kans spelen in andere aarde

Een onderzoek naar kansspelproblematiek onder allochtone Nederlanders

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Summary

Games of chance in other cultures A study of problem gambling in immigrant communities in the Netherlands

In the period 2004 – 2005 the CVO conducted research into pathological gambling in the Netherlands (de Bruin et al., 2006). Aim was to gain insight in nature and extent of problem gambling in the Netherlands and formulate measures for increasing the effectiveness of policy for prevention of pathological gambling. The results were presented to parliament in late 2005. The research showed that the number of people involved in pathological gambling in the Netherlands is lower than the 70,000 which had been the assumed figure since the 1990's. The number was now estimated at 40,000. Besides these problem players there are an estimated 76,000 risk players. Specifically the number of risk players in the second generation of non-Western descent was a cause of concern to the Justice department. For this reason this research was conducted in a number of groups of non-Western descent. Immigrants of Surinamese, Netherlands Antillean, Moroccan, Turkish and Chinese descent were included because these together form the predominant number of non-Western immigrants in the Netherlands.
These groups are referred to in Dutch by the term allochtoon literally other land. In this report we use the CBS definition of allochtoon as being those people with at least one parent born outside the Netherlands. Distinction is made between those themselves born outside the Netherlands (first generation allochtoon) and those born in the Netherlands (second generation allochtoon).

There were four research questions in the study.
What is the prevalence of problem gambling among Surinamese, Netherlands Antillean, Moroccan, Turkish and Chinese populations in the Netherlands?
What is the nature of problem gambling among Surinamese, Netherlands Antillean, Moroccan, Turkish and Chinese populations in the Netherlands?
How effective is current preventative policy for these groups?
In which ways can current preventative policy be improved?

Various research methods were used to answer these questions. Firstly, literature research was conducted in national and international literature concerning problem gambling in immigrant populations. Secondly, interviews were conducted with key informants (n=20) and a number of these later participated in a focus group. Thirdly, written questionnaires were completed by experts (n=15). Fourthly, in-depth interviews were conducted with Surinamese, Netherlands Antillean, Moroccan, Turkish and Chinese frequent players (n=131). A frequent player was defined for this study as a person participating in games of chance at least 4 times per month. The questionnaire and selection procedures used for the in-depth interviews with frequent players of non-Western descent, were the same as those used in the study 'Verslingerd aan meer dan een spel' (on the nature and extent of problem gambling in the Netherlands) (de Bruin, Meijerman et al., 2006). 413 in-depth interviews were held with frequent players in the period 2004 – 2005. The data from both studies was then combined and the analyses for the study here reported was whenever possible executed on this combined data (n=544). Furthermore, the combination of the two bodies of data makes comparison possible between non-Western immigrant players and frequent players of Dutch descent (referred to hereafter as the Dutch). As a final research method, secondary analyses were conducted of three studies conducted by the CVO in the past.

A population study of problem gambling in the Netherlands (n=5575); data were gathered in 2004 (de Bruin, Meijerman et al., 2006).

- A survey of visitors of Holland Casino (n=972), data were gathered in 2000 (de Bruin et al., 2001).
- A survey of visitors of amusementcenters in the Netherlands (n=2040); data were gathered yearly from 2000 to 2004 (de Bruin, Benschop et al., 2006).

It is important to note that the four studies each had a different scope. Firstly, a study of gambling participation and problem gambling in the population of Dutch descent older than 16 years (1), two studies of subpopulations, specifically visitors of Holland Casino (2) and visitors of amusement arcades(3) and finally the previously described study of frequent players (4), in this case a subpopulation of the visitors of gambling venues.
In all of these studies the South Oaks Gambling Screen (SOGS) was used as instrument to detect problem gambling. The SOGS consists of 20 items and is an often used screening instrument with good psychometric characteristics. (Gambino & Lesieur, 2006; Stinchfield et al., 2001). Based on the psychiatric classification system DSM, the SOGS can differentiate three groups of players: recreational players (SOGS 0-2), risk players (SOGS 3-4) and problem players (SOGS5+). The SOGS can be conducted in differing time frames; its questions can relate to lifetime prevalence (LTP) but also to the last year, the last year prevalence (LYP).

Gambling culture in country of origin and gambling participation

Games of chance are prohibited by law and by Islam in Morocco and Turkey, but this is violated on a small scale. First generation immigrants from Turkey and Morocco often first encounter legal games of chance in the Netherlands. The Turkish coffee-house custom of playing cards for money or a round of coffee is continued in the coffee-houses in the Netherlands. Similarly, gambling is officially prohibited in China but key informants say that card games and mahjong are played 'everywhere by everyone', often for money, and that illegal betting is common. Wealthy Chinese may go to gamblers' paradise Macau or to casino's in neighbouring countries. Chinese immigrants to the Netherlands have taken their gambling traditions with them. Many first generation Chinese immigrants, often working in restaurants, stay after hours to play mahjong. Key informants indicate these Chinese players often go to casino's or gambling arcades. Suriname counts many casino's and lotteries and the influence of the Javanese and Chinese communities is felt in illegal gambling associated with card games. In the Netherlands Antilles the population can gamble in tourist casino's and various lotteries. Surinamese and Netherlands Antilleans continue to visit casino's and gambling arcades and play illegal card games, sometimes for large sums, after arrival in the Netherlands. Once in the Netherlands they also encounter the Dutch 'bingo' game.

Secondary analyses of the 2004 population survey show that lotteries, slot machines and casino's are especially popular with the Dutch and with western immigrants, and less with non-Western immigrants. Scratch card gambling is more popular with the immigrant groups than with the Dutch. Of the immigrant respondents 35% say to have purchased scratch cards at some point, and 15% in the last year. For the Dutch respondents these figures are 30% and 11% respectively.
Lottery participation reveals the greatest disparities between Dutch and immigrant groups. Of those of Dutch descent plus the western immigrants and in this instance also the Surinamese respondents, 62% had recently bought lottery tickets. The figure for non-Western respondents was 33%. It should be noted that lotteries are not associated with high risk of addiction due to the longer time interval between obtaining the ticket and its resolution

(long odds). Games with highest risk of problem gambling are those with short intervals between stakes and results: slot machines, casino games such as blackjack and roulette, and scratch cards (short odds).
The 2004 population survey further revealed that the Dutch and Western immigrants play significantly more on slot machines than non-Western immigrants. Of the Dutch 37% has played on a slot machine at some time, with 11% doing so in the last year. For the non-Western community these figures were 29% and 6%. The Dutch Peilstationonderzoek 2003, a survey of school students, and research of Moroccan youth (Planije et al., 2000), confirm this result.
Similarly, casino games show less participation from the non-Western community (13%) than from the Western immigrants and Dutch (25%). Recent participation in casino games shows no difference between the groups; an average of 6% of respondents of the population survey took part in casino games in the past year.
Other games of chance including internet gambling, horse racing, illegal games and bingo revealed no significant participation differences between groups with Dutch or immigrant community origins.

In contrast with the 2004 population survey, with relatively few immigrant community respondents, two studies conducted on location among visitors to Holland Casino (2000) and amusement arcades (2000 – 2004) revealed a relatively large proportion of immigrant community respondents. 41% of respondents at amusement arcades and 26% at Holland Casino were from immigrant communities. In the general population of the Netherlands, immigrant communities account for 19%. The percentages of respondents in these surveys are much higher, indicating that immigrant community players use these venues more often than do the Dutch.
Among the visitors of the Holland casino we saw a relatively high number of immigrants with a Western background; in the amusement arcades a relatively large number of immigrants with a non-Western background. We saw especially respondents with a Turkish, Moroccan or Chinese background relatively often in amusement arcades. Surinamese and Netherlands Antillean respondents were encountered relatively often in both the amusement arcades and the Holland Casino.

The extent of problem gambling

Estimating the extent of problem gambling in the immigrant communities is difficult. It can not be determined precisely because available data are limited. In this chapter we will discuss a number of estimation methods. Each method has its associated margin of uncertainty. Research results can not be generalised because no random selection was made, and results can not be extrapolated to the population as a whole because we only have data concerning sub-populations (for example immigrant community visitors of gambling parlours) or the number of respondents from the five community groups is so small that extrapolation is not reliable.

We employed various estimation methods and sources to gain insight in the extent of problem gambling in the five community groups.

- expert estimation
- estimations from literature
- estimations based on the 2004 population survey
- estimations based on sub-populations of players (visitors Holland Casino and amusement arcades)
- estimations based on the numbers of treatment seekers (LADIS/IVZ)

The experts (n=15) we interviewed for this study have limited view of the extent of problem gambling in immigrant communities in the Netherlands and refrained from making estimations. The literature search also provided little information as to the prevalence of problem gambling in the groups subject of this study. The remaining sources however were able to give an indication of the size of the problem.

A first important source is the 2004 population survey. As the number of immigrant community respondents here was relatively small, we must be careful about making conclusions based on these data. Moreover, we must be aware that potential immigrant community risk groups are not, or insufficiently, represented in the population survey. Nevertheless, we may carefully conclude on the basis of the population survey that problem gambling occurs more frequently in the non-Western immigrant community than in the Dutch descent and Western immigrant communities. An estimated 32% of risk- and problem gamblers has an immigrant community background, while the proportion of the immigrant communities in the Netherlands population is 19%. The groups at risk are the Surinamese and Chinese players and the players from the other non-Western countries of origin. The Moroccan, Turkish and Netherlands Antillean players do not appear as risk group here.
The second source of estimations of the extent of problem gambling are the previously mentioned studies of visitors of Holland Casino (2000) and amusement arcades in the Netherlands (2000-2004). The prevalence of problem gambling in Turkish and Moroccan casino visitors (and among casino visitors from the other non-Western communities in the Netherlands) is the highest: 32% of these players is characterised as problem gambler. The prevalence of problem gambling among Surinamese, Netherlands Antillean and Chinese is about 10%, while this figure is 3% for visitors with a Dutch background. Problem gambling among Turkish and Moroccan casino visitors is therefore ten times more prevalent than among Dutch players. For Surinamese, Netherlands Antillean and Chinese players this factor is three. The picture is similar for the visitors of amusement arcades. Among respondents with Moroccan and Turkish origins (and the respondents with other non-Western origins) we count the most problem gamblers: more than half (54%) of this group say they have problems with gambling. While for Surinamese, Netherlands Antillean and Chinese this percentage is lower (26%) it remains significantly higher than the figure for those the Dutch (16%).
A final source used to estimate problem gambling among immigrant community players are the data from the National Alcohol and Drugs Information System (LADIS) which is maintained by the Stichting Informatievoorziening Zorg (IVZ). The LADIS registers a wide range of characteristics of clients of the extramural care for people suffering from addiction. These figures show that the proportion of treatment-seekers of non-Western origins has increased from approximately 10% in 1994 to about 30% in 2005. Noteworthy here is that this proportion is now higher than the proportion of this group in the population as a whole, 19%. We have seen an increase in the number of immigrant community treatment seekers from at least 500 in 2002 to at least 800 in 2005.

	Population survey 2004	Visitors HC 2000	Visitors Amusement Arcades 2000-2004	Frequent Players 2004, 2005, 2007	LADIS 2005
	Odds Ratio: Percentage SOGS5+ (LJP) in immigrant groups/Percentage SOGS5+Dutch	Odds Ratio: Percentage SOGS5+ (LJP) in immigrant groups/ Percentage SOGS5+ Dutch	Odds Ratio: Percentage SOGS5+ (LJP) in immigrant groups/ Percentage SOGS5+ Dutch	Odds Ratio: Percentage SOGS5+ (LJP in immigrant groups/ Percentage SOGS5+ Dutch	Odds Ratio: Percentage treatment seekers LADIS/Percentage of general population (CBS)
Morocco	0,0	10,7	3,4	4,9	3,4
Turkey	1,0	10,7	3,4	4,9	4,3
Other, non-Western	5,0	10,7	3,4	4,9	1,0
Suriname	4,0	3,3	1,6	1,3	1,7
N. Antilles	1,0	3,3	1,6	4,9	2,3
China	5,0	3,3	1,6	1,0	-
Other, Western	1,0	3,3	1,6	1,3	1,0
Netherlands	1,0	1,0	1,0	1,0	0,9

Table 35 Odds Ratio's for various estimation methods

To facilitate comparison of the different estimation methods Table 1 lists the odds ratio's , that is the relative chance of problem gambling in a specific group in relation to the chance for those the Dutch. For the LADIS data the odds ratio was calculated by relating the number of treatment-seekers from the various origin groups to the proportion that group has in the overall population[14]. Where the odds ratio is 3,4 such as for the Moroccans, this means that the proportion of Moroccan treatment-seekers is 3,4 times higher than would be expected based on population proportion. The figure for Moroccan treatment-seekers in addiction care is 5,5, while the Moroccan community comprises 1,6% of the general population of the Netherlands.

The estimation techniques described here present an essentially consistent picture, with the exception of the 2004 population survey. The non-Western immigrant community, and especially Moroccan and Turkish respondents, has a higher prevalence of problem gambling than the Dutch and Western immigrant communities. Depending on the data source, pathological gambling is from 3 to 11 times more prevalent among Moroccans and Turkish respondents than among Dutch respondents. Among the Netherlands Antillean respondents we see, depending on the data source, 2 to 5 times more problem gambling as among the Dutch. Surinamese and Chinese respondents have, of the five groups studied, the lowest prevalence of problem gambling, but still have 1 to 3 times higher prevalence of this problem as do the Dutch respondents.

The population survey 2004 shows that 32% of the risk- and problem players have an immigrant community background. The LADIS data generate a similar percentage; 31% of care-seekers have an immigrant background. The proportion of immigrant community respondents among the risk- and problem players at the gambling venues is clearly higher. Of the problem players in Holland Casino (2000), respondents scoring SOGS5+, 64% had immigrant community origins. Of these 14% had a Western background and 50% a non-Western background. Of the risk players at Holland Casino 39% had an immigrant community background, of which 23% Western and 16% non-Western immigrant community origins.

14. The question whether the proportion of an immigrant community within the overall population provides a sound norm is open to debate. That proportion includes all those living in the Netherlands, regardless of age, region, population density and so on. Some readers may well prefer a different norm

The nature of problem gambling

The problem players from the amusement arcades (2000-2004) present a comparable picture: of these 62% had immigrant community origins, including 10% with a Western and 52% with a non-Western background. The risk players from the amusement arcades totalled 44% with immigrant community origins, including 12% Western and 32% non-Western backgrounds.

This report approaches the nature of problem gambling among immigrant communities in the Netherlands from three perspectives, namely the demographic characteristics of the problem gamblers, the participation in games of chance and problems related to games of chance. While describing the demographic characteristics (sex, age, social economic status (SES), place of abode) these are continually checked for a possible relationship with the country of origin and subsequently whether these indicate a relationship with problem gambling. If both appear to be the case, the specific demographic characteristic may provide an alternative explanation for the apparent relationship between country of origin and gambling problem.

Demography

The interviews with frequent players (n=544) showed that the majority (69%) of risk- and problem players was male and the minority (31%) female. A similar proportion was seen among Surinamese respondents, 64% risk- and problem players being male, 36% female.
The Netherlands Antillean risk- and problem players showed a slightly larger portion being male than the Surinamese: 71% with 29% female. The Turkish, Moroccan and Chinese risk- and problem players reveal a different situation: in the groups we saw (with the exception of one Turkish female respondent) exclusively males. Among Dutch, Surinamese and Netherlands Antillean risk- and problem players we therefore see clearly more females than among Turkish, Moroccan and Chinese risk- and problem players. It is apparent that problem gambling is also related to gender: occurring more frequently among men than among women. Of the male frequent players 16% is a problem gambler, of the female respondents 7%. Merely comparing all immigrant respondent groups would give an incorrect result, because some groups have larger or smaller proportions of female respondents. To facilitate accurate comparison of immigrant respondent groups the gender variable has been held constant in the analyses. It then becomes clear that the country of origin remains a factor. Not all variations in prevalence of problem gambling between the immigrant groups can be explained by gender variations. Between Dutch and immigrant female respondents we see no differences in problem gambling prevalence, between male respondents there are clear differences. Of the male Turkish, Moroccan and other non-Western immigrant respondents 41% is problem player and of the male Netherlands Antillean, Chinese, Surinamese and Western immigrant respondents 9% is problem player.

The respondents from the nationality groups also reveal variations in age. Moroccan, Turkish and other non-Western immigrant respondents have a lower average age (32 years) than the other respondents. Surinamese, Netherlands Antillean and Chinese respondents average 39 years, and Dutch and Western immigrant respondents average 47 years. This shows that, as was the case with gender, also the age of respondents is a factor in problem gambling. The age group 27-40 years has at 23% the highest prevalence of problem gambling. The youngest group, under 27 years, has 12% and the group 41-57 years 13%. The oldest group has the lowest prevalence of 2%. This shows that

respondents' age is related to both the factors country of origin and problem gambling. The age differences between respondents from the nationality source groups offer an alternative explanation for the high prevalence of problem gambling in the immigrant community respondents.
The average Social Economic Status (SES, expressed in education level, income and participation in society) of non-Western immigrant respondents is lower than that of the Dutch and Western immigrants. We also see that problem gambling occurs more frequently in respondents with a lower SES. As with gender and age, the SES also can offer an alternative explanation for the higher prevalence of problem gambling among the immigrant community source groups.
Finally, an alternative explanation was also found in the factor urbanisation. Immigrant community respondents more often live in large cities than Dutch respondents, while problem gambling more frequently occurs in respondents from large cities than in those living in smaller communities. It may be that the greater availability of gambling venues in cities and the greater anonymity there lead to an increased prevalence of problem gambling among immigrant communities, and that this is less related to country of origin of the player.

Participation in games of chance by frequent players

Interviews taken for this study with frequent players show that respondents from the various source groups have distinct preferences for specific games of chance. As already seen in the 2004 population survey, lotteries are unpopular with Moroccan players while casino games appeal to Turkish and Netherlands Antillean respondents. Slot machines are most popular with Moroccan, Surinamese and non-Western immigrant communities.
The interviews with frequent players further revealed participation in more different games by immigrant community respondents than by the Dutch. Immigrant respondents counted 3,5 games while Dutch respondents indicated playing 2,7 different types of games in the past year. The frequency of participation itself is also characterised by relatively large differences between immigrant community and Dutch community players. Dutch and Western immigrant players participate nearly twice weekly (112 times per year). Chinese and Surinamese respondents take part in games of chance more than three times weekly (165 times per year) and Moroccan, Turkish an Netherlands Antillean players counted an average of five times weekly (232 times per year). Moroccan and Turkish players use slot machines (176 times per year) more often than other immigrant community players (93 times yearly) and the Dutch (50 times yearly). Turkish and Antillean players more often visit casino's (44 times yearly) than the others (13 times yearly).
As most immigrant community respondents have lower incomes and also participate more often in games of chance than the Dutch respondents, they necessarily spend a larger percentage of their incomes on games of chance. Nearly half (46%) of the Turkish, Moroccan and Chinese respondents spend more than quarter of their incomes on games of chance. For Antillean and Surinamese respondents this percentage is 33%, while of Dutch and Western immigrant players 9% spend more than a quarter of their incomes on games of chance. We further noted that immigrant community respondents display higher risk characteristics in the other factors involved in playing games of chance. They start participation at a younger age and their game participation pattern more often shows a tendency to increase.

Problems related to gambling

More than half (54%) of Turkish and Moroccan frequent players indicate having gambling related problems, as do 26% of Surinamese and Antillean respondents. Dutch and Chinese players share the lowest percentage, 16%.

Of the gambling related problems, financial problems and debt are the most obvious. Of Moroccan and Turkish frequent players 36% have gambling debts, of the Surinamese and Antillean frequent players 19%. 5% of the Chinese and Dutch players have gambling debts. Financial problems occur most often in Moroccan, Turkish and Surinamese respondents, 41% of these have financial problems. In the other groups this is an average of 11%.
Further analysis however shows that the respondents' SOGS score is a more reliable predictor for gambling related problems than the cultural background. More than half of the problem gamblers (SOGS5+) have debts while only 1% of recreational players do. Similarly, the other gambling related problems such as problems with personal relations, housing, work and school are more directly related to severity of gambling and less to country of origin. Prevalence of gambling related problems is therefore an issue for risk- and problem players rather than for players from immigrant communities in general. Gambling related problems are equally common for immigrant community and Dutch risk- and problem players.
An average of 10% of respondents indicate having psychic problems. Moroccan and Turkish respondents score higher (31%) than the others. Antillean and Chinese indicate having no psychic problems, while 7% of Dutch, Surinamese and other immigrant community respondents say they have psychic problems. However, when the extent of problem gambling is included in the analyses, this factor is seen to be the predominant factor for psychic problems. Of the lifetime problem gamblers, 39% indicate having psychic problems, of the risk players 6% and of the recreational players none.
The key informants (n=20) state that the backgrounds of immigrant community and Dutch players are in part comparable. The motivation to play may be the same for all source groups. The gambling venues, casino's, amusement arcades and bingo halls exert the same appeal on all source groups.
According to the key informants, immigrant community players are however at greater risk of problem gambling. They refer to the lesser social skills, career perspectives and meaningful activities of the immigrant community players. The key informants also name poverty as a factor; the opportunity of winning a large sum through gambling is seen as one of the few possibilities to escape poverty. Not only the social pressure to gain wealth, but also the related pressure to exhibit this may be a factor in certain immigrant communities.

Alternative explanations

Now that we have seen problem gambling to be especially prevalent among players from non-Western immigrant communities, the question arises whether the country of origin should be seen as the cause of the problem gambling. To answer this causal question it is important to eliminate any alternative explanations for the relationship between country of origin and problem gambling as far as possible. This process was studied using multivariate analyses. In this way it became apparent in the survey of visitors to Holland Casino (2000) that age, income and gender offer alternative explanations for the variations in prevalence of problem gambling between the nationality-based source groups. We saw that problem gambling was most prevalent among male respondents younger than 50 years with a monthly income of less than Hfl. 3000.- (the data from 2000 predates the euro). We also saw that the group of non-Western immigrant respondents had a similar profile; these too are predominantly male, under 50 years with a relatively low income. The variables age, income and gender are related to both country of origin and prevalence of problem gambling and can offer an alternative explanation for the relation between country of origin and problem gambling. This

reduces the chance that, besides being a factor, there is also a causal relationship between country of origin and problem gambling.
The process of looking for and eliminating alternative explanations was also carried out in the other studies. In the survey of visitors of amusement arcades we found that 'country of origin' was a good predictor for problem gambling, but also that other factors could be involved in the apparent relationship between prevalence of problem gambling and country of origin. These factors included gender, education and social activity. The unemployed, males and those with lower levels of education are most at risk of problem gambling. Non-Western immigrant respondents were more often unemployed and less educated than was the case with Dutch respondents. These factors relate to both country of origin and to problem gambling and may again offer an alternative explanation for the relationship between these variables. The explanation for the high prevalence of problem gambling in non-Western immigrant respondents should then not be sought in cultural factors but in demographic or personal characteristics of the respondents. Especially males with a low SES are at risk, and specifically the immigrant community respondents included a relatively large number of males with a low SES.

Prevention: awareness, reach and effectiveness

Players may use various personal techniques to control their gambling problem. They may play with a pre-determined maximum amount, limit themselves to a maximum playing time, leave their credit cards at home or in custody of a friend or partner. Visiting gambling venues in company may have a preventative influence. There are no differences here related to country of origin of problem players: both immigrant players and players of Dutch descent use these forms of self control equally.

The gambling industry has, often in cooperation with caregivers, developed various protective and preventative measures. The three most important are:

- developing and distributing informative flyers
- having staff personally addressing risk- and problem players
- offering possibilities for visit limiting measures

In both Holland Casino and the amusement arcades flyers and prevention material concerning problem gambling was made available. We found no differences between respondents from the various countries of origin concerning awareness of prevention material, reading these or the experienced influence on playing behaviour. Even though country of origin is not an important factor in this area of prevention policy we do note a relationship here with the extent of problem gambling: risk- and problem players are more aware than recreational players of the prevention material, its contents and they more often claim that this material has influenced their playing behaviour.
Concerning staff addressing risk- and problem players, we saw no differences between respondents from the various countries of origin. Immigrant community players are addressed equally often as respondents of Dutch descent. Country of origin is in other words not a factor in the addressing by staff of players in the gambling industry.
The Holland Casino visitor survey (2000) showed that immigrant respondents were less aware of participation limiting measures at Holland Casino than Dutch visitors, but their requests for these measures equalled such requests from the Dutch visitors. The making of these requests is mainly related to problem gambling. Problem players (SOGS5+) and risk players (SOGS3-4)

more often request denial or limitation of admittance than recreational players (SOGS 0-2).
While immigrant community respondents in the Holland Casino study were less aware of prevention policy than Dutch respondents, this disparity was not found in the study of frequent players (n=544). Here we found no differences between immigrant and Dutch players concerning awareness of participation limiting measures or in requests for such limitations to be implemented. As in the Holland Casino (2000) visitor survey, limiting measures were mainly requested by problem players, although we noted some risk players and recreational players also requesting visit limitations, possibly in an attempt to avoid problem gambling. Of the frequent players who had also visited amusement arcades (299 of 544), nearly half was aware of the possibility of volunteer admission denial (the white list). Again, the awareness of the measure was more closely related to problem gambling than to country of origin. Respondents actually having themselves placed on a White List was also mainly related to problem gambling and less to country of origin.

Among problem players in the population survey (2004) and problem players at the Holland Casino no differences were found between immigrant and Dutch respondents concerning requests for help. In the study of frequent players we do see such variations. Turkish and Moroccan players (and players from the other non-Western countries of origin) made more requests for help (10%) than other players (5%). In this case also, the extent of the problem gambling was the major factor related to requests for help: of the problem players, 24% has at some point requested help, of the risk players 3% and of the recreational players none had ever requested assistance.

Problems and possibilities for improvement of prevention and care

Key informants find that the gambling industry is devoting serious attention to prevention of pathological gambling, although often noting that 'it could always be more'. For that reason prevention policy is continually refined and developed. For example, the GGZ Netherlands and the VAN slot machine trade organisation are cooperating in the development of protocols for care and of networks between amusement arcades and addiction care on a local level. Work is being done on the improvement of prevention material and further training of staff, and a monitoring study of the effects of these measures and the development of problem gambling in the future has been started.
Key informants say that at Holland Casino there is also a clear prevention policy which is continually adapted and improved. In 2005 and 24 hour telephone help desk (HANDS) was established for risk- and problem players. However, key informants also question some of the prevention policies in the gambling venues. They note that not all venues have sufficient flyers in the various languages, and that there are large differences between the venues concerning attitude and commitment of staff to prevention. There are some doubts about the effective distribution of prevention material and the effectiveness of the implemented preventative measures. A number of key informants see structural problems in a lack of attention for problem gambling at schools, in the media and in organisations for treatment of the addicted.

In Netherlands' literature concerning addiction and mental health problems in immigrant communities problem gambling is rarely discussed. The literature we studied indicated that the relations between immigrant clients and addiction caregivers were often strained, and that the available care did not always fit immigrant community clients. Both literature and interviews with key

informants identified a number of factors detrimental to adequate prevention and treatment of immigrant community problem players. These are on the one hand factors related to available care for the addicted and on the other certain cultural barriers which limit contact between the (Dutch) caregiver and the (immigrant community) client.

A number of key informants held the view that the available care for problem gambling was insufficient and that immigrant players were insufficiently aware of its existence. Members of an immigrant community often have problems reaching care-givers. Conversely, key informants also believed care organisations had little view of immigrant players and insufficient knowledge and grasp of the immigrant community culture. Due to the declining numbers of requests for addiction treatment from problem gamblers – in 1994 addiction care had 6000 registered clients, a number reduced to 3000 in 2005 – much expertise has been lost from addiction treatment centres.

Existing available care is not well matched to the needs of immigrant community problem players. Many players are unfamiliar with the phenomenon of care and want only practical assistance, such as with financial problems and debt. Immigrant community problem players also appear less inclined to look at their problem and go into therapy. 'Problems can't be resolved by talk'. Debt collectors and financial assistance agencies are, according to key informants, not well adapted to immigrant communities. When immigrant problem players admit needing help they often first look for this within their own community. Key informants believe immigrant problem gamblers only approach professional addiction treatment when all options within their own community are exhausted and that initiating this discussion will require extra time and attention.

One cultural barrier key informants name as detrimental to accessible care and satisfactory personal contact between client and care-giver is the feeling of shame in discussing personal problems with another person. All cultures have some measure of this and it may take considerable time before personal problems can be openly discussed. In some cultures gambling is taboo. Language problems especially in first generation Turkish, Moroccan and Chinese can frustrate prevention and care.
Care-givers and prevention workers working on location often have better results. They have (had) time to build personal contacts in the immigrant community and know the people involved and who to approach. They may also have a working knowledge of the different cultures. Besides this, it is a matter of the correct – respectful – attitude and social skills.

To make a better contact in the community groups and spread a message of prevention there, key informants advise spending more time developing relationships based on trust, which are important if one wishes to address these groups. Bridge builders are important here and these may be members of the group in question. Some key informants suggest women from the same community group, especially mothers, as well suited to bridge building, because they are often responsible for upbringing and education. Also heard was the view that the messenger did not need to come from the same ethnic group, as long as they have a suitably empathic attitude. A member of the own group may be counter-productive if ashamed of a member of the group or concerned about internal gossip.

Concerning the prevention message, key informants agree it should be introduced with examples appealing to the interests of the group. As a media, besides television, theatre and music may be effective, once again connecting to the cultural background of the various immigrant groups. Theatre and music may be effective in schools and community halls. Nearly all respondents note the importance of providing young people with information about the risks of gambling at as early an age as possible.

Conclusions

This report started with a description of problem gambling in the Netherlands, including an examination of the prevalence of problem gambling in the five immigrant community groups central to this study. Subsequently a description was given of the nature of problem gambling as it occurs in these five groups. This was done in relation to demographic characteristics, gambling behaviour characteristics including type of game, frequency, expenditure and game participation patterns, and finally in relation to general problems associated with gambling.
Besides describing problem gambling in immigrant communities, the report also investigates explanations for the high prevalence of problem gambling in these communities. A simple explanation cannot however be given as the causes of problem gambling are impacted by a variety of factors: cultural factors, demographic characteristics, personality traits and factors of availability all play a part here.
Finally, this report examines methods of dealing with problems of gambling. On the one hand these involve interventions in the causes of problem gambling, on the other they require communication of the prevention message as effectively as possible. However, not all causes can be influenced. The effective communication of the prevention message can also be affected by cultural factors, demographic characteristics, personality traits and factors of care availability.

It is important to note that there is no one-to-one relationship between the causes of the problem and the effective communication of the message. For example, the causes of problem gambling may not involve cultural factors, but effective communication about the problem may well depend on cultural factors., and vice versa.

Description of problem gambling in immigrant communities.
The population survey (2004) shows that slot machines and casino games can be seen as games of chance with the highest risk of problem gambling, and lotteries and horse racing as having the least such risk. Bingo and scratch cards occupy an intermediate position. Secondary analyses of this study show non-Western immigrant respondents participating less in the higher risk games (slot machines and casino games) than Dutch and Western immigrant respondents.

Although participation in higher risk games by non-Western immigrant players is relatively lower than Dutch and Western immigrant players, we still see more problem gambling among non-Western immigrants than among Dutch and Western immigrant players.

Three of the four studies reviewed in this report indicate a higher instance of problem gambling among Turkish and Moroccan players than among Surinamese, Netherlands Antillean and Chinese players, and that in these last

three groups problem gambling is more prevalent than among Dutch and Western immigrant communities.
This is the case in both the Holland Casino visitor survey (2000), the amusement arcades visitor survey which was conducted every year from 2000-2004, and also in this study among frequent players in which data was collected in 2004 and 2007. Only the population survey (2004) presents slightly differing results. There we do see problem gambling as more prevalent in immigrant players than in Dutch players, but the highest risk groups here are not Moroccan and Turkish respondents but especially Surinamese and Chinese players. It is possible that the low level of participation by Turkish and Moroccan respondents in the population survey itself is the underlying factor here. Market research agencies have experienced very low participation by non-Western immigrants in telephone and written questionnaires. In the research conducted on location – in which interviewers and respondents meet face–to–face, we see a marked overrepresentation of immigrant community respondents.

Explaining problem gambling in immigrant players

The central question however remains, given that country of origin is a strong factor in problem gambling, whether country of origin can also be seen as a causal factor in problem gambling.
In methodological literature (Goede et al., 2005) we find that the chance of a causal relationship between country of origin and problem gambling increases when three preconditions apply. These are; (1) the country of origin is related to problem gambling; (2) the country of origin precedes problem gambling; and (3) alternative explanations – factors involved in both country of origin and problem gambling – are eliminated wherever possible.
The first two preconditions are applicable. The third precondition, the search for alternate explanations, has been central to our analyses.

Our analyses of the studies have revealed a number of alternate explanations for the high prevalence of problem gambling in non-Western immigrant players. We saw that gender, age SES and urbanisation can pose alternate explanations because these factors relate to both country of origin and problem gambling.
Among non-Western immigrant respondents we find a higher proportion of males than among Dutch and Western immigrant respondents. Among males the prevalence of problem gambling is higher than among females.
In non-Western immigrant respondents we find more middle-aged (30-50 years)respondents than in Dutch and Western immigrant respondent. In middle-aged respondents the prevalence of problem gambling is higher than in the young and the elderly. Similar patterns are seen in the factors SES and urbanisation. Non-Western immigrant players include more people with a low SES than Dutch and western immigrant respondents. Among respondents with a low SES problem gambling is more prevalent than among respondents with a high SES. Lastly, non-Western immigrant respondents more often live in large cities than Dutch and western immigrant respondents. Respondents from large cities show a higher degree of problem gambling than respondents from towns and villages.

It is clear that gender, age, SES and urbanisation provide alternate explanations for the relation between country of origin and problem gambling. This implies that we should not necessarily see 'country of origin' as cause of problem gambling but that other factors are dominant here. This reduces the likelihood of a causal relationship between country of origin and problem gambling.

Prevention

The effective reach of preventive measures is equal among immigrant community risk- and problem players and Dutch risk- and problem players. We found in the respondents from the different countries of origin no variations of awareness of prevention flyers, reading the contents, or the experienced influence on player behaviour. The Holland Casino (2000) visitor study showed that immigrant community respondents, though less aware of the possibility of asking for visit limitation than Dutch visitors, actually requested implementation of such measures no less frequently than the Dutch. The frequent player study (n=544) also revealed no variations between immigrant community and native Dutch concerning the awareness of, and requesting of, visit restricting measures.

Bottlenecks in prevention and care

Literature study shows that the relationship between immigrant community clients and addiction care-givers is often problematic and that available care is not always best suited to immigrant community clients. From both the literature and the interviews with key informants we learn that a number of factors inhibit adequate prevention and treatment of immigrant community problem players. These inhibiting factors comprise on the one hand factors related to the available care supply for pathological gambling and on the other hand a number of cultural barriers which may block contact between the (Dutch) care-giver and non-Western immigrant client.
A number of key experts share the view that the available care is inadequate and that immigrant community clients are insufficiently conscious of it. For these clients the path to care-givers has many obstacles. The key experts also note the converse, that care-giving agencies' view of immigrant community players is often blocked, leading to a lack of knowledge of and grasp of these immigrant cultures.
The declining numbers of problem players seeking assistance from addiction care-givers – the 6000 registered clients in 1994 having decreased to 3000 clients by 2005 – has caused a loss of much expertise in addiction care agencies.

Dealing with problem gambling

One of the possibilities for intervention in the gambling problem is to address the causes of pathological gambling. If the causes of problem gambling are found in cultural factors, prevention and care-giving must focus on these factors. Where the causes of problem gambling are more related to gender, age, SES or urbanisation, then the preventative measures and care-giving also should be more focussed on these determining factors.

Another approach to dealing with pathological gambling concerns the effective communication of the content of the message. The effectiveness of communication may involve cultural factors, demographic characteristics, personality traits, and factors of care supply. There can be no one-to-one relation between the causes of problem gambling and the effective communication of the prevention or treatment message. If the causes of problem gambling are not related to cultural factors the effective communication the effective communication of the treatment message may still be determined by cultural factors. A number of key experts advocate that the message be specifically formulated and communicated for each cultural group.