (23%) wanted any form of informal support or advice (such as from family and friends, support groups, websites or books). Over a quarter (28%) of Black African gamblers want some form of treatment and/or support/advice, comparable to the proportion (31%) of Asian gamblers that do.

In line with the pattern seen among gamblers from BAME communities regarding existing usage of treatment and support, those classified with higher scores on the PGSI tool were much more likely to have a demand for treatment, advice or support. Among low-risk gamblers, just three percent wanted any form of treatment, support or advice. This rises to 15% of those with a moderate risk score and three in four (76%) problem gamblers. For problem gamblers, there was a greater desire for any form of treatment from professional sources (65%), with a slightly lower proportion wanting any informal types of support and advice (55%).

Gamblers from BAME communities with a PGSI score of 1+ were more likely than their white counterparts to say that they want some form of treatment, support and advice (31% vs. 15%). A greater proportion of problem gamblers from BAME communities reporting this (75% vs. 49%) drives this difference. The numbers of low (3% vs. 4%) and moderate risk (15% vs. 16%) gamblers from BAME communities wanting any form of treatment, support and advice is comparable to the proportion of white gamblers in each category who reported this.

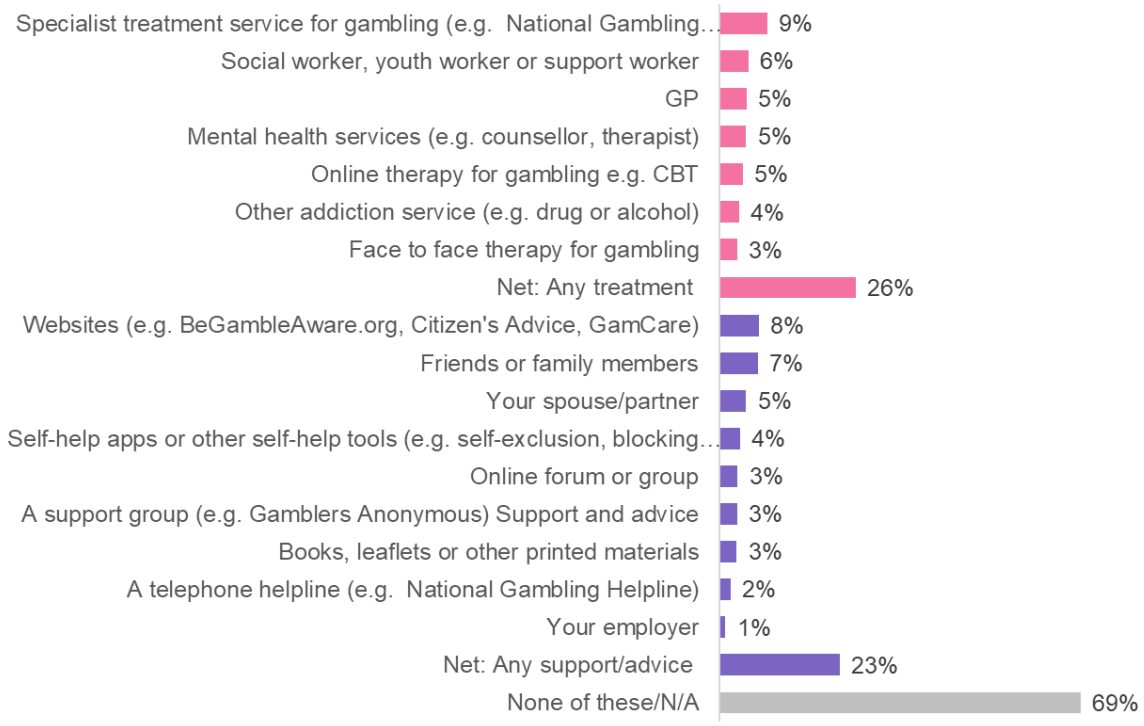
Table 28. Demand for treatment and support/advice among gamblers from BAME communities – by PGSI score category

	All BAME PGSI 1+ gamblers (n=281)	Low-risk (1-2) (n=105)	Moderate-risk (3-7) (n=77)	Problem gambler (8+) (n=99)
Want any treatment	**26%**	**2%**	**9%**	**65%**
Want any treatment and have received some before	21%	-	8%	55%
Want any treatment and have not received any before	5%	2%	1%	10%
Want any support/advice	**23%**	**2%**	**13%**	**55%**
Want any support/advice and have received any before	17%	-	9%	44%
Want any support/advice and have not received any before	6%	2%	4%	12%
Want any treatment/support/advice	**31%**	**3%**	**15%**	**75%**
Want any treatment/support/advice and have received some before	27%	-	13%	69%
Want any treatment/support/advice and have not received any before	4%	3%	2%	6%
Do not want any	69%	97%	85%	25%

The Phase 2 study explored the demand for treatment, support and advice among gamblers from BAME communities in greater detail. The demand for treatment, support and advice mirrors usage, with the same sources of treatment, support or advice being mentioned. Furthermore, gamblers from BAME communities tended to have the same top sources as white gamblers.

Most commonly, gamblers from BAME communities felt they would like treatment to help them cut down their gambling from specialist treatment services for gambling (e.g. National Gambling Treatment Service) (9%) or a social worker, youth worker or support worker (6%). Among informal sources of advice/support, there is greatest appetite for support from websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare) (8%) or talking to family and friends (7%). A telephone helpline (.g. National Gambling Helpline) ranks much lower down the list (2%).

Figure 5: Sources that gamblers from BAME communities want to receive treatment/support/advice from



Base: all gamblers from BAME communities with a PGSI score of 1+ (n=281)

Gamblers from a BAME background with a PGSI score of 1+ were much more likely than white gamblers to say that they wanted any form of treatment, support or advice to help them cut down their gambling (31% vs. 15%), driven by a greater proportion of problem gamblers from BAME communities reporting this (75% vs. 49%). This is the case for both male (31% vs. 16%) and female gamblers (30% vs. 12%) from BAME communities. Gamblers from BAME communities with a PGSI score of 1+ were more likely than white gamblers to say that they want treatment from a specialist treatment service for gambling (9% vs. 3%) which is a result of male gamblers from BAME communities (who are more likely to be problem gamblers) wanting treatment from these services (9% vs. 4%). This alludes to a gap in the provision of current gambling treatment services as despite this survey evidencing demand for these services among gamblers from BAME communities, there is previous research that indicates that 1) gamblers from BAME communities are under-represented in specialist gambling treatment services[9] and 2) gamblers from BAME communities are more likely to disengage (e.g. drop out) from these[10].

Gamblers from BAME communities with a PGSI score of 1+ were also more likely than their white counterparts to want advice on cutting down their gambling from websites (7% vs. 3%). Female gamblers from BAME communities were more likely than their white counterparts to say that they want to talk to friends or family members about advice for cutting down their gambling (9% vs. 2%), as well as having higher demand for self-help apps or other self-help tools (e.g. self-exclusion, blocking software and blocking bank transactions) (8% vs. 2%).

[9] 'Secondary Data Analysis of the Data Reporting Framework and the Health Survey for England' (NatCen, 2019): https://about.gambleaware.org/media/2182/secondary-data-analysis-of-the-data-reporting-framework-and-the-health-survey-for-england.pdf

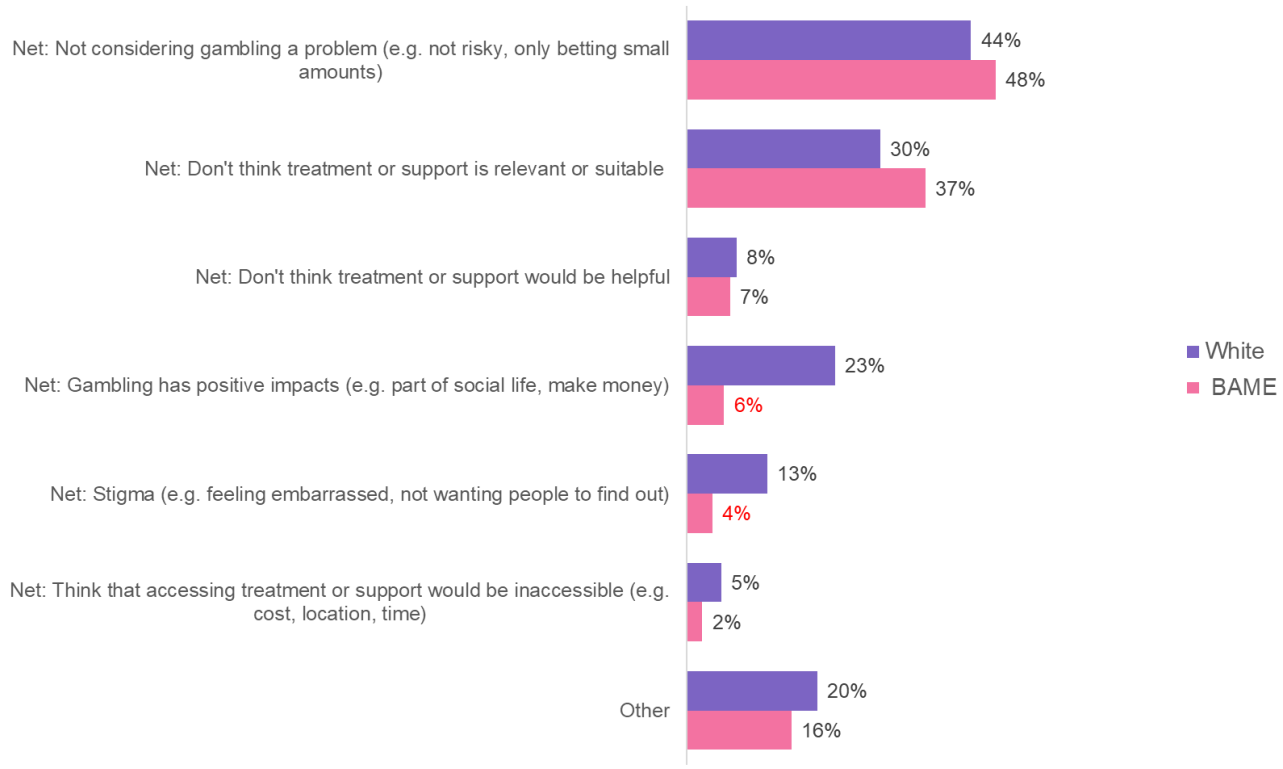
[10] 'Gambling Treatment Services Needs Assessment Report' (ACT Recovery, 2019): https://about.gambleaware.org/media/2184/gambling-treatment-services-needs-assessment-report.pdf

In addition to being more likely to say they have sought treatment, advice or support, gamblers from BAME communities with responsibility for children in the household were also more likely than those without to *want* treatment, advice or support related to their gambling. Overall, two in five (42%) said they wanted any form of treatment, advice or support, compared with one in five of those without children in the household. Among the more formal treatment services, they were particularly likely to say they want a specialist face-to-face treatment service for gambling (13% vs. 5%) or a social worker, youth worker or support working (10% vs. 3%). Among the informal sources, they have higher demand for advice or support from their spouse or partner (9% vs. 3%) or an online forum or group (7% vs. 1%).

5.2 Barriers to seeking treatment and support

Among respondents stating that they did not want any form of treatment, advice or support, the barriers were further explored. Most commonly, gamblers from BAME communities stated that they did not consider their gambling risky enough or that they only bet small amounts of money (48%). This was followed by an idea that treatment and support was not relevant to them or would not be suitable for someone like them (37%). A much smaller proportion stated that they did not think treatment or support would be helpful (7%) or that gambling has positive impacts (e.g. part of social life, make money) (6%). Only four percent felt that stigma (e.g. feeling embarrassed, not wanting people to find out) was a barrier to accessing treatment, advice or support.

Figure 6. Barriers to seeking treatment/support/advice among gamblers from BAME communities



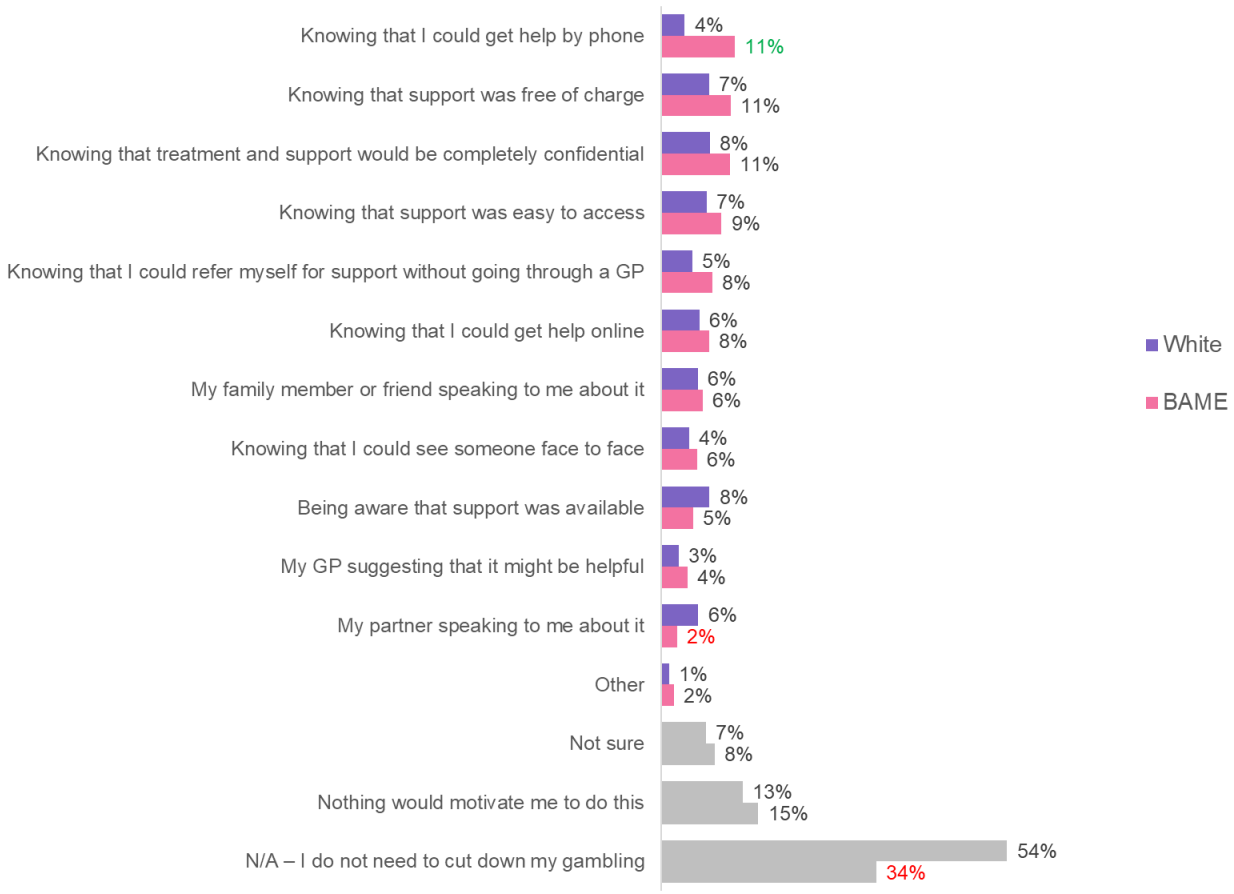
Base: All gamblers from BAME communities (59) and white gamblers (579) with a PGSI score of 1+ who would not want to receive treatment, advice or support

White gamblers with a PGSI score of 1+ who would not want to receive treatment, advice or support were more likely to say that this stems from a perception that gambling has positive impacts (23% vs. 6% of gamblers from BAME communities) or to cite stigma as a barrier (13% vs. 4%). Among gamblers from BAME communities, there was a common perception that the activities they participate in are not risky (27% vs. 14%)

5.3 Motivators to seek treatment and support

Overall, two in five (43%) gamblers from BAME communities with a PGSI score of 1+ recognised one or more factors which might motivate them to seek treatment, support or advice, much higher than the proportion of white gamblers that did (26%). This includes those who said they had already accessed some form of treatment, support or advice in the last 12 months as well as those who had not. Most commonly, gamblers from BAME communities felt that awareness of channels (e.g. knowing they could get help by phone / online) would motivate them to seek treatment, support or advice on behalf of their gambling (20%). There was also a perception that awareness of features of support (e.g. knowing it was free of charge / confidential) would motivate them to seek help (14%).

Figure 7. Factors that might motivate gamblers from BAME communities to seek support/advice



Base: All gamblers from BAME communities (209) and white gamblers (1,744) with a PGSI score of 1+

Gamblers from BAME communities with a PGSI score of 1+ were more likely than their white counterparts to say that awareness of channels would motivate them to seek treatment, support or advice (20% vs. 10%), in particular, knowing that they could get help by phone (11% vs. 4%). This is particularly the case for problem gamblers from BAME communities (25%), suggesting that it is important to increase awareness of different channels, including telephone helplines such as the National Gambling Helpline, in order to make accessing treatment, advice and support easier for gamblers from a BAME background. By contrast, white gamblers were more likely to cite their partner speaking to them about it (6% vs. 2% of gamblers from BAME communities).

Unsurprisingly, problem gamblers from BAME communities recognised several factors which might motivate them to seek treatment or support and were more likely than those with lower PGSI scores to mention most of the factors. The vast majority (83%) of problem gamblers from BAME communities mentioned one or more, higher than the proportions of moderate (43%) and low risk gamblers (12%) that did so. For example, knowing that they could get help by phone would motivate one in four problem gamblers (25% compared with 9% of moderate 2% of low risk gamblers). Knowing that it would be completely confidential and that support is free of charge (both 18%) would also motivate problem gamblers from BAME communities to seek treatment, advice and support, suggesting it is important to communicate messages of confidentiality and cost when targeting this group.

Gamblers from BAME communities with responsibility for children in the household were more likely than those without to recognise one or more factors that might motivate them to seek treatment or support in order to cut down their gambling (64% vs. 25%). This is likely a result of them having higher PGSI scores on average.

6 Conclusions

This report provides clear evidence of the ways in which the profile of gamblers from BAME communities differs from white gamblers, in addition to their treatment, support and advice needs.

The research has also shown that adults from BAME communities are more likely to be classified as gamblers with a PGSI score of 1+ than white adults. There is considerable variation among individual BAME ethnic groups. Respondents from Pakistani and Indian backgrounds were also more likely than other groups to fall into the PGSI 1+ category, and gamblers from a Pakistani background were particularly likely to be classified as problem gamblers. There are also notable differences between those of Black African and Black Caribbean heritage, with Black African gamblers participating in different activities and appearing to experience greater harms. Further research with a larger sample could be conducted in order to fully understand the complex treatment and support needs of gamblers from BAME communities, unpicking the BAME grouping and understanding the differences between ethnic subgroups.

Given the large proportion of problem gamblers from Pakistani backgrounds, it is important that consideration is given to the specific needs of the Pakistani community. Policy, planning and commissioning of services must consider the complex and unique needs of ethnic subgroups, tailoring services where applicable. A larger sample would allow for more meaningful conclusions about ethnic groups, such as those from Pakistani backgrounds, to be drawn. The potential role of religion in these findings also warrants discussion and is a key area for research to further explore.

A larger sample size would also allow for a more detailed analysis of some of the barriers to seeking treatment, support and advice among gamblers from BAME communities. Areas of focus could include not thinking that treatment, advice or support would be suitable or relevant to the gambler, in addition to better understanding perceptions of risk (e.g. those not thinking their gambling was risky enough) among the ethnic subgroups.

In keeping with their higher PGSI scores, 1+ gamblers from BAME communities have a higher demand for treatment, advice and support in comparison to their white counterparts. Three in ten (31%) gamblers from BAME communities with a PGSI score of 1+ say that they want some form of treatment/support, compared to 15% of white 1+ gamblers. This is driven by a higher proportion of problem gamblers from BAME communities reporting this, suggesting it is vital that appropriate forms of support are provided to this group.

Overall, gamblers from BAME communities were more likely than their white counterparts to report one or more factors which might motivate them to seek treatment, support or advice; further research could explore the reasons underpinning this further. There is a common feeling among gamblers from BAME communities with a PGSI score of 1+ that increasing awareness that help was available by phone would motivate them to seek treatment, support or advice, in contrast to white gamblers. This is particularly the case for problem gamblers from BAME communities, suggesting that it is important to increase awareness of different channels, including telephone helplines such as the National Gambling Helpline, to make accessing treatment, advice and support easier for gamblers from a BAME background. It is also important to reinforce messaging around confidentiality and cost when targeting this group.

7 Technical appendix

This appendix describes the methods used for data collection, sampling and weighting.

7.1 Sampling and data collection methods

The two YouGov surveys were conducted online, with respondents drawn from YouGov's online panel of over 1,000,000 adults in the UK. YouGov employ an active sampling method, drawing a sub-sample from its panel that is representative of the group in question in terms of socio-demographics (in this case, age; sex; region; NRS social grade, and ethnic group).

YouGov has a proprietary, automated sampling system that invites respondents based on their profile information and how that aligns with targets for surveys that are currently active. Respondents are automatically, randomly selected based on survey availability and how that matches their profile information.

Respondents are contacted by email and invited to take part in an online survey without knowing the subject at this stage. We use a brief, generic email invitation which informs the respondent only that they are invited to a survey. This helps to minimise bias from those opting in/out based on level of interest in the survey topic.

7.2 Weighting

Weighting adjusts the contribution of individual respondents to aggregated figures and is used to make surveyed populations more representative of a project-relevant, and typically larger, population by forcing it to mimic the distribution of that larger population's significant characteristics, or its size. The weighting tasks happen at the tail end of the data processing phase, on cleaned data. In order to ensure that the data is representative by ethnicity, the weighting has been amended since the original GambleAware 'Treatment and Support' study.

In order to make this study representative, the Phase 1 sample was weighted to be representative of the GB adult population according to age, gender, UK region, socio-economic group and ethnic group. The statistics used to create the weighting targets were taken from the ONS mid-year population estimates (2018) in the case of age, sex, region and ethnic group, and the National Readership Survey (2016) in the case of socio-economic group.

The Phase 2 data was weighted to match the profile of the group of PGSI 1+ gamblers and affected others found in Phase 1, according to age, sex, socio-economic group, region, gambler/affected other status and PGSI score category. The basis for this was that external, authoritative information on 'PGSI gamblers and affected others' as a group did not exist, and therefore the data from the Phase 1 (nationally representative) survey was considered the best available source of demographic information on this particular group.