



Final Report:

Gambling Harm Needs Assessment 2021

April 2021



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Glossary

EGM	Electronic Gaming Machine
HLS	Health and Lifestyle Survey
Lotto NZ.....	New Zealand Lotteries Commission
MVE	Multi-Venue Exclusions
NGS	National Gambling Study
NPS	National Prevalence Survey
PGSI	Problem Gambling Severity Index
SOGS-R	South Oaks Gambling Screen – Revised
TA	Territorial Authority
TAB NZ.....	Totalisator Agency Board New Zealand

Executive summary

Background

Under the Gambling Act 2003 (s318), the Ministry of Health (the Ministry) is required to undertake a Needs Assessment to inform the development of the three-year Strategy to Prevent and Minimise Gambling Harm (the Strategy). In late December 2020, the Ministry commissioned Malatest International to conduct the Gambling Harm Needs Assessment 2021 to inform the Strategy for 2022/23-2024/25.

As with previous years, the Needs Assessment is purposed to:

- Identify changes in the evidence since the last Needs Assessment completed in 2018
- Identify gaps in service delivery.

An additional requirement of the 2021 Needs Assessment was to summarise the Ministry's progress across the 11 Objectives set out in the current Strategy 2019/20-2021/22.

Methods

Methods used to inform the Needs Assessment included:

Literature review: This Needs Assessment provides an updated review of the literature since the last Needs Assessment in 2018. It focuses on literature published between March 2018 and February 2021 relevant to gambling participation, access to different gambling forms (including online gambling and changing technologies) and expenditure. It also examines recent evidence relating to harmful gambling prevalence, motivations, risks, provider services and clients and gaps in services.

Interviews and focus groups: Ten individual and 14 group interviews were conducted with a total of 67 representatives from gambling agencies (government agencies, research institutions and gambling harm services), the gambling industry (Class 4 societies, Lotto NZ, hospitality and casinos), gambling harm service providers (public health and/or clinical intervention), consumers and lived experience representatives (current and historical harmful gambling experiences).

Online surveys: The Needs Assessment was expected to replicate the online workforce and consumer surveys conducted in the 2018 Needs Assessment.

- **Workforce survey:** A total of 67 responses were received for the workforce survey.
- **Consumer survey:** A total of 12 responses were received for the consumer survey. Due to a low response rate, consumer survey responses were not analysed or included in the Needs Assessment. However, open-text qualitative survey feedback was included in analysis and detailed consumer and lived experience representation were sought through the qualitative in-depth interviews.

Ethics approval for the Needs Assessment was received from the New Zealand Ethics Committee on 15 February 2021 for consumer engagement.

What does the evidence tell us?

Most people gamble for leisure and recreation. Harmful gambling affects a small proportion of those participating and can have detrimental effects on individuals, families and wider communities. Although gambling participation has decreased for the general population, harmful gambling prevalence has not changed.

All forms of gambling remain widely accessible - COVID-19 lockdowns led to increased national and offshore online gambling participation. Class 4 Electronic Gaming Machines (“EGMs”, also known as “pokie machines” and “non-casino gaming machines”) remain the most frequently cited form of gambling that causes harm, cited by both gamblers and family/affected other clients. Class 4 venues remain inequitably distributed in areas of high deprivation. Evidence is mixed about the effectiveness of policies restricting access to Class 4 EGMs.

Access to online gambling for money has increased. Offshore online gambling participation has increased slightly. New Zealanders are accessing ‘free to play’ online gambling, (i.e. not for money).

Evidence shows a link between online gaming and harmful gambling. Recent research has identified gaming as a potential gateway behaviour to harmful gambling, and higher rates of at-risk and harmful online gambling among adults who bet on gaming enhancements as children compared with those who did not. Interviewed participants highlighted increasing numbers of parents asking for support for young people ‘addicted’ to gaming. Gaming is not currently recognised as gambling and therefore not funded by the gambling levy.

Gambling expenditure decreased during COVID-19 lockdowns but returned to pre-COVID levels shortly after lockdown lifted. Gambling expenditure across all forms of gambling continued to increase (pre-COVID). Post-COVID-19, despite a decline in Class 4 venues and EGM machine numbers, gambling expenditure on these forms of gambling continued to increase. EGM profits have returned to pre-COVID levels.

Māori, Pacific and young people continue to have the highest prevalence of harmful gambling compared with other groups. The prevalence of harmful gambling remains relatively unchanged. A focus on harmful gambling neglects low to moderate gambling and impacts.

Harmful gambling risks remain extensive and can be categorised into individual and environmental factors. Māori and Pacific peoples remain the most at-risk of harmful gambling. New evidence has identified comorbidities as a risk in transitioning into risky gambling behaviour. Online gambling and changing technologies present a new risk.

Much evidence infers that supporting one social problem (i.e., distributing gambling funds to community and sports groups) through the support/creation of another (harmful gambling and expenditure) is not real progress for our society. Much evidence suggests the costs (individual, family and community harms) associated with gambling outweigh the benefits (e.g., employment, community funding). Harmful gambling continues to impact all aspects of wellbeing for individuals and their whānau.

The enablers and barriers to help-seeking remain the same – understanding the barriers within cultural contexts remains critical. Since 2018 there have been slight decreases in the number of clients accessing intervention services and significant decreases in those accessing the Gambling

Helpline. Gaps in gambling harm provider services exist in relation to residential treatment services and the peer support workforce.

What progress has been made against Objectives set out in the Strategy

There was a common perception among interviewed participants from all gambling stakeholder groups, and many workforce survey respondents that limited progress had been made across most Objectives set out in the Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22. Participants' views were contextualised within perceived service gaps and risks, which also informed opportunities to strengthen harmful gambling policy, outcomes, participation, practice and research.

Two overarching factors pertinent to strengthening progress against Objectives in the Strategy included:

- Developing and maintaining genuine and mutually respectful partnerships and relationships, consultation and engagement between the Ministry, gambling harm services, industry, researchers and communities
- Stronger gambling harm sector leadership and stakeholder relationships. Qualities for effective leadership included sector knowledge and open and frequent communications.

It is important to note that the current Strategy will be in place until 30 June 2022. This needs assessment was undertaken part way into the delivery period for the current Objectives. The Government's Response to COVID-19 has impacted on the Ministry's ability to deliver the current Strategy and resulted in delays to the delivery of key commitments. The Ministry remains committed to delivering these commitments.

How can gaps in service delivery be addressed?

Addressing gaps in 'policy' relating to Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm

Addressing policy gaps: Develop proactive policies and strategies, and respond to policy gaps relating to offshore online gambling, as well as gaming and gambling.

Acknowledgement and inclusion of gambling services in mental health and addiction services and responses: Acknowledge gambling services as siloed and isolated from wider mental health and addictions services, and ensure inclusion for future strategies and potential funding.

Responding to provider contracting gaps and risks: Such as short-term and non-sustainable contracts, separate contracts for public health and intervention services, narrow contract scope and Western contracting and service specifications.

Addressing gaps in 'outcomes' relating to:

Objective 1: There is a reduction in gambling-related-harm inequities between population groups (particularly Māori, Pacific and Asian peoples, as the populations that are most vulnerable to gambling harm).

Objective 2: Māori have healthier futures through the prevention and minimisation of gambling harm.

Prioritising equity: Ensure the Strategy sits within an overarching equity framework and prioritises:

- Māori ownership and determination
- Gambling sector adherence to established equitable systems and process
- Meaningful and genuine engagement and relationships between the crown, iwi and ethnic-specific services
- Addressing inequities for Māori and ethnic-specific service providers and workforces in mainstream services.

Addressing gaps in ‘participation’ relating to Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm.

Broadening lived experience representation and input: Ensure interventions and public health approaches are informed by all stakeholders, including those with lived experience. It is commendable that the Ministry has established a Lived Experience Advisory Group – it would also be beneficial to promote and broaden the value of lived experience perspectives across governance, gambling harm services, practice and research.

Community action: Develop policies/practices that enable and empower local participation and community action within and across Territorial Authorities (TA).

Addressing gaps in ‘practice (workforce capacity and capability)’ relating to Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm.

Gambling harm workforce capacity and reach: Improve access to services in remote areas, review opportunities to share back-office functions across gambling harm service providers, recognise and broaden the peer support workforce.

Gambling harm workforce development and cultural safety: Recognise specialist skillsets required within gambling harm services and increase opportunities for workforce development and cultural safety. Participants suggested a need for collaboration between training providers and ethnic-specific gambling services to ensure adequate cultural safety training across the gambling sector.

Addressing gaps in ‘practice (enhancing wellbeing, life skills and resilience)’ relating to Objective 7: Services enhance people’s mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm.

Multi-sectoral approaches and responses: Acknowledge harmful gambling as a complex issue in need of systems change and multi-sectoral responses, commitment, action and potentially funding. Address the social determinants of health and wellbeing including a focus on client’s holistic and cultural needs, mandating all sectors to screen for harmful gambling, and integrating gambling harm services into primary care and social service settings.

Addressing gaps in ‘practice (intervention services)’ relating to Objective 10: People access effective treatment and support services at the right time and place.

Improve services: For relapse and drop-out clients, whānau/families, whānau affected by gaming and gambling, online self-help and intervention services.

Integrate responses for comorbidities and co-existing issues: To minimise potential client re-traumatisation and deliver more efficient and effective services.

Addressing gaps in ‘practice (public health)’ relating to:

Objective 5: People understand and acknowledge the range of gambling harms that affect individuals, families, whānau and communities.

Objective 8: Gambling environments are designed to prevent and minimise gambling harm.

Objective 9: Services raise awareness about the signs and range of gambling harms that affect individuals, families, whānau and communities, and how to respond.

Promotion and public health messaging: Review public health activities, resources and messaging to ensure messages are consistent, informative and aligned with different cultural worldviews, individuals, affected others and wider whānau. Promote key messages to increase understandings about harmful gambling definitions and behaviours – and when to seek help, collective community connections and responsibility, engaging in safe conversations about wellbeing, mana-enhancing and destigmatising themes, whānau/family intervention services, community funds and gambling industry marketing.

Public health and health promotion capacity and capability: Ensure adequate capacity to provide consistent health promotion outputs, resources and activities. Reconsider the production of merchandise for public health and intervention service provider and community engagements.

Addressing gaps in ‘research and evaluation’ relating to Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm.

Evidence to inform provider contracting and procurement: Ensure adequate evidence is available/provided to ensure funding and service models measure service delivery in equitable and culturally responsive ways.

Evaluation: Embed evaluation into all pilot projects and services. Ensure research and evaluation projects are coordinated and well-timed to inform policy and practice development and strategy.

A commitment to action from the Ministry/Government in response to research

recommendations: Strongly encourage government agency feedback on how research findings have/will be used to inform strategic thinking, practice and policy.

Accessible research findings: Ensure research findings are disseminated and accessible to the entire gambling sector and communicated in ways that resonate with different communities.

Addressing research gaps: Broaden the evidence-base for gaming and gambling, clients who relapse/drop-out or do not attend, and gambling harm. Provide frequent data collection and monitoring of robust prevalence data – synthesise multiple and conflicting databases and analysis.

1 Background

Under the Gambling Act 2003 (s318), the Ministry is required to undertake a Needs Assessment to inform the development of the three-year Strategy to Prevent and Minimise Gambling Harm. The Ministry commissioned external agencies to conduct Needs Assessment reports in 2009¹, 2012², 2015³ and 2018⁴ for consultation and to inform the development of the respective three-year strategies. The Ministry commissioned Malatest International to conduct the Gambling Harm Needs Assessment 2021 to inform the 2022/23-2024/25 Strategy.

As with previous years, the Needs Assessment is purposed to:

- Identify changes in the evidence since the last Needs Assessment completed in 2018
- Identify gaps in service delivery.

An additional requirement of the 2021 Needs Assessment was to summarise the Ministry's progress across the 11 Objectives set out in the current Strategy 2019/20-2021/22.

1.1 Methods

1.1.1 Literature review

A literature review was conducted to provide an update of national and international literature published between 2018 and December 2020. The literature reviewed recent evidence of relevance to prevalence and participation, harmful gambling risks, gambling venues and expenditure, gambling harm minimisation services, forms of gambling and changing technologies and potential impacts, social and cultural impacts, and comorbidities.

The search methods and sources used to identify and access relevant literature include but are not limited to:

- Recent issues of the four main gambling journals: Journal of Gambling Studies, International Journal of Mental Health and Addiction, Journal of Gambling Issues, and International Gambling Studies
- A supplementary search of the Cochrane Library database and other journals that may include New Zealand specific articles
- Ministry funded gambling harm research and evaluations (completed between 2018 and February 2021 – including unpublished reports)
- Key websites involved in New Zealand gambling (e.g., The Department of Internal Affairs, Te Hīringa Hauora/Health Promotion Agency (Te Hīringa Hauora), TAB NZ and Lotto NZ for relevant reports)

¹ <http://www.health.govt.nz/publication/informing-2009-problem-gambling-needs-assessment-report-ministry-health-0>

² <http://www.health.govt.nz/system/files/documents/publications/gambling-harm-report-jul2012.pdf>

³ <https://www.health.govt.nz/system/files/documents/publications/informing-2015-gambling-harm-needs-assessment-jul15.pdf>

⁴ <https://www.health.govt.nz/publication/gambling-harm-reduction-needs-assessment>

- Gambling harm services clinical and public health provider reports and decision documents about service implementation
- Ministry gambling intervention services data
- National Telehealth Service quarterly reports
- Routinely collected synthesised data on gambling prevalence, participation in gambling and the risks of harmful gambling
- Review of the references included in recent key publications.

1.1.2 Interviews and focus groups

Ten individual and 14 group interviews⁵ were conducted with 67 gambling stakeholders (Table 1).

Table 1: Individual and group interviews

Stakeholder group representatives	Description
Gambling agency	Individual and group interviews with five providers (government agencies, research and training institutions).
Gambling industry	Individual and group interviews with five providers (Class 4 societies, Lotto NZ, hospitality and casinos).
Gambling harm service provider	Nine individual and group interviews with seven national and regional service providers (including ethnic-specific service providers).
Consumer/lived experience	Seven individual and group interviews with consumers and lived experience representatives (representing both current and historical harmful gambling experiences).

Gambling sector and lived experience (historical) recruitment and engagement: The research team worked with the Ministry to identify key contacts across the range of gambling sector stakeholder groups. The research team engaged with stakeholder representatives from their own professional networks and the Ministry's database to promote the Needs Assessment and invite potential participants to partake in individual and/or group interviews and focus groups – information sheets about the Needs Assessment were disseminated. Verbal consent was sought before the start of interviews, and focus groups commenced via Zoom or in-person.

Ethnic-specific provider and lived experience (current) recruitment and engagement: The research team engaged with four ethnic-specific gambling harm service providers to connect with clients and staff. Service providers were given promotional material to disseminate to clients. Those who expressed an interest in participating in the Needs Assessment were invited to a focus group

⁵ Group interviews were conducted on request from participants. The synergistic nature of group discussions enabled participants to build on each other's insights in ways that would be less possible in individual interviews. Group interviews also provoked rationalisation and explicit reasoning and helped to unpack more nuanced understandings of phenomena. Group discussions were facilitated by a senior and experienced team member to ensure inclusive, respectful and safe conversations and to minimise the potential for power dynamics in a group setting.

discussion held at the provider premises. Information sheets and consent forms were shared with potential participants during this process, and they were given opportunities to ask questions.

Interviews were audiotaped and transcribed. All consumer/lived experience participants received a koha/meaalofa in the form of a gift voucher as a token of appreciation for their involvement.

Interview and focus group question guide: A semi-structured interview and focus group guide was developed in collaboration with the Ministry based on the Needs Assessment aims. In addition to identifying gaps in service delivery, the question guide sought to summarise the Ministry's progress across the 11 Objectives set out in the current Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22.

1.1.3 Online surveys

The Ministry expected the Needs Assessment 2021 would replicate the online workforce and consumer surveys conducted in the last Needs Assessment in 2018. The research team forwarded the online workforce and consumer survey links to representatives from all gambling harm service providers (service providers were asked to forward the consumer survey link to their staff and clients) – data were collected in March 2021. Survey respondents who wished to enter a draw to win a \$100 Prezzy card were asked to provide a name and contact details stored separately to survey data.

- **Workforce survey:** A total of 67 responses were received for the workforce survey. A profile of survey respondents is provided in Appendix 3.
- **Consumer survey:** A total of 12 responses were received for the consumer survey.

1.1.4 Analysis

A general inductive approach was used to guide the analysis of the interview and focus group data. We developed a coding framework to identify emergent themes. Our team frequently met throughout the Needs Assessment to discuss emergent themes and explore similarities and differences between and across the different gambling stakeholder groups.

Our culturally diverse team members of Māori, Pacific, Pākehā and Asian ethnicity and heritage, and immersion in their respective communities led the analysis, brought their interpretive frameworks, and reflective positioning to ensure that our interpretations were contextualised within different cultures where possible and that findings were framed accordingly.

1.1.5 Ethics approval

An ethics application for the Needs Assessment was submitted for review by the New Zealand Ethics Committee on 15 January 2021. Approval was received on 15 February 2021.

1.1.6 Strengths and limitations

The strengths of this research included:

- A close working relationship with the Ministry throughout the Needs Assessment

- The research team's experience and understanding of the harmful gambling sector and networks across the sector
- A mixed-methods approach to gather information to inform the Needs Assessment.

The limitations of this research included:

- **Limited timeframes:** Data collection was between January-March 2021. The Needs Assessment examined a broad and sensitive topic with numerous stakeholders in a tight timeframe.
- **Low consumer survey response rate:** Due to a low response rate, consumer survey responses were not analysed or included in the Needs Assessment. However, open-text qualitative survey feedback was included in analysis and detailed consumer and lived experience representation were sought through the qualitative in-depth interviews. Potential future consumer surveys may benefit from investing adequate time in promoting the Needs Assessment (and survey) and engagement with providers and potential respondents.
- **Limited workforce survey response rate:** The workforce responses and findings are limited and cannot be generalised across the harmful gambling sector. The online survey was complemented by good coverage of provider and other stakeholders' perspectives through in-depth interviews.

2 Gambling in Aotearoa New Zealand

2.1 Gambling participation

Evidence shows that many adults have engaged in gambling at some time in their lives. New Zealand's National Gambling Study (NGS)⁶ found that overall gambling participation rates continue to trend downwards⁷ (Abbott, Bellringer & Garret (2018). The most recent gambling participation and prevalence data captured in the Health and Lifestyle Survey (HLS)⁸ 2018 found:

- 67.2% of adults participated in some form of gambling (an estimated 2,650,000 adults), a 3% decrease from the 2016 Survey results (70.2%) and a 15.5% decrease from 2006 (82.7%)
- Gambling on lotteries products (including Strike, Powerball, Big Wednesday, Keno and Instant Kiwi) continues to be the most popular gambling activity for New Zealanders. Over half (55.5% or 2,172,000 adults) had bought a Lotto product in the last year (either in-store or online). The next most common forms of gambling New Zealand adults participated in include EGMs at pubs/clubs/casino (13%), horse/dog/sports racing (11.3%) and online gambling on overseas websites (2.2%).
- Compared with people from New Zealand European and other ethnic group, slightly higher proportions of Māori and Pacific participate in EGMs (casino and non-casino) and fewer participate in NZ Racing Board (TAB). A higher proportion of New Zealand Europeans and others participate in NZ Lotto products compared to Māori and Pacific, who participate in similar proportions. Asians have the lowest participation across all three activities.
- Differences in gambling participation across ethnic groups remain unchanged. In 2018, 72.7% of New Zealand European/Other adults, 69.3% of Māori adults, 60.4% of Pacific adults and 41.4% of Asian adults reported gambling in the last 12 months. This pattern of differences has not changed since the previous gambling harm Needs Assessment.

Between 2016-2018, the proportion of New Zealand adults gambling on EGMs at pubs/clubs/casino increased slightly by 1.1%. Gambling on lotteries products, horse/dog/sports racing and online gambling on overseas websites decreased slightly by 5.7%, 0.9% and 1.0%, respectively.

⁶ The NGS is a longitudinal survey that started in 2012 with an initial randomly selected national sample of 6,251 adults aged 18 years and older. Participants were re-interviewed in 2013, 2014 and 2015. In 2014/15, an additional cohort of 106 moderate-risk/problem gamblers was recruited to boost numbers of participants in those risk categories; these participants were reinterviewed in 2015/16.

⁷ Respondents are asked about participation in different gambling activities either online, at home, or elsewhere. Respondents who answer yes to any of these questions are defined as gamblers.

⁸ The HLS is a biennial survey of New Zealanders aged 15 years and older. The gambling questions are designed to be comparable with earlier surveys and the Gaming and Betting Activities Survey (GBAS) series. Gambling harm is measured using the Problem Gambling Severity Index (PGSI) (see section 2.2)

2.2 Defining and measuring harmful gambling

Interviewed gambling harm service and lived experience representatives commonly described gambling participation in Aotearoa New Zealand as a normalised activity which for some people can evolve into harmful gambling behaviour.

You don't look at scratchies as gambling, but it is. (Clients)

It's all fun and games, and then it's not fun and games. (Lived experience representative)

The Gambling Act 2003 (Section 4, Part 1) defines gambling harm as “distress of any kind arising from or caused or exacerbated by, a person’s gambling” to themselves, their family, whānau, workplace or society (Parliamentary Counsel Office, 2003).

The HLS, National Prevalence Survey (NPS) and NGS measure harmful gambling using the Problem Gambling Severity Index (PGSI). The NPS and NGS also use the South Oaks Gambling Screen-Revised (SOGS-R). Both include questions about problems that people might experience as a consequence of their gambling behaviour. The PGSI provides a measure of current (past 12 months) problems and classifies participants as:

- Non-gamblers (not gambled in the past 12 months)
- Non-problem gamblers (score 0)
- Low-risk gamblers (score 1-2)
- Moderate-risk gamblers (score 3-7)
- Problem gamblers (score 8+).

The SOGS-R, as administered in the national prevalence surveys, provides a measure of lifetime problems. Again depending on their scores, participants are classified as:

- Non-problem gamblers (score 0-2)
- Problem gamblers (score 3-4)
- Probable pathological gamblers (score 5+).

With regard to SOGS-R, non-problem gamblers are all people who do not meet the criteria for problem or probable pathological gambling, including people who report not having ever gambled in their lives.

Harmful gambling exists on a continuum which describes different levels of gambling severity and indicators from non-problem to mild, moderate and severe/problem gambling behaviours (Korn & Shaffer, 1999) (See Appendix 1 for the continuum of prevention and harm reduction).

2.2.1 Participants questioned the adequacy of harmful gambling definitions and measures

Interviewed participants from all stakeholder groups highlighted concerns with the definition and measurement of harmful gambling, noting that:

- There remained a lack of understanding among the general public about the definition and behaviours associated with harmful gambling

People don't realise that they're actually addicted for quite a while. So they're still gambling, and they're not recognising that they're addicted. So even though there are

the little cards and all the notices on the pubs and stuff, it's actually not entering the heart that they're actually addicted. (Lived experience representative)

- Harmful gambling definitions and measurements may contribute to under-reporting

We suspect there's a lot more unreported gambling happening...(Gambling harm service provider 7)

We know a lot of people are actually not reporting they have a gambling problem...If you ask my [family member]...he would definitely dumb down his gambling issues...He wouldn't acknowledge...When I saw the prevalence, I always felt a little bit unsure...If you look at the amount of money that has been lost...then the number of people who actually say they have a problem gambling, it doesn't quite make sense. (Lived experience representative)

- Measuring changes in gambling harm prevalence does not provide an adequate measure of changes in the severity of harm experienced by individuals, families and communities. In other words, a reduction in harmful gambling behaviour may not necessarily imply a reduction in the severity of associated harms.

What's missing overall in the Ministry of Health's concept or measurement is the severity of harm versus the problem gambling severity because they're two different things that PGSI talks about - the severity of your problem but not necessarily the severity of harm. (Gambling industry 4)

- Harmful gambling definitions are not inclusive of low to moderate gambling behaviour and associated harms.

That is all adding up why people end up presenting to us with suicidal ideation, really severe mental health or at a 'having lost everything' stage. We don't want to see that. We want to do more early intervention and prevention. (Gambling harm service provider 1)

In line with these views, interviewed agency representatives noted a need to review current gambling screens.

If we're talking about wider spread community screening, I really don't think the Lie/Bet is the screen we should be using...I do think it is time to review it... (Gambling harm agency 1)

...they're not very clinical in nature. We're seeing service providers pulling their hair out and getting really frustrated that they're seeing changes in their clients, but it's not showing in the screens we're using. (Gambling harm agency 1)

2.3 Gambling regulation and legislation

Gambling legislation in Aotearoa, New Zealand, is set within the Gambling Act 2003 (the Gambling Act). The Gambling Act has specific purposes, which are:

- To control the growth of gambling
- To prevent and minimise the harm caused by gambling

- To authorise some gambling and prohibit the rest
- To facilitate responsible gambling
- To ensure the integrity and fairness of games
- To limit opportunities for crime or dishonesty
- To ensure that money from gambling benefits the community
- To facilitate community involvement in decisions about the provision of gambling.

There are four main types of gambling legally allowed in New Zealand:

- Racing and sports betting through the TAB, run by TAB New Zealand (TAB NZ - a statutory monopoly)
- Class 4 EGMs run in clubs and pubs by a corporate society
- The national lottery and associated products through the New Zealand Lotteries Commission (Lotto NZ) (available at many supermarkets, petrol stations, local dairies, other retail outlets and online)
- Casinos (the Gambling Act includes a ban on new casinos).

The Gambling Act classifies gambling based on the amount of money spent and the risk of problems associated with that type of gambling. The Gambling Act divides gambling into six legal classes. Subpart 2 of the Act details the meaning of Class 1-4 gambling. Subpart 4 details the licensing of casino gambling, and Part 3, subpart 2, covers Lotto NZ.

2.4 Gambling sector roles and responsibilities

Under the Gambling Act:

- The Department of Internal Affairs is responsible for regulating gambling in Aotearoa New Zealand, and enforcing the Gambling Act. Regulatory activities include:
 - Non-club societies have to apply to the Department for a gambling licence. Currently, a society must re-apply for a licence every year.
 - The Department monitors the amount of funds non-club societies return to communities to check that it reaches the minimum required under regulations.
 - Gambling inspectors inspect venues to check they are operating according to the Gambling Act, including the venue's responsibilities around harm minimisation and measures to limit problem gambling.
 - Other regulatory activities include efforts to reduce theft and fraud, minimise harm from gambling and maximise returns to the community.

On 12 March 2021, the Department of Internal Affairs publicised a new harm minimisation focus, direction and strategy to deliver community wellbeing through reducing gambling-related harms. The new focus consists of:

- Working to ensure New Zealanders can enjoy safe and fair gambling that efficiently and equitably contributes to community wellbeing.

- The Gambling Group ensuring that gambling in New Zealand is run by trusted operators, that harm to gamblers is minimised and that New Zealand communities benefit from the proceeds of gambling.
- Regulatory activities across multiple modes of gambling, including casinos and classes 1-4, and undertake gambling licensing, compliance and enforcement functions to achieve the purposes of the Gambling Act 2003.
- The Ministry of Health is responsible for developing and implementing the 'integrated problem gambling strategy focused on public health' described in section 317 of the Gambling Act. The Act states that the strategy must include:
 - Measures to promote public health by preventing and minimising the harm from gambling (see below for a definition of harm)
 - Services to treat and assist problem gamblers and their families and whānau
 - Independent scientific research associated with gambling, including (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts of gambling on different cultural groups
 - Evaluation.
- The Gambling Commission is an independent statutory decision-making body. The Commission hears casino licensing applications and appeals on licensing and enforcement decisions made by the Secretary of Internal Affairs in relation to gaming machines and other non-casino gambling activities.

Under section 318(5) of the Gambling Act, the Gambling Commission is required to report to the responsible Ministers making recommendations on the total annual amount of the proposed problem gambling levy for a three year period and a proposed levy rate for each gambling sector.

- Local councils (territorial authorities – TA) must have a TAB venue policy (legislated under the Racing Industry Act 2020 s93-97⁹) and Class 4 venue policy (under the Gambling Act) that sets out Class 4 gambling rules in their districts. Class 4 venue policies must be reviewed every three years (with communities) and include:
 - Whether Class 4 gambling venues may be established in their district
 - If permitted, where venues may be located
 - Consideration of the social impact of gambling within their district.

⁹ <https://www.legislation.govt.nz/act/public/2020/0028/latest/whole.html>

3 Access to gambling in Aotearoa New Zealand

3.1 All forms of gambling are widely accessible

Lotteries products: Lotto NZ offers many products, including Lotto, Instant Kiwi, Keno, and others. These products were sold from 1,564 Lotto retail outlets across the country for the FY 2019/20, an increase of 92 outlets since FY 2017/18 (Lotto New Zealand, 2020). In 2020, during COVID Alert Level 4, all sales moved online and registered MyLotto players increased by 385,000 (845,000 in 2019) to 1,230,000 (see section 3.4.2) (Lotto New Zealand, 2020).

Casinos: Under the Gambling Act (Reprint as of 30 January 2021), the number of casinos in New Zealand is capped at six (Parliamentary Counsel Office, 2003) and are located in Auckland, Hamilton, Dunedin, Christchurch and Queenstown¹⁰ (Gambling Commission, 2020).

Class 4 EGMs: There are just over 1,000 Class 4 venues and over 16,000 EGMs across New Zealand. The number of Class 4 venues and EGMs (non-casino) continue to decrease (Figure 1 and Figure 2). Up to September 2020, there were a total of 1,068 Class 4 venues – 60 fewer venues compared with September 2019 (Figure 1) (Department of Internal Affairs, 2021b). Up to December 2020 there were a total of 14,781 EGMs across New Zealand – 75 fewer EGMs compared to December 2019 (Figure 2) (Department of Internal Affairs, 2021b).

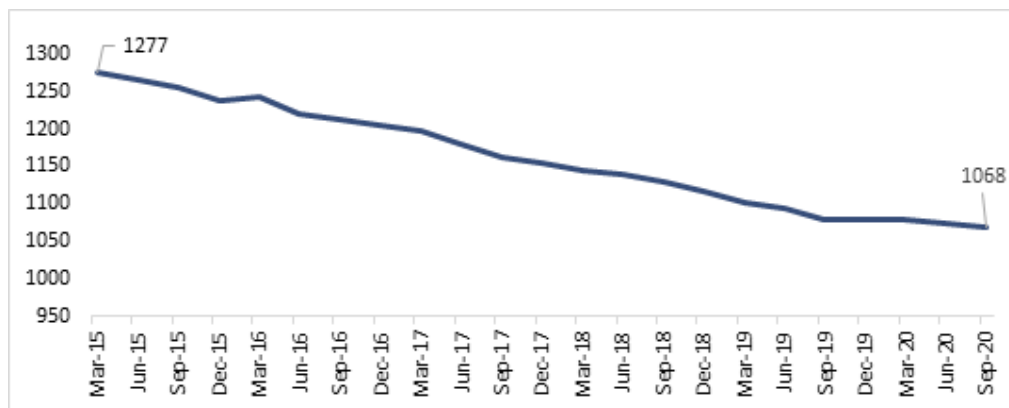


Figure 1: Number of Class 4 venues

¹⁰ There are two casinos in Queenstown

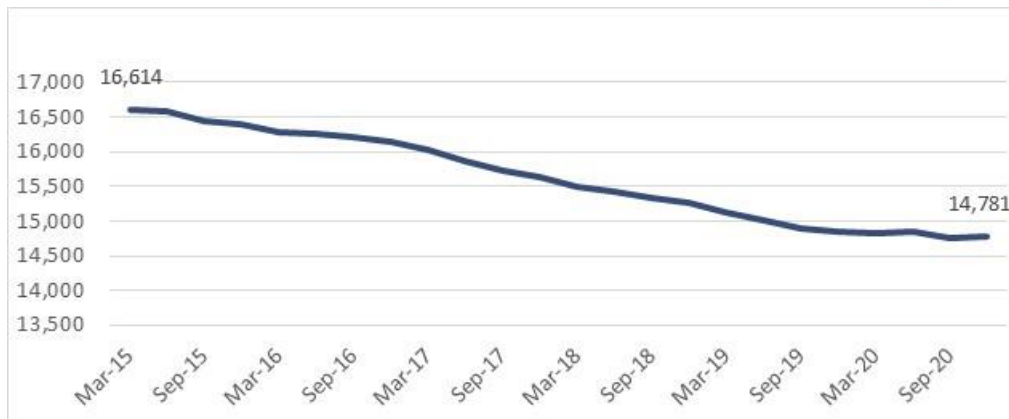


Figure 2: Number of Class 4 EGMs

TAB New Zealand (TAB NZ) sports and race betting: Available on the TAB NZ mobile app and website, at raceways and, through TAB venues (some TAB venues also operate non-casino EGMs). In the 2018/19 financial year there were 580 retail TAB outlets, and more than 220,000 active TAB accounts. A total of 44 of 67 TAB operated venues also hosted EGMs (compared with 33 TAB venues hosting EGMs in 2013/14 and 43 in 2016/17) (New Zealand Racing Board, 2019). The move to Alert Level 4 in March 2020 resulted in racing and sporting activities being suspended or cancelled and temporary closure of their retail outlets, although TAB was still able to operate and take bets online via its website and mobile app (TAB NZ, 2020).

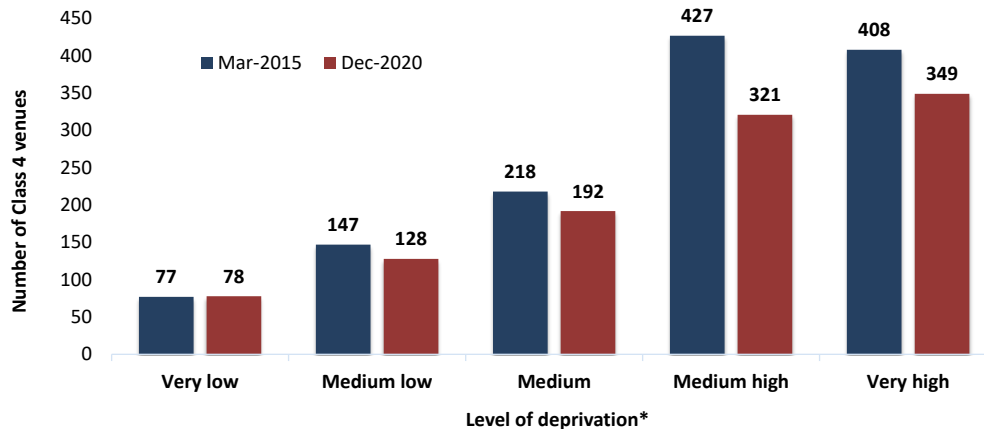
Online gambling: There are two authorised providers of online gambling products in New Zealand; Lotto NZ and TAB NZ - both operate websites and apps. Lotto NZ sells some of its products online, including Lotto, Powerball, Strike, Keno, Bullseye, and Instant Kiwi. TAB NZ offers online racing and sports betting, including live sports betting (Department of Internal Affairs, 2019a).

New Zealanders can also access offshore gambling services (see section 3.4.1) which are not currently regulated under the Gambling Act, such as casino operator SkyCity Entertainment Group's Malta-licensed online casino that offers a mix of live and random number generator (RNG) casino games as well as slots and virtual sports.

3.2 Class 4 venues remain inequitably distributed, with more placed in areas of high deprivation

Despite slowly declining numbers of EGMs, Class 4 venues remain primarily in areas of economic deprivation (Figure 3) (Department of Internal Affairs, 2021b). These areas are more likely to have an over-representation of Pacific and Māori residents, who are also most at risk of harmful gambling¹¹ (see section 5.2). Venue reduction is only helpful if it includes reductions in areas of economic deprivation.

¹¹ Research has shown that ethnicity remains a significant risk factor when other factors (such as socio-economic deprivation, gender and age) are controlled for (Welte et al, 2004; Ministry of Health 2006).



*Note. As measured by the 2013 New Zealand Index of Deprivation (NZDep)¹² Reproduced from: Gaming machine profits GMP dashboard (Department of Internal Affairs, 2021b).

Figure 3: Raw number of venues by deprivation rating

3.3 There are mixed views on the effectiveness of policies restricting access to EGMs

As noted above, under the Gambling Act, TAs must have a Class 4 venue policy that is renewed every three years (with the community) that sets out Class 4 gambling rules in their districts (Ministry of Health, 2009). The policy options available to the 67 TAs across New Zealand include:

- No restrictions, i.e. no limit on the number of total venues/machines
- Restrict where Class 4 venues are allowed
- Restrict the number of gaming machines
- Venue sinking lid – do not allow new Class 4 venues
- Gaming machine sinking lid – do not allow new gaming machines (Ministry of Health, 2009).

As of December 2020, 43% of TAs had adopted a sinking lid policy, while 37% had no restrictions on the number of venues or machines that could be established within their district (see Table 2). There are mixed views on the effectiveness of these various policies.

¹² Very low = NZDep 1-2, medium low= NZDep 3-4, medium = NZDep 5-6, medium high = NZDep 7-8, very high = NZDep 9-10.

Table 2: Gambling policies adopted by territorial authorities

Policy	Count	% of the total
Number of TLAs with no restrictions	25	37%
Number of TLAs with a sinking lid (no new machines or venues)	29	43%
Number of TLAs with a cap (max number of machines and/or venues)	5	7%
Number of TLAs with machine/venue to population ratio	8	12%

Note: Adapted from Worksheet in territorial authority gambling venue policies (Ministry of Health, 2020).

In 2018, a descriptive analysis of sinking lids by the Sapere Research Group (2018) indicated that reductions in EGMs were not strongly correlated with reduced EGM expenditure in high deprivation areas. Although some Territorial Authorities (TAs) showed reductions in both EGMs and gambling expenditure, many did not. In fact, many TAs (especially those with high levels of deprivation) were said to exhibit increased gambling expenditure despite a reduction in EGMs.

More recently, in 2020, Erwin and colleagues provided contrasting evidence identifying that TAs with sinking lid policies or absolute and per capita caps on EGMs effectively reduced Class 4 venues and EGMs compared with the reference group, i.e. those with no restrictions in place beyond the requirements of the Gambling Act.

The number of EGMs were estimated to decrease by 67 under an absolute cap (on a per 100,000 population basis over one year) and by 85 under per capita caps. Absolute and per capita caps were also estimated to reduce the number of venues by seven and eight, respectively. Further, sinking lids and per capita caps were estimated to effectively reduce EGM expenditure by 13% and 14%, respectively.

Compared with the reference group, per capita caps were also associated with increased service use by new clients receiving face-to-face and full interventions in the following year.

3.4 Access to online gambling for money has increased

The advent of new technologies has led to increased online gambling opportunities. Forms of online gambling include NZ Lotto products, betting on TAB racing and sports events, online card games, online pokies, and online casino games (Sense Partners, 2019).

Across the NGS data collection waves, online Lotto participation increased between Wave 1 (4.9%) and Wave 4 (6.9%) (Abbott et al., 2018). Online TAB gambling participation remained stable across the waves. Other online/remote gambling activities occurred to a very low extent – 3% or less (Abbott et al., 2018). Overall, online/remote gambling participation was substantially less than the same gambling via land-based means (Abbott et al., 2018).

In 2014, online gambling participation measured within the HLS was relatively low. Four per cent of adults had bet money or bought tickets online for money or prizes, and 2.3% had bet on horse or

dog race or sports events through a website (Tu & Puthipiroj, 2017). The most recent HLS results show that online gambling rates¹³ have significantly increased since 2014, with 13% of adults reporting gambling online in the last 12 months (Rendall et al., 2019). The most common mode was the MyLotto website and app (9%), followed by the TAB website and app (4%) and overseas online gambling (2%) (Rendall et al., 2019). In 2018, for the first time since the HLS began in 2008, participation in online gambling equalled playing EGMs at pubs, clubs or casinos.

3.4.1 Offshore online gambling participation has increased slightly

Participation in offshore online gambling has increased from roughly 40,000 in 2009 to 70,000 in 2019, the equivalent of 1.7% of the working population, or 1.4% of the total New Zealand population (Sense Partners, 2019). These results are similar to the HLS results, which have remained stable at around 2% since 2010 (Rendall et al., 2019).

More males across all age groups gambled on an online offshore website than females (Sense Partners, 2019). These findings are consistent with the HLS, which has consistently shown that men across all age groups gamble on overseas websites more than women (Te Hiringa Hauora, 2018b).

The most popular form of offshore online gambling (based on expenditure) is online casinos, followed by sites that offer a combination of gambling (Figure 4) (Sense Partners, 2019).

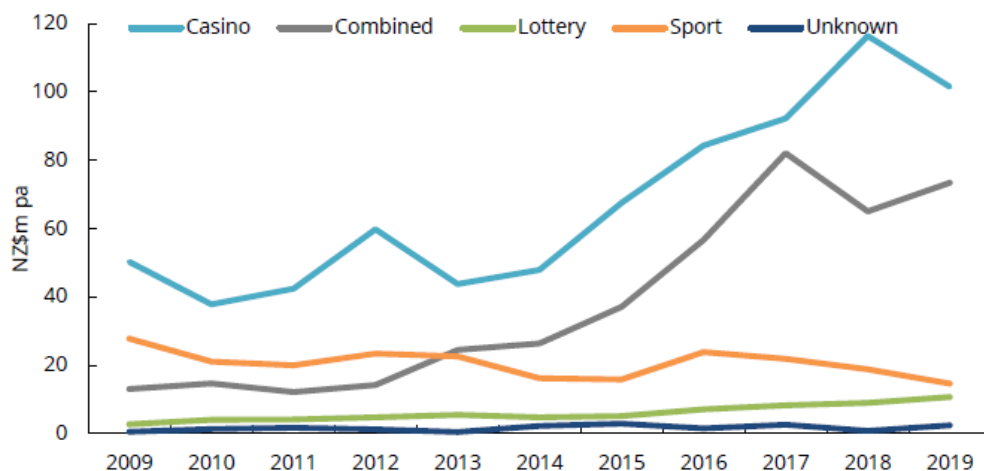


Figure 4: Offshore gambling spend by type of merchant

Internationally, online gambling and betting has increased through sites offering:

- **Microbets in sports:** Rather than betting on the outcome of a game, microbets (also known as “live-action” or “micro event” betting) allow consumers to gamble on outcomes within a game - for example, the next ball in cricket (Russell et al., 2019). This form of gambling can become continuous, tends towards impulsive decisions and offers

¹³ Online gambler is defined as a respondent who gambled over the internet on New Zealand hosted websites and apps (domestic), or on overseas hosted websites, in the last 12 months.

variety (Russell et al., 2019). Overseas studies have identified young males as most at risk of experiencing microbetting related gambling harm (Russell et al., 2019).

3.4.2 COVID-19 lockdowns have led to increased online gambling participation

COVID-19 prompted the New Zealand government to enforce a series of regulations to eliminate COVID-19. Mandates such as social distancing and staying at home disrupted normal gambling behaviour and immediately impacted the gambling industry. During lockdown level 4:

- Retail stores closed, and the sale of Lotto NZ products moved exclusively online via the MyLotto website and app (Lotto New Zealand, 2020).
- TAB venues closed, and New Zealand racing and sports events were cancelled (Racing Industry Transaction Agency, 2020). TAB continued to take bets on overseas sports such as Eastern European Table Tennis (Racing Industry Transaction Agency, 2020).
- Online gambling participation increased by about 43% (Sense Partners, 2020).

Despite the growth in online gambling during the COVID-19 lockdown, gambling's overall level was lower (Sense Partners, 2020). This is consistent with a survey undertaken by Te Hīringa Hauora (2020) on the impact of lockdown on health risk behaviours, where 50% of gamblers¹⁴ reported gambling less, and 41% reported gambling the same amount as they usually would. Of the 9% of respondents who reported gambling more, a higher proportion were Māori (15%) or aged 18-24 years (22%) (Te Hīringa Hauora, 2020).

3.4.3 New Zealanders are accessing 'free to play' online gambling (i.e. not for money)

In 2015, wave 4 of the NGS identified that 13% of participants reported playing gambling type games, not for real money or prizes, in the prior 12 months (Abbott et al., 2018). Māori were more likely to play these games across all data collection waves. The proportion of adults who participated in 'free to play' gambling-type games, reduced from 16% in 2012 to 13% (Abbott et al., 2018). In 2015, skill games were the most common (7.2%), followed by fantasy football (4.1%) and internet poker (2.3%) (Abbott et al., 2018).

'Free to play' online casino games were played by 1.5% of adults. Māori were more likely to play 'free to play' gambling-type games - 21% in 2015. The higher participation by Māori was constant across the years (Abbott et al., 2018).

Interviewed gambling harm service representatives described 'free to play' online gambling as a potential pathway to gambling for money.

Anecdotally a lot of people talking about...the free slot machines online... "My mother plays free slots online. But there's a time when she's asking for [my] credit card to buy more credits that start off as a free game. (Gambling harm service provider 3)

¹⁴ It is important to note that findings from the Te Hīringa Hauora 2020 report are not comparable with the HLS surveys due to different definitions and measures of gambling participation and harm.

It is also important to note that although advertising of overseas gambling is prohibited under the Gambling Act¹⁵, 'free online casinos' do have jurisdiction to advertise on New Zealand television because they are not played for money and are therefore not technically defined as gambling.

3.4.4 Online gambling (offshore and national) is not adequately regulated

Offshore online gambling: Interviewed participants from all gambling stakeholder groups commonly agreed that offshore online gambling in Aotearoa New Zealand was not well regulated. Tighter restrictions were needed to minimise novel, increased and uncontrolled access to online gambling and related harms.

Unregulated offshore online gambling offers none of the safety mechanisms offered by the physical gambling environments. On the contrary – offshore online gambling environments: Are highly accessible, being available 24 hours a day from the comfort and privacy of households; Have no restrictions on bet sizes; Have no capacity for staff to observe and assist people in trouble; Are accessible to vulnerable groups of people; Provide no guaranteed return to players; Are easily abused by minors; Allow promoters to encourage gamblers to gamble more by offering inducements such as the opportunity to gamble on credit... (Gambling Industry 1)

National online gambling: Gambling harm service, lived experience, and some gambling industry representatives highlighted a need for tighter regulation and controls to manage a fast-growing online gambling participation rate and potential gambling harm prevalence in Aotearoa New Zealand.

How easy it is to start to gamble. Just out of boredom. Instead of going to the pub, you can just stay home, download the apps, and enter your card details. So it's definitely changed within the past three years. It used to just be going down to the pub. Now it's so effortless you just pop out your phone. (Lived experience representative)

Gambling industry representatives also indicated a need to open opportunities for Aotearoa New Zealand's gambling industry to deliver, monitor and manage online gambling products. Many noted benefits for in-country expansion and control of online gambling include increased community funding and contributions to the gambling levy. Increased access and referral to Aotearoa New Zealand intervention services were also noted.

Online slots game...can't be hosted in New Zealand...you [can] base them out of Malta...That's tax dollars going overseas for Class 4; that's the 40% that should be going to grants which are going in the back pocket of somebody. (Gambling industry 3)

Gambling industry representatives further described continued restrictions and control over Aotearoa New Zealand based online gambling as *negligence* and a barrier to preventing and minimising gambling harm.

¹⁵ <https://www.legislation.govt.nz/act/public/2003/0051/latest/DLM208240.html>

[New Zealand] you've had that door shut for so long...You're essentially burying your head in the sand...You're also neglecting the harm element...[and] not actually invest[ing] in the harm min[imisation] measures around online gambling. But you know it's there, and people are doing it. And people are spending...The harm being caused by that is not being measured is not being counted by anything. (Gambling industry 3)

3.4.5 Evidence shows a link between online gaming and harmful gambling

International evidence highlights that:

- Video gaming problems appear to be a gateway behaviour to problematic gambling behaviour as identified in a Norwegian longitudinal study (Mold et al., 2019)
- Children who bet on gaming enhancements such as skins should be considered at-risk for the experience of harms because of their heightened engagement in gambling and gambling-like activities. A British Youth Gambling Survey found that children who bet on gaming enhancements such as skins and as adults gambled online had higher rates of at-risk and problem gambling than those who did not (23% vs 8%) (Wardle, 2019).
- The growth of offshore online gambling and the so-called gamblification of sports and gaming over recent years requires attention (Christopher, 2021).

In New Zealand, preliminary findings from research examining video games and Pacific youth gambling suggest that these are a potential gateway to problem gambling behaviour (PGF Group, 2020):

- 28% of young Pacific survey respondents spend more than \$20 on loot boxes
- Pacific young people drew parallels between problem gaming and problem gambling.

Some gambling harm service representatives highlighted the potential accelerated growth among technologically savvy Pacific young people and those across the Pacific region.

So it's not regulated...[In] five to six to 10 years time, what are we going to see as more and more of our people become online savvy?... We know anecdotally that the online spaces are exponentially growing and growing in the Islands, with kids on [social media]. I mean, every Pacific Island person you see in Samoa has a smartphone. They're already entering competitions online in Samoa through texts, dollar texts to enter a competition. So that behaviour has been normalised in Samoa. (Gambling harm service provider 3)

4 Gambling expenditure

4.1 Gambling expenditure across all forms of gambling continued to increase pre-COVID-19

Between 2014/15, New Zealand's gambling expenditure continued to increase, with approximately \$2.4 billion spent on gambling in 2018/19. In 2019/20, this amount reduced to \$2.25 billion (Table 3) (Department of Internal Affairs, 2021a) – likely an impact of the COVID-19 pandemic and variable levels of gambling access noted in section 3.

Table 3: Total gambling expenditure by gambling type

Gambling activity		2014/15 \$m	2015/16 \$m	2016/17 \$m	2017/18 \$m	2018/19 \$m	2019/20 \$m
NZ Racing Board (TAB)	Expenditure ¹⁶	\$325	\$342	\$338	\$350	\$332	\$315
	Prizes ¹⁷	\$1,748	\$1,928	\$1,907	\$1,913	\$1,926	\$1,854
	Turnover ¹⁸	\$2,073	\$2,270	\$2,246	\$2,262	\$2,258	\$2,169
NZ Lotteries Commission	Expenditure	\$420	\$437	\$555	\$561	\$530	\$631
	Prizes	\$473	\$537	\$652	\$686	\$645	\$754
	Turnover	\$894	\$974	\$1,027	\$1,246	\$1,175	\$1,384
EGMs (non-casinos)	Expenditure	\$818	\$843	\$870	\$895	\$924	\$802
	Prizes	\$8,141	\$8,550	\$8,931	\$9,154	\$9,440	\$8,209
	Turnover	\$8,849	\$9,393	\$9,801	\$10,049	\$10,364	\$8,209
Casinos	Expenditure	\$527	\$586	\$572	\$578	\$616	\$504
Total	Expenditure	\$2,091	\$2,209	\$2,334	\$2,383	\$2,402	\$2,252

Table 3 also shows the highest spend in 2019/20 was on non-casino EGMs (\$802 million), followed by Lotteries products (\$631 million), Casinos (\$504 million) and TAB (\$315 million) (Table 3).

¹⁶ Expenditure: also known as "gross profit" or "casino win", means the gross amount wagered by gamblers, less the amount paid out or credited as prizes or dividends. In other words, "expenditure" is the amount lost or spent by players, as well as the gross profit of the gambling operator (Department of Internal Affairs, 2021a).

¹⁷ Prizes: Also known as "dividends", means the cash amount, or the cash value of prizes, paid out or credited to players (Department of Internal Affairs, 2021a).

¹⁸ Turnover is the total (gross) amount wagered by gamblers. This figure is published by the New Zealand Lotteries Commission and by the New Zealand Racing Board for TAB betting. It includes a "churn" factor, or re-investment, where the same dollar is counted more than once. This is particularly relevant for rapid re-investment forms of gambling, like gaming machines or race betting. For example, if a player has \$20 to spend on a gaming machine and plays until the full \$20 is lost, it is likely that this \$20 will be recorded on the machine's meters as \$120 or more of turnover (gross amount wagered). Turnover is not an indicator of the amount spent by players or of the profit of the operator (Department of Internal Affairs, 2021a).

Unsurprisingly, between 2018/19 and 2019/20, expenditure increased on non-Lotteries products and decreased for TAB, non-Casino EGMs and Casinos¹⁹.

Sense Partners (2019) identified increased expenditure on offshore online gambling between 2009 and 2019 with an estimated spend of \$200 million in the 2018/19 financial year (Figure 5).

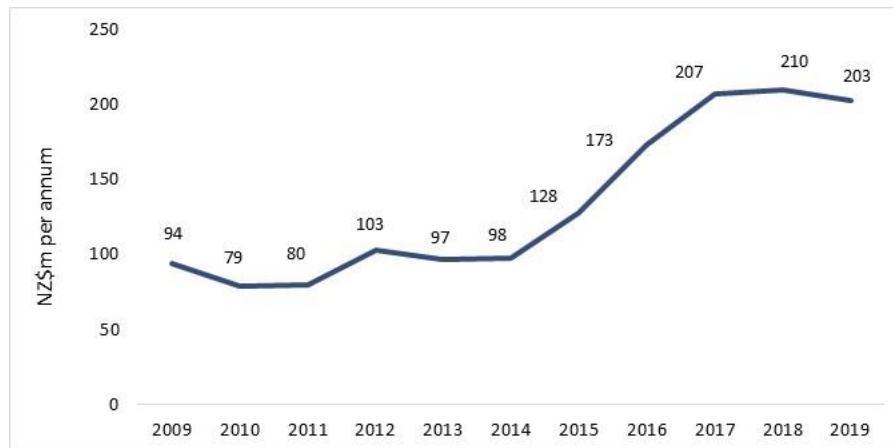


Figure 5: New Zealand online gambling spend

4.2 Post-Covid online gambling expenditure increased

During COVID-19 lockdowns in 2020 (see section 3.4.2), there was:

- A significant increase in online gambling expenditure: Online gambling expenditure increased from an average of \$4.1 million a week at the start of 2020 to \$6.25 million a week. (Sense Partners, 2020)
- Men spent more on overseas gambling than women during the level 3-level 4 periods
- Spending across all ages increased, but it will be important to monitor those aged under 40 years old who may have experienced a more permanent increase
- Registered MyLotto players increased by 385,000 (845,000 in 2019) to 1,230,000 (Lotto New Zealand, 2020)
- A drastic reduction in EGM expenditure: Gambling expenditure at physical gaming machine outlets fell from an average of \$17 million a week at the start of 2020 to zero (Sense Partners, 2020).

SkyCity's online casino, introduced in August 2019,²⁰ operates out of Malta and is expected to increase gambling expenditure in 2020/21. As of 31 August 2020, there were 35,000 registered customers. Expenditure on the SkyCity online casino is not included in the DIA expenditure figures noted in section 4.1 (i.e. approximately \$2.4 billion).

¹⁹ It is worth noting that these trends appear quite different when taking into consideration inflation and population adjustments (see Department of Internal Affairs, 2021a).

²⁰ Sourced on 11 May 2021: <https://www.skycityentertainmentgroup.com/media-centre/asxnzx-announcement-launch-of-offshore-skycity-online-gaming-site-090819>

“We have observed a slight reduction in online gaming revenue following the reopening of our properties in May, but we saw an increase in activity during the second Auckland closure period in August. We now have over 35,000 customer registrations, and we continue to prepare for a regulated gaming industry in New Zealand.”²¹

4.3 Quarterly gaming machine profits have returned to pre-COVID levels

GMP comparisons between December 2019 and December 2020 decreased by 13.6% - an impact of COVID-19 and Class 4 venue closures. However, **Figure 6** shows that GMP per quarter quickly returned to pre-COVID levels shortly after COVID-19 lockdowns ceased in 2020, indicating a surge of Class 4 gambling activity as the sector recovers from the impact of COVID-19 lockdowns throughout 2020.

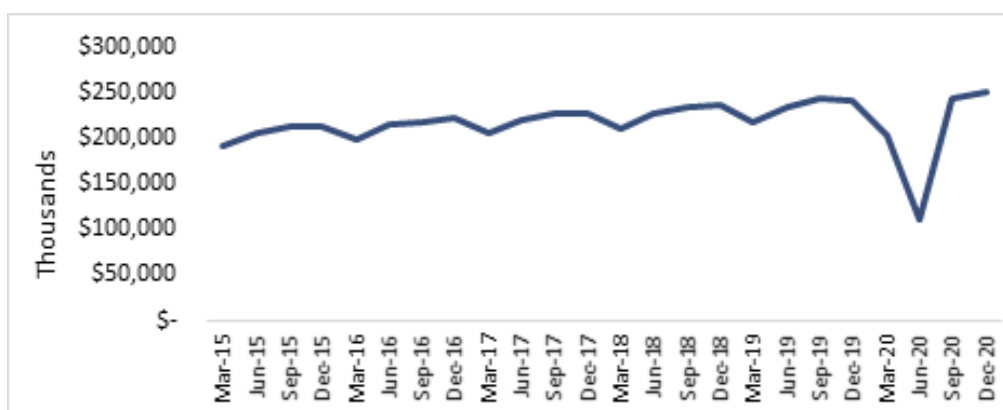


Figure 6:

Gaming machine profit (GMP per quarter)

Between September and December 2020, GMP increased 3.7% (Figure 7) (Department of Internal Affairs, 2021b). Quarterly GMP for December has been the highest quarterly figure recorded since 2007 (Department of Internal Affairs, 2021b; 2021c).

	GMP	
	Quarterly GMP	Rolling 12 mnth. GMP
Prior quarter	\$ 243,250,907.56	\$ 800,946,637.89
Current quarter	\$ 252,300,861.54	\$ 810,951,666.69
Δ	\$ 9,049,953.98	\$ 10,005,028.80
% change	↑ 3.7%	↑ 1.2%

Figure 7: Quarterly GMP

²¹ Sourced from: <https://www.skycityentertainmentgroup.com/media-centre/skycity-announces-full-year-results>

5 The prevalence of harmful gambling

5.1 The prevalence of harmful gambling in Aotearoa New Zealand remains relatively unchanged

The most recent gambling participation and prevalence data captured in the HLS survey showed that between 2016 and 2018, the prevalence of harmful gambling among adults (aged 15 years and over) in Aotearoa New Zealand remained relatively unchanged (Te Hiringa Hauora, 2018). It also identified that although not statistically significant:

- The prevalence of low-risk gambling among adults increased slightly from 3.3% to 3.6% (approximately 142,000 people)
- The prevalence of moderate-risk and harmful gambling among adults increased slightly from 1.5% to 1.9%, representing a further 76,000 adults in 2018.

It is important to note that the 2018 HLS does not capture the impact of COVID-19 lockdowns (and the consequent shift from land-based to online gambling) on gambling prevalence (see section 3.3). HLS was in the field surveying in 2020, but results were not available at the time of writing the Gambling Harm Needs Assessment literature review 2021.

It is also important to note that prevalence rates may not tell the whole story. Abbott, Bellringer, & Garrett (2018) caution that due to New Zealand's population growth and changing demographics since the initial 1990 national study, although gambling harm *rates* may appear unchanged, the *total number* of people experiencing harm may have increased. To gain a more accurate understanding of harm in the community, Abbott, Bellringer, & Garrett (2018) recommend reporting gambling harm rates *and* absolute numbers.

5.2 The prevalence of harmful gambling among Māori and Pacific peoples remains higher than other ethnic groups

New Zealand's National Prevalence Surveys have consistently identified Māori and Pacific ethnic groups as having the highest prevalence of harmful gambling behaviour compared to all other ethnic groups (Abbott & Volberg, 1991; Abbott & Volberg, 2000; Abbott et al., 2014). In line with this:

- The New Zealand Health Survey 2011/12 identified that Māori and Pacific people were approximately three times more likely (OR=3.2 for Māori, OR=3.0 for Pacific) than people from New Zealand European/Other ethnic groups to be categorised as moderate-risk/problem gamblers (Rossen, 2015).
- The HLS (2014) identified that Māori and Pacific gamblers have the highest prevalence of current harmful or moderate-risk gambling (6.2% and 8% respectively) when compared with Asian (3%) and New Zealand European/other ethnic groups (1.8%) (Ministry of Health, 2014).
- The HLS (2018) identified that despite having lower gambling participation rates (see section 2.1), the prevalence of harmful gambling continued to impact Māori and Pacific gamblers disproportionately. Between 2016-2018:

- Although the proportion of Māori and Pacific low-risk gamblers decreased (from 5.3% to 4.5% and 7.3% to 3.0% respectively), there were increases in the proportion of Māori and Pacific moderate/problem risk gamblers (from 4.6% to 5.9% and 2.4% to 3.5% respectively)
- The proportion of Asian low-risk gamblers increased (from 3.2% to 3.8%), and moderate/problem risk gamblers decreased (from 2.2% to 1.1%).

5.3 Youth gambling rates appear to be decreasing

International evidence has consistently shown that high proportions (between 20-90%) of young people across the UK, North America, Europe and Oceania participated in various forms of gambling in the past year – with between 4-8% gambling at problem/pathological gambling levels, and a further 10-15% at risk of developing a gambling problem (Rossen et al., 2013).

The 2018 HLS found that 45% of young people (aged 15-24) surveyed had gambled in the past year, the equivalent of 305,000 people. A decrease of 8% from 2016 HLS results, when 53% of young people surveyed reported having gambled in the past year (Figure 8). Young people made up approximately 27% (21,000 people) of the total proportion of moderate-risk and harmful gamblers (1.9% of all adults – 76,000 people)²² (Te Hiringa Hauora, 2018).

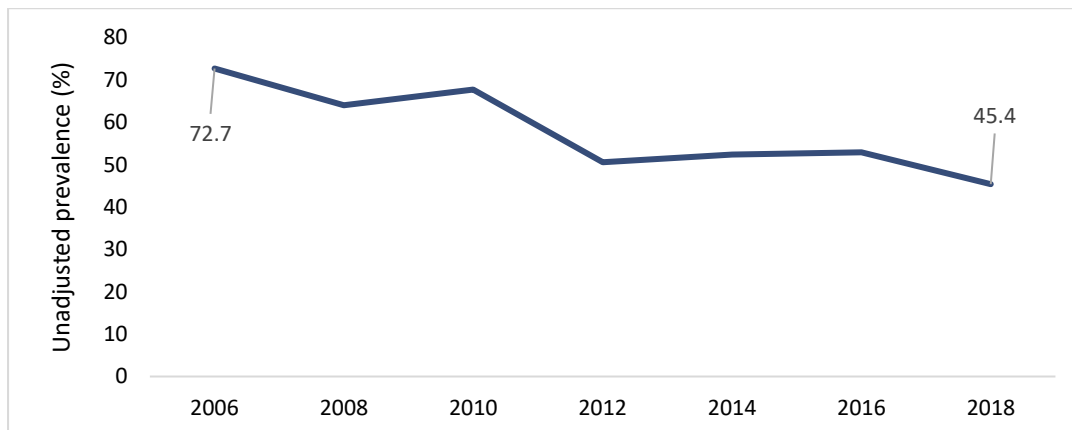


Figure 8: Gambling prevalence of 15-24-year-olds

The Youth'12 survey showed that one in ten students aged 13 to 17 had gambled in the past four weeks, and almost one-quarter (24%) had gambled in the last year. The survey also showed a higher proportion of Pacific (14.2%) and Māori (12.1%) students gambling in the past four weeks compared with New Zealand European (8.7%), Asian (9.3%) and Other (11.6%) (Rossen et al., 2013).

New evidence since 2018 has highlighted that one in 40 young Pacific males (17 years old) reported harmful gambling behaviours compared with one in 167 young Pacific females. Significant risk factors associated with harmful gambling at age 17 for Pacific young people included male gender,

²² Sourced from: <https://kupe.hpa.org.nz/#!/gambling/gambling-harm/hls-gamblers-pgsi-moderate-risk-and-problem>

attending secondary school, electronic cigarette smoking, gang involvement and family members or friends as gang members (Bellringer et al., 2019)

5.4 There are increased gambling harm risks for women

In 2019/20, although similar proportions of adults males (50.7%) and females (49.3%) presented to gambling harm intervention services (Ministry of Health, 2021), recent evidence suggests there are gender differences in relation to gambling engagement in Aotearoa New Zealand. The HLS 2018 found that women living in areas with a high social deprivation index score were two times (2.18) more likely than women in areas of low deprivation to experience gambling-related arguments or money problems related to gambling²³ (Te Hiringa Hauora, 2018). A mixed methods analysis of gambling harm for women in New Zealand identified (Palmer du Preez et al., 2019):

- Heightened gambling harm risks for women, especially in non-casino EGM contexts
- Gambling risk for women was associated with six gambling engagement categories in order of risk magnitude: non-casino EGMs, cards not in a casino, housie/bingo, casino gambling, horse/dog race betting and Instant Kiwi. This could have implications for gender-aware public health strategies and interventions.
- Though a much smaller proportion of women engaged in card games or poker than men (6.4% men, 2.2% women), they engaged in ways similar to men (frequency and expenditure) associated with a similar gambling risk level.

Palmer du Preez et al. (2019) infer that women, who are commonly the primary caregivers within their family or whānau, are also particularly vulnerable to the economic strain caused by harmful gambling. The authors cite research that has shown that women's socio-cultural positioning as primary caregivers for families contributes to gambling harm by placing unrealistic expectations on women while simultaneously constraining their ability to prioritise their own well-being and access rest, relaxation, and support. Gambling venues in local communities appear to offer women respite, distraction, comfort, time-out and/or connection - while placing them at heightened risk of experiencing problems and harm.

²³ <https://kupe.hpa.org.nz/#!/gambling/gambling-harm/hls-household-level-gambling-harm>

6 Harmful gambling risks remain extensive

The majority of general population gambling research nationally and internationally recognises the importance of identifying the socio-demographic variables and risk factors associated with harmful gambling because of the major role they can play in the development and maintenance of harmful gambling behaviour.

Internationally, the risk factors for developing harmful gambling include: being male, being young, belonging to a particular ethnic group²⁴, single marital status, low educational and/or occupational status and residence in urban areas (Abbott & Volberg, 1991, 1992; Becona, 1996; Dickerson, Baron, Hong, & Cottrell, 1996; Shaffer, Hall, & Vander-Bilt, 1997; Volberg, 1996; Volberg & Abbott, 1994; Welte, Barnes, Wieczorek, Tidwell, & Parker, 2002, 2004).

6.1 Māori and Pacific peoples remain most at-risk

New Zealand's NPS's have consistently identified Māori and Pacific ethnic groups as the most at risk of developing harmful gambling. Abbott et al. (2014) and more recently, the HLS (2018) verified that Māori and Pacific peoples remain more at risk of developing problems from harmful gambling than people from New Zealand European and other ethnic groups (Abbott et al., 2014; Rendall et al., 2019) and are likely to be affected by other harmful gambling risk factors such as low socioeconomic status (Marcolin & Abraham, 2006) and deprivation (Tu et al., 2014).

6.2 Risk factors can be categorised into individual and environmental factors

Since 2018, evidence has validated the consistency of gambling harm risk factors. Recent evidence categorises risk factors as either individual or environmental. Examples of individual risk factors include Māori or Pacific ethnicity, male gender, younger age, low income, unemployment, substance use, gambling frequently, and never married status (Bellringer et al., 2020). Prior research identified environmental risk factors, including larger household size, living close to gambling venues, and recently experiencing major life events (Abbott et al., 2018; Bellringer et al., 2020).

Bellringer et al. 2020 also identified that:

- *Transitioning* into risky gambling behaviour was more likely to be associated with continuous tobacco smoking, cannabis use and low quality of life
- *Transitioning* into risky gambling was more likely to be associated with stopping memberships of organised groups

²⁴ Research has shown that ethnicity remains a significant risk factor when other factors (such as socio-economic deprivation, gender and age) are controlled for (Welte et al, 2004; Ministry of Health 2006).

- Gambling risk level transitions were not associated with other social connectedness factors such as being able to access help from family, friends or neighbours, liking living in the community, and the quality of services available in the community.

6.3 There are mixed views about the association between gambling and mental and physical health

There is growing national and international evidence suggesting that there is a huge potential that the increase in online gambling participation is likely to increase gambling harm behaviours, including increased mental health, anxiety and depression (Abbott et al., 2019).

In contrast with the majority of literature on this topic, it is important to note recent evidence provided (Bellringer et al., 2020) suggests that mental health (e.g. anxiety, depression, past trauma) and physical health (e.g. disability, obesity) were not associated with the transition levels of gambling risk.

7 Harmful gambling impacts

7.1 Much evidence infers that supporting one social problem through the support/creation of another is not real progress for our society

Many international and national gambling studies have consistently identified both costs and benefits associated with gambling behaviour and expenditure.

7.1.1 On one side of the coin, gambling can be viewed positively

On one side of the coin, evidence has consistently identified that gambling can be viewed positively as a form of fun, socialising, relaxation, entertainment, and provide a reprieve from stress and worry (Abbott, 2001b; Berl, 2019; Morrison, 2004; Perese & Faleafa, 2000; Productivity Commission, 1999; Wong & Tse, 2003). Gambling contributes to economic development and employment, and gambling proceeds are used as funding sources for community and sports groups. In 2019, the Class 4 sector returned about \$241 million to 13,000 community groups in the form of grants funding (in addition to tax and duty payments to the government) (see Appendix 2) (PGF Group et al., 2020).

7.1.2 On the other side of the coin, there are extensive social costs and harms

On the other side of the coin, a plethora of evidence has consistently identified there are extensive social costs and gambling-related harms that impact individuals, families and communities (Centre for Social and Health Outcomes Research and Evaluation & Te Ropu Whariki, 2008; Guttenbeil-Po'uhila et al., 2004; Abbott et al., 2000; Perese & Faleafa 2000; PGF Group et al., 2020; Rankine & Haigh, 2003).

Findings from the New Zealand Institute of Economic Research (NZIER) (2020) on the retail and employment tax costs of Class 4 gambling in New Zealand contradicted findings above that gambling increases economic development and employment. NZIER (2020) contend that:

- The cost to retail industry sales of Class 4 gambling is estimated to be \$445 million for 2018/19.
- The increased retail sales would generate an additional 1,127 full-time equivalent jobs for 1,724 workers, worth approximately \$50 million in wages and salaries.
- These additional jobs and workers would be concentrated in the food and beverage services, specialised food retailing, and supermarkets and grocery stores.
- The additional GST revenue expected is estimated to be \$58.01 million, with the biggest shares coming from sales in the motor vehicle and parts retail sector (consistent with transport being a major expenditure category for households) and supermarkets and grocery stores.
- Income tax collected from additional retail sector workers is expected to be between \$7 million and \$7.6 million. The greatest contributor to this amount is expected to be the food and beverage sales industry, followed by specialised food retailing and supermarket and grocery store workers.

In 2020, the PGF Group, Hāpai Te Hauora and The Salvation Army validated early evidence identifying that:

- Up to two-thirds of the money paid out in community grants comes from the money problem gamblers have spent and lost on gambling. The NGS reiterates extensive expenditure from problem and moderate risk-gamblers on Class 4 EGMs and highlights that problem gamblers' self-reporting of EGM expenditure is likely lower than actual expenditure. The NGS self-reported EGM expenditure estimates for Class 4 gambling were \$296m in 2012, \$193m in 2013, and \$157m in 2014; the actual expenditure recorded by the DIA was \$854m, \$826m, and \$808m, respectively.
- Only 1.3% of New Zealanders regularly use Class 4 EGMs, and 50% of the 15,476 machines (7,700) are in the most deprived communities (decile 8-10)²⁵ (Ward et al., 2020)
- Community groups and services and sports funding recipients have become dependent on the grants system for survival.
- The grants paid out by Trusts and Societies to community groups and services, and sports funding recipients come from New Zealanders who can least afford it.

Importantly, the overall distribution of funds has shifted away from local communities. While Class 4 gambling provides more local community funding, it also comes with the highest risk of harm from problem gambling than other forms of gambling (Department of Internal Affairs, 2016a).

In line with these views, it is important to note a BERL report (2020) showing an inequitable distribution of community grants back into the most deprived communities where the majority of Class 4 venues are located and EGM expenditure is high (NZIER, 2020).

²⁵ Using NZDEP2013 Index of Deprivation. Sourced from: <https://www.health.govt.nz/publication/nzdep2013-index-deprivation>

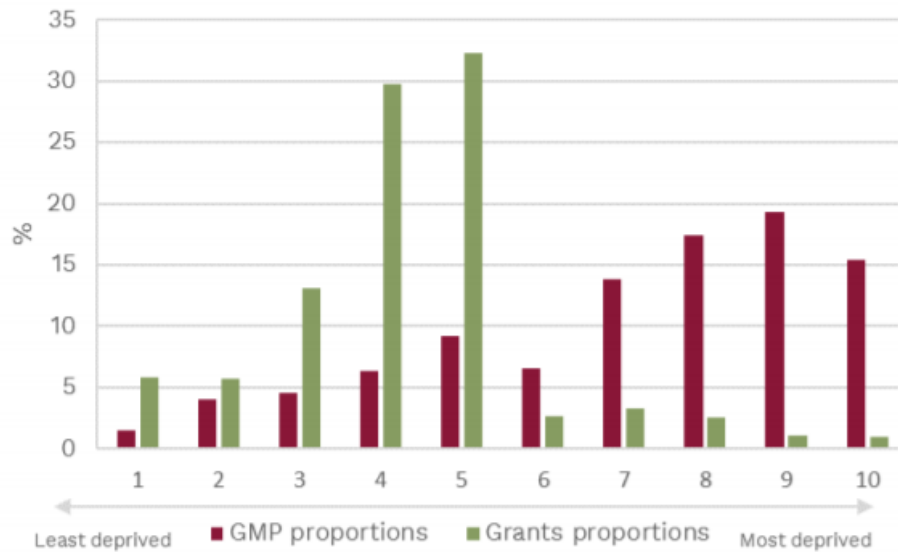


Figure 9: Origin of Gaming Machine Profit and destination of community and sports grants by deprivation.

The PGF Group, Hāpai Te Hauora and the Salvation Army (2020) argue that replacing the grants system with a government grants programme would ensure sustainable delivery of community and sports services and the equitable and transparent distribution of funds.

7.2 Harmful gambling impacts all aspects of wellbeing for individuals and their whānau

The consequences of harmful gambling behaviour experienced by gamblers and their family and friends are far-reaching. For example, numerous studies have identified negative impacts on finances, mental health and wellbeing, physical health, work or study performance, relationships with others, increased crime, and potential suicidality (Bellringer et al., 2019).

7.2.1 Māori and Pacific peoples and their whānau remain disproportionately negatively impacted by gambling-related harms

It is important to note that evidence has consistently identified that one problem gambler can affect at least five to ten others (Productivity Commission, 1999; Goodwin et al., 2017). Perese (2009) contends these estimates are conservative in light of many Māori and Pacific communities' collective nature and the negative profile of harmful gambling within these communities.

Historically, extensive evidence has shown that Māori and Pacific problem gamblers and their family/whānau/aiga are exposed to numerous social, cultural and economic gambling-related harms at an individual, family and community level. For individuals, these include depression, anxiety, suicidal ideation, loss of identity, ill health, stress and mental health problems, erosion of savings, debt, and eviction or housing mortgagee sales. Familial impacts include neglecting children, relationship break-ups, family violence, anger, arguments, frustration, resentment, loss of trust and severed familial relationships. Community impacts encompass crime, health system costs, impacts on friends, employers, work colleagues and cultural community connectedness, participation and sense of belonging (Centre for Social and Health Outcomes Research and Evaluation & Te Ropu

Whariki, 2008; Department of Internal Affairs, 2001; Dyll, 2009; Guttenbeil-Po'uhila et al., 2004; Morrison, 2004; Rankine & Haigh, 2003).

8 Gambling harm minimisation approaches

Gambling harm minimisation approaches in Aotearoa, New Zealand include:

- **Public health services:** Primary prevention, workforce development, awareness and education programmes, National co-ordination service, consumer network and conference support. It specifically promotes healthy gambling policies and environments, raising awareness of the signs of gambling harm and counselling services, and mobilising and supporting community action and resiliency.
- **Intervention services:** Helpline and web-based services, psychosocial intervention counselling and support.

Workforce survey respondents identified a range of public health and/or interventions services they provided within Ministry funded gambling harm services.

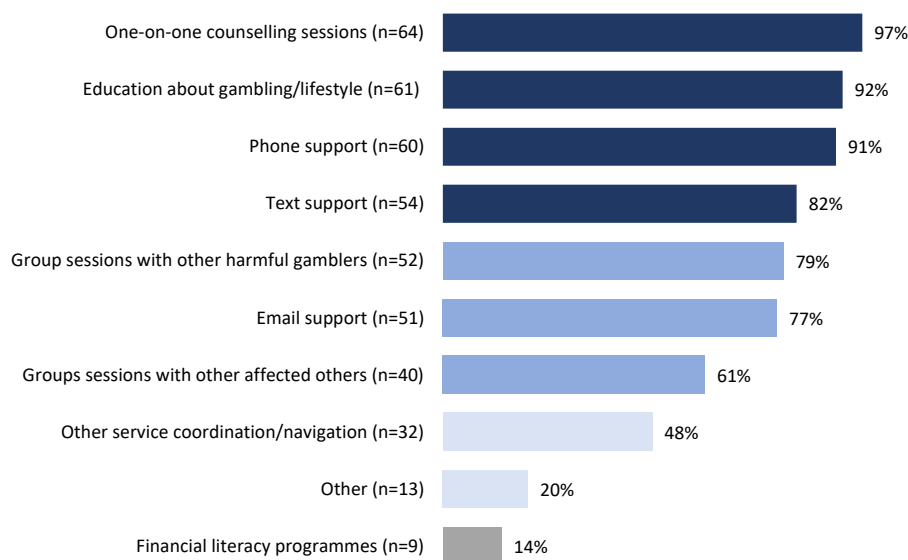


Figure 10: Types of support provided (n=66)

Under the Gambling Act, Class 4 venues also have a legal duty to minimise gambling harm and responsibilities to keep gamblers safe. Harm minimisation approaches include:

- Problem gambling awareness training for venue managers and staff
- Signage for pubs, clubs and casinos
- Self-exclusion orders (including Multi-venue exclusion).

Casino Licence conditions require Host responsibility programmes (including the provision and display of adequate gambling harm minimisation information and signage, a policy for identifying harmful gamblers, staff training, adequate support for staff with potential harmful gambling, tailored provision of support and information for different cultural groups, responsible marketing and advertising, a gambling environment conducive to minimising and identifying gambling harm, and liaison with harmful gambling provider services). Casino's are also required to comply with exclusions in a similar way to Class 4 venues.

TAB NZ are legally required to provide and display information about harmful gambling (encouraging players to gamble only at levels they can afford, and advice about how to seek assistance for harmful gambling), as well as harmful gambling awareness training for all employees.

The unique COVID-19 situation in 2020 prompted a different harm reduction response from some parts of the gambling industry. Lotto NZ added information on their website about responsible gambling and where to get help. New and existing MyLotto players received emails with information about harm minimisation, such as lowering online spending limits and blocking themselves from games, and Lotto NZ established a new Lottery COVID-19 Wellbeing fund worth \$40 million to support community and social initiatives that lost access to funding.

8.1 The profile of clients accessing intervention services remains relatively unchanged

The numbers of clients who have received treatment services for harmful gambling recorded by the Ministry of Health intervention data between July 2019 and June 2020 (Ministry of Health, 2021) included:

- The total number of clients for all interventions was 9,502 (including 2,875 existing clients²⁶ and 6,627 new clients) – a decrease of 10.4% (-1,100 clients) compared with the previous year.
- The total number of clients excluding brief interventions was 4,439 (including 2,487 existing clients and 1,952 new clients) – a decrease of 8.6% (-417 clients) compared with the previous year.
- The proportion of clients receiving support (all interventions) for their gambling behaviour (58.4%) was slightly higher than those identifying as family/affected others (41.6%).
- The highest proportion of clients receiving support (all interventions) identified as Other²⁷ (38.2% - n=3,627) followed by Māori (32.0%, n=3,041), Pacific (20.0%, n=1,897) and Asian (9.9%, n=937).
- The highest proportion of clients receiving support excluding brief interventions identified as Other (45.6%, n=2,023), followed by Māori (25.3%, n=1,125), Pacific (19.8%, n=881) and Asian (9.2% n=410).

8.2 Class 4 EGMs remain the most common primary gambling mode for clients accessing intervention services

In 2019/20, the primary gambling mode for more than half of all clients accessing intervention services (52%) was Class 4 EGMs, followed by Lotto NZ products (10.6%), Casino EGM and NZ Racing

²⁶ Existing clients are those who have accessed a service in a previous year.

²⁷ Other includes New Zealand European and ethnic groups otherwise not stated.

Board (9.6% and 9.5%, respectively), Casino EGM (7.7%), Other (7%), Housie (2.3%) and Cards (1.4%) (Ministry of health, 2021).

Table 4: Intervention clients assisted by primary problem gambling mode – 2019/20

Gambling mode		Client type	Total ²⁸
Non-Casino EGMs	Full and F/U ²⁹	Affected other	416
		Gambler	1682
	All clients ³⁰		4945
Casino EGMs	Full and F/U	Affected other	86
		Gambler	327
	All clients		735
Casino Table	Full and F/U	Affected other	80
		Gambler	405
	All clients		909
Lotteries commission products	Full and F/U	Affected other	162
		Gambler	346
	All clients		1003
TAB NZ	Full and F/U	Affected other	81
		Gambler	325
	All clients		900
Cards	Full and F/U	Affected other	8
		Gambler	47
	All clients		134
Housie	Full and F/U	Affected other	48
		Gambler	37
	All clients		218
Other	Full and F/U	Affected other	88
		Gambler	302
	All clients		659
Total	Full and F/U	Affected other	969
		Gambler	3470
	All clients		9502

²⁸ Including existing and new clients.

²⁹ Follow-up.

³⁰ Including brief intervention clients.

8.3 Use of the Gambling Helpline has decreased

Homecare Medical is a social enterprise organisation with 21 years of experience providing virtual healthcare. Since November 2015, they have been contracted by the Ministry of Health to provide the National Telehealth Service (NTS)³¹, which includes the Gambling Helpline³². The NTS also includes Healthline, the national mental health and addictions helpline 1737 Need to talk?, Quitline and other specialist services, delivered across many different channels – inbound phone calls, text/SMS, apps, website, email, webchat and Facebook.

Between 2017 and 2019, the Ministry of Health commissioned the Sapere Research Group and Litmus (2020) to evaluate the NTS using a three-phase approach. Phase three of the evaluation, undertaken between June 2018 and October 2019, focused specifically on mental health and addiction services, including the Gambling Helpline. The evaluation showed that in 2018-19, although contacts to the NTS mental health and addiction services increased, the number of contacts to the Gambling Helpline dropped by around 1800. Users of the Gambling Helpline also decreased by 30% and fell from 4806 users in 2017 to 3328 in 2019..

The NGS qualitative phase report (Bellringer et al., 2019) offers some insight into why the Gambling Helpline users are decreasing. The report identified mixed reactions among respondents about the Gambling Helpline's usefulness. Some clients felt supported and noted having someone to talk to (in-person or over the phone) before they embarked on a gambling session would help them stop. Others felt they did not receive the help they needed to control their gambling. For example, repeated calls resulted in the same information being given and on one occasion, a survey respondent was directed to a counsellor who became unavailable.

8.4 Multi-venue exclusion is effective and the process has been strengthened

Internationally, self-exclusion has been identified as an effective tool in the treatment of harmful gambling (Bellringer et al 2010; Gainsbury 2013; Hing et al 2015). Since 2003, the Gambling Act has allowed a person in New Zealand to self-exclude from a gambling venue. This means that once the exclusion process is initiated, it is an offence for a gambler to enter the gambling area of a venue from where they are excluded, and for a venue operator to allow an excluded gambler to enter their gambling area.

Multi-venue exclusion (MVE) is an extension to single venue self-exclusion and was introduced as an intervention tool in New Zealand in 2011. It enables people experiencing harm from gambling to self-exclude from multiple venues without visiting each individual site. Over the last 10 years MVE has evolved and extended to reach every region in New Zealand.

In 2015 a working group, including representatives from the Ministry, DIA, gambling harm service providers and the gambling industry, was formed to review MVE practices in New Zealand. The

³¹ <https://www.health.govt.nz/our-work/national-telehealth-service>

³² The Gambling Helpline consists of the general number and four specialist lines (Māori, Pacific, Debt, and Youth Gambling Helplines) (Sapere Research Group & Litmus, 2020).

resulting report (Department of Internal Affairs, 2016b) identified several potential areas for improvement and prioritised the need for national MVE administration, standards and consistency, and the development of a database to capture all MVE data.

In 2018 the Ministry contracted The Salvation Army (TSA) to establish the National Administration Service to oversee and administer the nationwide operation of the MVE process. The service employs a dedicated National MVE Administrator.

An early formative and process evaluation led by the Ministry during 2018 and 2019 demonstrated that the service had successfully:

- Established effective working relationships and communication channels with all MVE stakeholders (including Class 4 gambling societies, venues and Ministry-funded gambling harm provider services, and the DIA)
- Developed a national MVE Framework with consistent processes, standards, forms and templates for MVE stakeholders
- Brought all gambling harm service providers under the new MVE framework
- Identified issues and implemented improvements and quality control to MVE processes, efficiencies, data collection and quality
- Conducted training sessions for services providers and DIA staff
- Extended MVE to regions where the MVE process was previously not available.

A study by Malatest International (2018), which explored the effectiveness of different multi-venue exclusion (MVE) systems for excluded gamblers in the Hawke's Bay region, also identified that:

- Gaps in understanding harmful gambling as a complex mental health issue throughout Māori communities inhibits the ability of whaiora/clients to seek help for their gambling.
- There is a need for information about MVE and how to sign up for exclusion from gaming venues to be more widely disseminated.
- MVE registration and commitment was most effective when undertaken alongside culturally appropriate intervention services, and there was ongoing, face-to-face interaction between harmful gambling provider staff and venue staff.

In 2019 the Ministry commissioned Torutek Limited to supply and trial CONCERN, a cloud-based database with a web portal, that electronically manages the exclusion process and serves as a central repository of all gambling exclusions. The database went live in July 2020. The TSA National Administration Service is responsible for processing MVEs, entering data on the database and provides training to Class 4 stakeholders.

8.5 Enablers and barriers to seeking help have not changed – understanding barriers is important

Effective intervention and counselling services include counsellors who provide helpful gambling management strategies, opportunities to build a trusting relationship and engage in objective and empathetic discussions. A lack of understanding about gambling was considered detrimental to positive progression and gambling harm minimisation (Bellringer et al., 2019).

Understanding the barriers to seeking help is an important step towards facilitating early access to services. Recent studies have explored barriers to seeking help from the Gambling Helpline and gambling intervention services more generally and identified a number of systemic and cultural barriers, which remain consistent with early research and evidence (Bellringer et al., 2008; Suurvali et al., 2009; Pulford et al., 2009). For example:

- **Systemic barriers** include a lack of awareness of appropriate services, inability to find a convenient time for an appointment, being sceptical of the number of gamblers who utilise professional services and repeated calls to the gambling helpline resulting in the provision of the same information (Bellringer et al., 2019; Sapere Research Group & Litmus, 2020).

In addition, stakeholders of the NTS MHA services evaluation identified several concerns specific to the Gambling Helpline and Quitline. The concerns centred around low referrals numbers to face-to-face providers, the Gambling Helpline marketing, and call-takers' cultural competency, particularly for Asian and Pacific callers (Sapere Research Group & Litmus, 2020).

- **Personal barriers** include denial of a problem, pride, shyness, and shame about their gambling behaviour (Bellringer et al., 2019).
- **Cultural barriers**, for example, language barriers and, for some cultures, the principle of not seeking help from outsiders (e.g. Asian NGS participants noted they were more likely to seek help from family or close friends to save face and avoid stigmatisation). Bellringer et al. (2019) argued the need for increased awareness-raising about culturally appropriate services and assurance of confidentiality to remove cultural barriers to accessing treatment services.

8.6 Gaps in gambling harm provider services remain

Recent evidence has identified gaps that exist within aspects of gambling harm provider services which the Ministry committed funding to addressing under the current Strategy 2019/20-2021/22:

- **Peer support workers:** Intervention gambling harm provider services are currently delivered by qualified counsellors and practitioners. Te Pou (2020) conducted a study to explore gambling harm provider services and peer workers' views on the need and potential for peer worker roles across intervention services. Peers and providers that participated in the study were commonly supportive of establishing peer support worker positions to better meet the Objectives of the Strategy to Prevent and Minimise gambling harm. New peer support worker roles to support clients, facilitate access and follow-up support were considered necessary and complementary to harmful gambling treatment pathways and outcomes. However, there was disagreement about what responsibilities new peer support workers would hold and how they would carry them out (Te Pou, 2020). The key impediments to developing peer worker roles included a lack of funding, contracting processes and service specifications (Te Pou, 2020).

- **Residential treatment:** Previous studies have established that gamblers referred to residential treatment services are more likely to have greater gambling severity, greater mental health and psychosocial needs (Ledgerwood & Arfken, 2017; Ledgerwood et al., 2020). However, it is important to recognise that clients in residential services are not homogeneous and may include those with mild to moderate problems and a range of co-existing mental health conditions which require different supports and resources (Sharman et al., 2019).

Other research has shown that residential treatment is shown to provide promising and complementary treatment for comorbid conditions (such as harmful gambling, sex addiction, compulsive buying and stealing, internet gaming disorder, alcohol and cigarette addiction) (Chan et al., 2018; Re et al., 2019). However, it is important to note:

- The need for a broad approach (assessment and intervention) is necessary because a focus on symptoms results in high relapse. (Chan et al., 2018; Re et al., 2019).
- One study identified a high proportion of clients did not complete their residential treatment for harmful gambling. Significant predictors of treatment dropout included older age of the client, higher levels of education, higher levels of debt, online gambling, gambling on poker, shorter duration of treatment, higher depression, the experience of previous treatment programmes and medication, and adverse childhood experiences. It is critical that residential clinicians are aware of comorbidities and co-existing conditions and work to retain those at risk of non-completion (Roberts et al., 2020).

9 Progress against Objectives in the Strategy

Participants generally considered that limited progress had been made across most Objectives set out in the current Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22³³.

Participants' views on progress were commonly described in relation to perceived service gaps and risks specific to policy, outcomes, participation, practice and research.

It is important to note at this point that the response to COVID-19 has resulted in a delay to the implementation of the current strategy. This includes commitments that address a number of the themes raised by participants in the Needs Assessment. Notably:

- New service and innovation pilots, including pilots to address inequities, a peer workforce pilot, residential pilot and Technology Innovation Fund
- The cancellation of the bi-annual International Gambling Conference think tank planned for 2020 and reductions in opportunities for face-to-face sector engagement
- Delays to Te Hīringa Hauora's delivery of education and awareness campaigns to prevent and minimise gambling harm
- Delays to the research and evaluation programme for both the delivery of some funded projects and planned procurements.

Two overarching themes noted by all interviewed stakeholders as pertinent to the gambling sector were a need to establish stronger partnerships and leadership through improved communication, consultation and engagement between the Ministry, gambling harm service providers, industry and researchers.

Partnership:

Communication is one of the biggest things that's been missing... (Gambling harm service provider 6)

Developing and maintaining genuine and mutually respectful partnerships and relationships and strong communication between the Ministry and gambling harm service providers were noted as critical by many interviewed participants.

A real lack of consultation with specialist gambling services from the Ministry. I think [the gambling harm service providers are] very disconnected and fragmented... We're supposed to be the experts or the specialists, yet we're the last ones to be told or notified or discussed [with about] anything. Co-designed? We're not even engaged with. (Gambling harm service provider 6)

One gambling industry group described a commitment and value placed on building good working relationships with gambling sector stakeholders – this was exemplified in the establishment of an advisory group to inform strategic thinking and planning for minimising gambling harm.

³³ Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22
<https://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2019-20-2021-22>

Relationships always need work and can always be better...For us, it's something that we do put quite a lot of time and energy into...(Gambling industry 5)

A year ago, we set up a voluntary stakeholder engagement panel to provide an objective sounding board on responsible gaming...they're sitting at the frontline, or in research or they're having to deal with customers on the shop floor...Certainly open to considering lived experience representation, whether it's on the advisory panel or it's a separate thing...anything that can support [gambling harm minimisation] (Gambling industry 5)

However, all others interviewed noted a need for more communication, closer relationships and identification of shared and common goals across all stakeholders in the gambling sector. Some gambling industry representatives also highlighted a need for gambling harm service provider transparency and communication relating to client follow-up and closing the loop for those referred to intervention services through host responsibilities. It is important to that significant privacy implications and breaches would result from such activity.

There has not been any consultation with the Class 4 sector regarding the nature of the treatment services being provided. By way of example – what, if any, counselling is provided, and for what period. Class 4 venue operators repeatedly report frustrations with relapsing patrons supposedly receiving treatment exclusion orders. (Gambling industry 7)

Leadership: Across the sector, many interviewed participants highlighted the need for effective leadership to improve the co-ordination of the gambling sector and strengthen internal communication and collaboration.

There's been no leadership...There was a time that there was a hell of a lot of leadership within the sector itself. That's all gone...It's not as powerful as it used to be...(Gambling harm service provider 6).

Some participants suggested re-establishing and re-igniting the harmful gambling Think Tank and International conference to improve communications, strategic and co-ordinated thinking/planning and action. It is important to note that COVID-19 lockdowns led to the postponement of the biennial 2020 International conference until June 2022. Effective interventions and public health approaches were noted as being informed by all stakeholders and those with lived experience – the Think Tank was described as providing a forum and opportunity for shared and collective collaboration. It is important the Think Tank provides opportunities for robust discussion, critique, debate and knowledge creation for all participants.

9.1 Objective 4 – focus on policy

Objective 4: Health policy at the national, regional and local level prevents and minimises gambling harm.

9.1.1 What does the evidence tell us?

Under the Gambling Act, the Ministry is required to undertake a Needs Assessment to inform the development of the three-year Strategy to Prevent and Minimise Gambling Harm. The Strategy sets out the Ministry's approach and the range of activities it plans to undertake to minimise gambling harm for a three-year period.

The Ministry is committed to a long-term approach that has not significantly changed from the approach outlined in its first six-year strategic plan in 2005. The overall goal is:

Government, the gambling sector, communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities. (Ministry of Health, 2019)

The Ministry receives funding through Vote Health to develop and implement the strategy. The Crown then recovers the cost of this appropriation through a 'problem gambling levy' paid by the main gambling operators. The levy rates are set by regulation at least every three years. The Gambling Act sets out the process for developing and setting the levy rates needed to recover the cost of the strategy (refer to sections 318–320 of the Act).

9.1.2 Progress against Objective 4

Many interviewed gambling harm service providers and lived experience representatives perceived that little progress had been made against Objective 4. Just under one-half of workforce survey respondents said little to no progress had been made, one-third remained neutral in their views, and only 17% said progress had been made³⁴.

9.1.3 Strengthening progress against Objective 4

Policies: Gambling harm service provider, industry and agency representatives highlighted several gaps and risks relating to:

- **Unclear problem definition:** Participants described reactive rather than proactive policies and strategies.

For problem gambling strategies to work, there has to be a better understanding of the problem. MoH assesses the success of its strategy every three years and has repeatedly implemented the same strategy and, in doing so, achieved the same result. This

³⁴ See appendix 3.

approach suggests that there is little or no understanding of the problem and related co-morbidities. (Gambling industry 1)

- **Policy gaps:** Inadequate policies and regulation addressing offshore online gambling and gaming.

Gambling industry representatives considered a *race-based* Strategy to Prevent and Minimise Gambling harm as inequitable for Māori, Pacific and Asian peoples. This view contradicted gambling service, agency and lived experience representatives perspectives on the need to ensure the Strategy sits under an equity framework (see section 9.2.3)

A race-based harm minimisation strategy is inequitable and is patronising to the very groups that it claims to help. Gambling is a legal activity, and all New Zealanders should be able to enjoy the freedom to choose whether or not to gamble. Trying to restrict a specific population group's ability to access a legal form of recreation is unacceptable. (Gambling industry 1)

We are going to be asked to all be made accountable for stigmatising a particular group. (Gambling industry 4)

Mental health and addiction and the gambling levy: There were mixed views about the funding of gambling harm service providers and the gambling levy. Gambling industry representatives saw the levy as beneficial to service providers, researchers and communities – and noted a lack of independent monitoring of gambling harm service providers.

There is a lack of transparency or independent monitoring of the provision of treatment services. (Gambling industry 1)

Gambling harm service provider and agency representatives noted a strong dependence on the gambling levy within the gambling sector. While the levy was commonly valued, some gambling agency representatives noted a potential conflict of interest for the gambling industry between gambling harm minimisation approaches and research, due to their contributions to the primary funding source. Others also noted that gambling harm was siloed and isolated from wider mental health and addictions services, strategies and funding – which in part was considered an impact of receiving earmarked levy funds.

I think people just have that notion that a gambling harm service is funded by the levy [and] siloed...That can be quite damaging. And usually, we get pushed aside. (Lived experience representative)

Provider contracting: Gambling harm service provider, industry and agency representatives highlighted several gaps and risks relating to:

- **Short-term gambling harm service provider contracts:** Short-term and annual contracts for services were an ongoing challenge that threatened a specialised workforce's retention, sustainability, and capacity and set up a competitive funding environment. Some understood that delays from the Ministry in setting up and confirming longer-term contracts may have been impacted by legal challenges experienced several years ago, but considered it was time this was addressed.

Uncertainty around contracts being renewed to continue to be able to provide support to those affected by gambling. (Gambling harm service provider 7)

- **Separate contracts for public health and intervention:** Some gambling harm service provider representatives considered the separation of contracting for public health and intervention FTEs inadequate. Clinical and public health outcomes and the skills for those working in the sector were described as being interrelated, complementary, and necessary to ensure integrated service provision and seamless transitions for clients.

Clinical outcomes have to be incorporated in our public health activities...dual roles for all staff... if the Strategy is about prevention and clinical intervention, and making sure [services are] equitable and culturally appropriate... [then] services should have prevention and clinical intervention as a seamless [transition] (Gambling harm service provider 3)

- **Contract scope:** Current contracts were perceived as providing limited opportunity and scope for innovation and/or extended service provision based on clients' needs.

A lot of our services are still very much kind of designed and offered to the person who's got the gambling problem...Service managers want to develop their practice in this area and expand out to make these services more appropriate and oriented to families, but feel they kind of haven't had the opportunity to do that, or the funding to do that, or the support to do that...We know that when services don't engage appropriately with whānau they are not as successful with Māori populations and with other groups as well. (Gambling agency 2)

- **Western contracting models:** Gambling harm service and agency representatives noted that Western contracting and service specifications for ethnic-specific provider services were a barrier to delivering culturally responsive, significant and meaningful interventions that resonated with their clients' needs (e.g., contracts with a focus on individuals rather than whānau and limited opportunities for culturally significant engagement and practices).

We've got the ethnic-specific services, but I think they're constrained in the way they operate and cannot necessarily operate in the culturally appropriate way for whatever ethnicity or population they're trying to help. Because it's still a Western model, it's still that same funding model. They have to report on individual clients, etc., etc. So although it might be a Māori service, or a Pacific service or an Asian service that's trying to operate in a culturally appropriate way for that service and the clients, they still have to work within a Western model at some level. And I think that's very constraining. (Gambling agency 2)

If we were able as Māori to practice as Māori and do those things that we know will benefit...If we were able to do things, like the weaving...That's when the conversations start. That's when you start to let some of the stuff go that you're holding on to...It's those sorts of things that I think are the true medicine. It's making lasting connections...you have to create a support system...they all tautoko (support) each other. (Gambling harm service provider 8)

Gaming and gambling: Gambling harm agency, service provider and lived experience participants noted that gaming is not currently recognised as gambling and therefore not funded by the gambling levy. Participants suggested a need to:

- Extend services and funding from the gambling levy to encompass gaming

The gambling industry are not happy for gaming to be seen under what they see as the money that they provide. Hence services, they can't fit into their contract. Services can only fit gaming into their contracts if they can find some evidence of a family/ whānau connection with gambling. (Gambling agency 1)

- Consider legislative change under the Gambling Act to ensure gaming issues and harm are addressed

We need to change the definition under the Act for gambling because it's wagering for money. In many cases in gaming, it's wagering to win something with money, which you can immediately sell. (Gambling agency 1)

- Develop whānau/family-focused prevention strategies and plans for online gaming.

Part of our recommendations is around a prevention strategy for online gaming that includes parents as well...and also to recognise gaming addiction or gaming harm as [being] just as powerful as gambling...[for children] as young as ten years old. (Gambling harm service provider 3)

9.2 Objectives 1 and 2 – focus on outcomes

Objective 1: There is a reduction in gambling-related-harm inequities between population groups (particularly Māori, Pacific and Asian peoples, as the populations that are most vulnerable to gambling harm).

Objective 2: Māori have healthier futures through the prevention and minimisation of gambling harm.

9.2.1 What does the evidence tell us?

General population gambling participation has decreased, but harmful gambling prevalence remains unchanged. Māori, Pacific and young people continue to have the highest prevalence of harmful gambling and remain the most at risk of harmful gambling compared with other ethnic groups. Harmful gambling continues to impact all aspects of wellbeing for individuals and their whānau.

9.2.2 Progress against Objectives 1 and 2

Most interviewed participants and around half of the workforce survey respondents³⁵ considered that little to no progress had been made against both Objectives. One-third of survey respondents had neutral views and some did think progress was made against Objective 1 (13%) and Objective 2 (25%)³⁶.

I think it's still inequitable. I don't think we've smoothed it out in any sort of way. (Gambling harm agency 1)

Nothing's changed. The inequities are still there for Māori. (Gambling harm agency 2)

Some participants' views about limited progress were strongly influenced by evidence highlighting continuously high prevalence rates for harmful gambling among Māori and Pacific populations. Others also associated limited progress with high and inequitable relapse rates and suggested that more research was needed to understand clients who relapsed. It is important to note that the Ministry have committed research funds to examine this in the Strategy.

Recidivism/relapse rate amongst problem gamblers — approximately 66% of problem gamblers relapse and breach exclusion orders. (Gambling industry 1)

One of the reasons why the prevalence of harmful gambling behaviours have not changed in the last 15 to 20 years, even though fewer people are gambling, is because you're getting so many people relapsing. We don't understand what we can do to reduce it... (Gambling harm agency 2)

9.2.3 Strengthening progress against Objectives 1 and 2

Interviewed participants from all gambling stakeholder groups commonly noted that advancing progress against Objectives 1 and 2 required effective and efficient policy, practice and evidence, a strong equity lens and framework and increased participation of Māori in leadership.

It's an illusion to think that Māori have healthier futures whatsoever, at all. The way things are structured currently within their government and within our own city councils, or their own communities. We don't ever get any ownership of anything...That is an illusion to say that we are going to have healthier futures through the prevention and minimisation of gambling harm. (Gambling harm service provider 8)

I think that there really needs to [be] more Iwi representation into the development of what those expected outcomes are for Māori...Is there anything that industry can do that can help prevent those issues from arising among their communities? (Gambling industry 4)

Gambling harm service provider, agency and lived experience representatives highlighted a critical need to ensure the Strategy 2022/23-2024/25 sits under an overarching equity framework that prioritises:

³⁵ See appendix 3.

³⁶ See appendix 3.

- Māori ownership and determination

We still don't have any say or any authority about how we should be able to meet the needs of whānau, hapu and Iwi. I think that's one of our rights as a dedicated Māori service. (Gambling harm service provider 8)

- Adherence to established equitable systems and process

If you're looking at addressing equity, you have to be able to sit at the table to address it. We're not at the table. We are still being told what to do, how to do it. (Gambling harm service provider 8)

- Meaningful engagement and relationships between the Crown (i.e. the Ministry), iwi and ethnic-specific services

They know who we are, they give us contracts..., and they tell us how to do that contract, but there is the dedicated Māori, dedicated Pacific, but still it's left for us to make that relationship. I know they're busy. (Gambling harm service provider 8)

- Inequities for Māori, Pacific and Asian gambling harm services and workforces in mainstream services are addressed.

...Our gambling contract has been the same since 20 years ago...Our FTE has remained the same... (Gambling harm service provider 1)

Christchurch [is not recognised] as a priority area...so they haven't allocated FTE down there for funding... (Gambling harm service provider 3)

9.3 Objective 3 - focus on participation

Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm.

9.3.1 What does the evidence tell us?

There is evidence of the effectiveness of community participation at a local level. Participants noted that some communities were involved in influencing positive change relating to TA policies restricting access to EGMs – even though EGMs remained inequitably distributed.

I know of some people who are making huge movements around getting gambling sites closed down and restricted around where they are putting the pokie machines. (Lived experience representative)

Up to December 2020, 37% of TAs had no restrictions on the number of venues or machines that could be established within their district, while 43% of had adopted a sinking lid policy. The evidence on policy restrictions and sinking lids is limited, and provides mixed views about the correlation between sinking lids and reduced or increased EGM expenditure (see section 3.3).

9.3.2 Progress against Objective 3

The Ministry recently established a lived experience group. Their role is to provide consumer perspectives in strategic thinking, development and planning. This was considered a positive step toward making progress against Objective 3.

Involvement of the consumer in all areas of decision making [is needed]. I'm feeling really pleased about issues that are already happening. Things like this group's involvement with the [Te Hiringa Hauora] with the mental health and well being and with this group here have all been signs of the progress that has been made in the area of the consumers' involvement in gambling. (Lived experience representative)

However, some participants also highlighted that there was still much to do to include community voices in strategies and actions to reduce gambling harm. Just under one-half of workforce survey respondents said little to no progress had been made against Objective 3, one-third remained neutral in their views and only 17% said progress had been made.

We set up these services with our experts and our psychologists and sometimes our policy people. But we're not engaging communities and service users...You actually need to take it that step further and work with the people who are involved in the service provision to see if it's actually going to fly or not. (Gambling harm agency 2)

Most interviewed participants were appreciative of the opportunity to contribute to the Gambling Harm Needs Assessment 2021. Many also saw this as a positive shift in the Ministry's engagement with the sector since this was the first time they had been approached (and not had to request inclusion) to inform the Needs Assessment. It is important to note that a selection of gambling stakeholder groups participated in previous Needs Assessments and the Ministry engages in wide public consultation on the draft Strategy (informed by the Needs Assessment) prior to finalising the Strategy.

Last time around...we were going, "Are they going to actually talk to the service providers because that wasn't going to happen"...So thank you for the opportunity. (Gambling harm service provider 6)

Researchers haven't been involved in the Needs Assessment for the last few (years)...Researchers use[d] to be consulted separately. (Gambling harm agency 2)

The Class 4 gaming societies have not previously been approached to contribute to the MoH strategy for Harm Minimisation. We express our gratitude at being offered an opportunity to do so. (Gambling industry 1)

Although the latter quote from gambling industry representatives refers to a lack of consultation on the Strategy, it is important to note that under the Gambling Act s318(1)(h), Class 4 societies are always notified and approached in the Strategy consultation process. It is therefore assumed that this quote is in reference to the Needs Assessment process.

9.3.3 Strengthening progress against Objective 3

Broadening lived experience representation and input: Effective interventions and public health approaches were noted as being informed by all stakeholders including those with lived experience.

Promoting the value of lived experience perspectives across governance, gambling harm service providers, practice, research was noted as critical to strengthening progress against Objective 3.

Developing policies/practices that enable and empower local participation: Some participants talked about the effectiveness of community action groups (previously established and supported by the Problem Gambling Foundation) on sinking lid policies adopted by some TAs.

9.4 Objective 6 – focus on practice (workforce capacity and capability)

Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm.

9.4.1 What does the evidence tell us?

The Ministry currently funds a total of 22 gambling harm public health and intervention services across Aotearoa New Zealand. The three largest organisations provide national service coverage (one of these providers also houses two ethnic-specific services). Funded services include 11 Māori providers, five Pacific providers and one Asian provider.

Gambling harm service provider and lived experience representatives noted limited workforce capacity, particularly for the Asian gambling harm workforce and in remote rural regions. Gambling industry representatives also noted a lack of workforce capacity and access to gambling harm service providers in remote areas.

The lack of transparency, accountability, and missing treatment centres in areas of high deprivation are recurring themes. (Gambling industry 1)

9.4.2 Progress against Objective 6

Interviewed gambling harm service provider and agency representatives perceived that little progress had been made against Objective 6. However, just over one-half of workforce survey respondents said progress had been made³⁷. One-third of respondents remained neutral in their views and only 17% said little to no progress was made³⁸.

The ongoing provision of clinical training was described by interviewed participants as an example of progress made against this Objective.

I think there's almost a continual effort training counsellors and caseworkers are going on almost continually. This upskilling is something that's going on all the time. So if that's what you mean, then I think it's certainly happening. (Lived experience representative)

³⁷ See appendix 3.

³⁸ See appendix 3.

Participants also highlighted that there was a long way to go in light of limited opportunities for cultural safety training and workforce career pipelines.

It is a challenge that we have recruiting gambling specialists. It is a challenge. Certainly, in the work we do, we are lucky that we have got some of our team that has been in the gambling space for a long time, which is really good, but it can be really difficult to attract specialists in the gambling space. (Gambling harm service provider 2)

Gambling industry representatives noted the hospitality sector has made progress against this Objective and developed a national leadership training programme to complement current training provided by the Trusts and Societies. Some gambling industry representatives employed teams of people committed to gambling harm minimisation, strategy and operations.

We're here to generate funding for New Zealand communities but we can't do that if we're causing undue harm...[Harm minimisation] is absolutely critical in everything we do...Having that dedicated FTE is really important for us. (Gambling industry 5)

9.4.3 Strengthening progress against Objective 6

Gambling harm workforce capacity and reach: Gambling industry representatives highlighted the potential to improve access to services in remote areas and limited ethnic-specific workforce capacity by improving efficiencies and back-office functions across gambling harm service providers.

Service provider wise, there seems to be a lot...who are quite specific to Pacific or Māori or Asian family services? And I do sometimes question...Is that a lot of duplication of back-office services? Is that a lot of office managers? A lot of finance managers? I don't think you'll ever have enough people on the ground, actually delivering counselling or doing something to improve society....I just feel like there's an opportunity there to save some cost and put those savings back into frontline staff. (Gambling industry 3)

Interviewed gambling harm service provider and lived experience representatives noted a need for paid peer support workers, including those from different ethnic groups, who contribute to ensuring services are culturally safe. It is important to note that the Ministry have funded this in the current Strategy 2019/20 to 2021/22.

We haven't really done a lot to support the peer workforce in gambling, and I think that would be a good area to address...That is a really good process for having long term support out in the community to help people with gambling problems. (Gambling agency 1)

Also linked to what we discussed earlier about stigma and also about [ethnic-specific] society and the uniqueness of [ethnic-specific] society, because we are more of a relationship-based society, people judge each other and value each other, and also people take seriously what others see of us, as a society. That's why peer support, if you just do it in a mainstream way, it becomes a gossip source, people spread rumours, and there's no healing effect. (Gambling harm service provider 1)

Gambling harm workforce development: Gambling agency representatives highlighted the importance of ongoing training and upskilling for the gambling harm workforce. A small number of participants highlighted that there were few gambling practitioners engaging in workforce

development and upskilling opportunities through post-graduate addictions programmes offered in tertiary institutions. Others acknowledged numerous barriers to accessing training such as high workload demands and organisational outputs.

Things that they want to learn more about, like family-focused practice, they want to understand what that means and what that could be in their service and for their clients. But they feel unable to take on study...they don't have the time to fit that into their days. It's not a priority when you're fighting for contracts... (Gambling agency 2)

Alongside the need for workforce development, gambling harm service providers and agency representatives also noted the importance of recognising that specialist skills were required within the gambling harm sector, which generic addictions intervention and therapeutic approaches cannot adequately address.

Some gambling harm service provider, industry, and agency representatives noted that the inclusion of non-gambling trained counsellors in the Gambling Helpline services was likely to have contributed to decreases in utilisation (see section 8.3) and influenced a reluctance among the gambling industry to refer potential clients to the Helpline. Helpline acknowledges that more harmful gambling counsellors are needed:

We have addiction specialists, we have gambling specialists, but it's an area we need to increase in our service...It is a challenge that we have recruiting gambling specialists... (Gambling harm service provider 2)

Gambling harm workforce cultural safety: Some gambling harm service provider representatives noted limited cultural training and opportunities, alongside inadequate cultural assessment tools, frameworks and strategies.

A big gap that's missing in the gambling sector...clinical cultural competency...and training is a big gap. (Gambling harm service provider 3)

What is our [ethnic-specific] clinical cultural assessment...[and] framework...for problem gambling and for all the co-existing issues that families present [to] a service with...There's a gap that's missing at the moment in terms of delivery. (Gambling harm service provider 3)

I think the overarching Strategy for public health work isn't suited for every population...[The Strategy] has to be really reflecting on what a framework and model looks like within the [ethnic-specific] population context. It's not one thing fits all. (Gambling harm service provider 1)

Participants suggested a need for collaboration between training providers and ethnic-specific gambling services to ensure adequate cultural safety training for all gambling harm service providers.

[Clinical training provider] could just ask [ethnic-specific gambling harm providers] to do the training...They're not culturally competent to develop it [or] deliver it. (Gambling harm service provider 3)

A small number of representatives noted a need to review and condense training materials for brief assessments.

The tool was really long...I condensed it down. [Participants] don't want to sit there for 90 minutes while I [deliver training]. I might get their attention for 45 minutes. (Lived experience representative)

9.6 Objective 7 - focus on practice (enhancing wellbeing, life skills and resilience)

Objective 7: Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm.

9.6.1 What does the evidence tell us?

The costs (individual, family and community harms) associated with gambling outweigh the benefits (e.g., employment, community funding). Harmful gambling continues to impact all aspects of wellbeing for individuals and their whānau. Limited evidence³⁹ exists about the effectiveness of holistic and wellbeing focused approaches to address the social determinants and risks for harmful gambling.

9.6.2 Progress against Objective 7

Almost three-quarters of the workforce survey respondents⁴⁰ said progress had been made against Objective 7. Gambling industry and some gambling harm service provider, agency and lived experience representatives described ethnic-specific service providers and ethnic-specific teams within mainstream providers as examples of progress. Gambling industry representatives highlighted the importance of mana-enhancing practices integrated into host responsibilities training.

Yeah, they do. I think they do for the people who attend. (Gambling agency 2)

Yeah, manaakitanga is all about the mana of other people...It's not a gaming customer. It's not an alcohol customer. They are your customer. (Gambling industry 2)

9.6.3 Strengthening progress against Objective 7

Develop multi-sectoral approaches and responses: Harmful gambling was commonly noted as being virtually non-existent in mental health and wellbeing responses, approaches and funding and considered the '*poorer cousin*' to alcohol and smoking interventions and acknowledgement.

...like creating a service where people can access support for a lot of range of different issues that might be going on in their lives. And that seems to me, I mean, it seems to me the essence of the Whānau Ora approach, and yet we're not seeing that kind of translated across a lot of our gambling services or a lot of our national gaming services. (Gambling agency 2)

All interviewed gambling stakeholder groups highlighted a need to acknowledge harmful gambling as a complex issue in need of systems change and multi-sectoral responses, commitment, action and potentially funding. In line with this view, all workforce survey respondents said one of the

³⁹ Aside from the Sorted Whānau pilot conducted by Malatest International in 2016 (see Sapere Research Group, 2018)

⁴⁰ Ibid.

challenges they face in delivering services is ‘gambling not being as important as other issues the client and their whānau may have’⁴¹.

Policymaking and process by state and local and individual level development...primary health, mental health, other spaces. If they wanted to make real progress...they would need to be able to work collectively, and that's not there, and I think it's not there for a reason. It makes sure that is really pretty tokenistic. (Gambling agency 4)

Addressing the social determinants of health and wellbeing were considered critical to minimising gambling harm. This included a need to:

- **Focus on client’s holistic and cultural needs:** Participants described current harmful gambling services as focusing on the gambling behaviour rather than wider social supports and clients’ needs. Many noted a need for gambling services to provide access to a hub of services and whānau ora support.

You have to have that awareness in the first place that I need to get some help for my gambling. That can be a little bit difficult when there's a lot of other issues happening at the same time. (Gambling agency 1)

Need to be mandated better to work holistically with clients as co-existing problems need to be supported without having to "pass" clients off to another service. (Gambling harm service provider – workforce survey)

In relation to the latter quote, it is important to note the provision of holistic services would require legislative change due to the ringfenced nature of Strategy funding.

- **Mandate the need for all sectors to screen for harmful gambling**

I would like to see the Ministry of Health bringing pressure to bear on other Ministries, to screen. If they were screening prisoners, if GPs had a very simple screen to screen, not just alcohol and drugs and mental health and what have you, like the chat screen, was talking about gambling as well, I think the numbers being referred from a recognised, credible source such as a GP, would be huge. (Gambling agency 1)

- **Integrate gambling harm provider services into primary care and social service settings.**

The GP can refer someone to us, and then we can do a brief intervention...It's not necessarily picking up from the person who had gambling issue, but also family members, who are feeling anxious and knowledge and the GP don't have time to really talk about those issues...Even people in food banks, budgeting services where counsellors can go to...(Gambling harm service provider 1)

It is important to note that participants also highlighted the risk of gambling harm being minimised within a multi-sectoral response and a need to ensure that it remains the focus and priority area.

⁴¹ See appendix 3.

There is real danger of it getting lost in the unknown and in amongst the whole alcohol and drug in the mental health sector. (Gambling harm service provider 3)

9.7 Objective 10 - focus on practice (intervention services)

Objective 10: People access effective treatment and support services at the right time and place.

9.7.1 What does the evidence tell us?

There have been slight decreases since 2018 in the number of clients accessing intervention services and significant decreases in those accessing the Gambling Helpline. The enablers and barriers to help-seeking remain the same – understanding the barriers within cultural contexts remains critical. Gaps in gambling harm provider services exist in relation to residential treatment services and the peer support workforce.

9.7.2 Progress against Objective 10

Most gambling harm service provider and lived experience representatives and 44% of workforce survey respondents⁴² noted a wide range of opportunities to access services as progress against Objective 10. However, most gambling industry and some service and lived experience representatives also emphasised limited access in rural locations and/or limited ethnic-specific service provision.

Yes, they do if they know about them...I think we've got reasonably good coverage. I know there are some areas of the community that don't have the coverage, but there is always the Gambling Helpline. (Gambling agency 2)

There isn't enough help providers in more suburbs, gambling also is big with elderly see them mostly in gambling venues they need help because they're lonely. (Client survey respondent)

9.7.3 Strengthening progress against Objective 10

Strengthen service provision for:

- **Relapse and drop-out clients:** Gambling harm service provider and agency representatives noted a lack of emphasis and understanding within services to address gambling harm and related issues for clients who relapse and/or drop-out of service interventions early.

We have these people who are having problems and cycling in and out of them. And we still don't have a really good handle on it and the experience of relapse. (Gambling agency 2)

⁴² See appendix 3.

- **Whānau /families:** Gambling harm service provider and agency representatives noted that interventions mostly focused on adult harmful gamblers and affected others. A lack of services and adequate whānau/family group interventions, particularly for children affected by gambling harm, were identified as critical risks to preventing and minimising gambling harm.

I haven't seen anything about addressing the well being of children and young people. When there is gambling harm, there's family harm. (Lived experience representative)

Research showed that even though we theoretically offer these services to families actually the uptake is pretty low. And when families do contact us, it seems to be that brief one-off intervention or conversation in a community setting, and they're not really getting that kind of in-depth engagement. (Gambling agency 2)

- **Gaming and gambling:** Gambling agency, service provider and lived experience participants highlighted an increasing number of parents asking for support for young people 'addicted' to gaming. The response to this within Aotearoa New Zealand, was considered slow.

I get contacted all the time, 'Is there someone that I can get to see my children who are having real problems [with gaming]'...It's a behavioural addiction. It has all the same things as gambling. Why can't our services be seeing them and providing free service for them as well? Preventing a future [harmful] gambling cohort. (Gambling harm service provider 6)

We have a lot of family calling our service complaining about their children gaming...They have no place to go because there's no service currently addressing gaming problems, especially with young people...They became aggressive if the family turn off Wi-Fi...They became someone else...violence as well. That's not understood by a lot of people. (Gambling harm service provider 1)

- **Online self-help and intervention services:** Participants across the gambling harm stakeholder group indicated that Aotearoa New Zealand's gambling sector is not well prepared to respond to the growing prevalence of online gambling.

We're not really prepared...Trying to get information from all the research done. What's going to happen? How's it going to be rolled out? All the contracts are going to be needed to be changed around because we also have to engage in an online way and develop online digital platforms. (Gambling harm service provider 6)

Integrate responses for comorbidities and co-existing issues: Gambling harm service provider and agency representatives noted that siloed responses for clients with complex, comorbid and co-existing issues were not efficient and described the need for clients to re-share their stories with multiple providers as re-traumatising.

I think they need to stop working in silos...so [clients] can go between the two [e.g. gambling and alcohol services], [agencies/teams] can work with each other. If it wasn't so rigid, you could potentially bring in other people who have the potential or are in the [gambling] space. (Gambling harm service provider 8)

...Our gambling treatment services are funded only to treat gambling problems, gambling harms, people with gambling problems, and yet gambling problems don't exist on their own. They co-exist with mental health problems. They co-exist with substance abuse. They co-exist with all sorts of things, family violence...That person goes to see the alcohol counsellor, and they have to repeat their story all over again...You've got to go through that whole traumatic story all over again...There needs to be some way that the services work together. I understand the funding model and gambling funding [are] separate because of the levy. But there must still be a way where you can have gambling treatment services, where information is shared. (Gambling agency 2)

9.8 Objectives 5, 8 and 9 - focus on practice (public health)

Objective 5: People understand and acknowledge the range of gambling harms that affect individuals, families, whānau and communities.

Objective 8: Gambling environments are designed to prevent and minimise gambling harm.

Objective 9: Services raise awareness about the signs and range of gambling harms that affect individuals, families, whānau and communities, and how to respond.

9.8.1 What does the evidence tell us?

Much evidence infers that supporting one social problem (i.e., distributing gambling funds to community and sports groups) through the support/creation of another (harmful gambling and expenditure) is not real progress for our society. Class 4 EGMs remain the most commonly cited mode of gambling, causing harm for those seeking support (for gamblers and affected others). The enablers and barriers to help-seeking remain the same – understanding the barriers within cultural contexts remains critical.

9.8.2 Progress against Objectives 5, 8 and 9

Interviewed participants from all gambling stakeholder groups and 43% of the workforce survey respondents⁴³ commonly noted little to no progress against this Objective 5. One-quarter of survey respondents (26%) remained neutral in their views and 27% said progress had been made.

It's still seen as an individual problem. It's not seen as a community problem. People think they can just stop. So I think I don't think that's changed in the 20 odd years I've been involved. (Lived experience group)

I don't think the general public does. Awareness is raised when we have those "choice, not chance" campaigns. But how long has it been since the last one? They're so infrequent, people don't take notice and how many people sit there and watch television and watch all

⁴³ See appendix 3.

the ads when they come on? I think we need to think of better ways of getting the information out there and consistently. (Gambling agency 2)

Gambling industry representatives noted some industry operators had made progress against Objective 8 and were ‘moving in the right direction’. Different sectors/venues were noted as being at different levels of progress.

There are some people that are leading this and being at the summit, at the bottom, but in the middle, there's definitely been a move to get that a better environment. And definitely, the room is not the dungeon anymore. (Gambling industry 2)

One gambling industry representative described a strong commitment to building gambling literacy and the importance for individuals to make informed and responsible choices.

Gambling literacy in New Zealand is relatively low...what we talk about in the business is informed players make informed choices, and that we really want to make sure that everybody playing our games is informed...We're very committed to making sure that people are aware that our products are gambling and they do have the potential to cause harm...that they actually understand the odds of winning, that they know \$10 or \$50 actually their odds of winning are pretty much the same... (Gambling industry 5)

In contrast, only 12% of workforce survey respondents said progress had been made against Objective 8, and most interviewed gambling harm service provider and lived experience representatives thought little progress had been made – although a small number of services had observed small changes in some Class 4 venues.

They're definitely lighter. There are more lights. But there's still no clocks, and the advertising of the different jackpots is still also out in the main bar [which] can be triggering for recovering gamblers. (Lived experience representative)

Most gambling industry representatives also noted exclusion as an effective form of preventing and minimising harm. It was also noted that this approach was limited in effectiveness prior to the introduction of facial recognition – a tool developed by the gambling industry. It is important to note that it is not within the Ministry's mandate to fund hardware in gambling venues but they did support this progress through funding the Multi-Venue Exclusion database that enables facial recognition to be used more widely. Wider utilisation of facial recognition was noted as necessary within Class 4 gambling venues to strengthen Multi-Venue Exclusion practices.

There is currently no interaction post initial uploading of the MVE request by the administrator of the CONCERN Database - with the Venue Operators. By way of example - this means that the Venue Operator is not given updates on the physical appearance of the excluded person for a period of 23 months, which makes identification difficult without the benefit of facial recognition equipment. Facial recognition equipment has been developed by the Class 4 Sector and is funded by societies without financial contribution for MoH. (Gambling industry 1)

Facial recognition has been a huge help for us as in our toolkit...It will pick out some people's faces change so often, or they might change their hair. This has got an up to 90% strike right

that comes through your eyes, so we've had a lot of hits on that that wouldn't have probably picked up manually. (Gambling industry 2)

Some interviewed gambling harm service provider and lived experience representatives and one-third of workforce survey respondents⁴⁴ noted a little progress had been made against Objective 9. One example included public health services and promotion undertaken by gambling harm service providers at large community events. Some gambling industry representatives considered this the responsibility of gambling harm service providers and did not consider much progress had been made.

The services do a good job, and the gambling harm Awareness Week also helps. And that's the services really putting an effort into that. So I think the services, yes, from what I can see, do a good job about it...It shouldn't be up to treatment services to do all the awareness-raising around it. We've got choice, not chance, but that's fragmented, and it's hardly anything. (Gambling agency 2)

9.8.3 Strengthening progress against Objectives 5, 8 and 9

Promotion and public health messaging: Participants noted a need to review public health activities, resources and messaging to assess reach and impact on target communities (Māori, Pacific and Asian) and opportunities for advancing technologies.

I don't think we're offering online options widely...We know that people like to do things on their own, and we know in this technological world where and especially with COVID, where people are using technology, even more, I don't believe that we have the technological options available to people other than the face-to-face and the phone. (Gambling agency 2)

Effective public health and health promotion were noted as needing consistent, and informative messaging that aligns with different cultural worldviews and resonates/engages with individuals, affected others and wider whānau. Participants also highlighted a need for messaging to promote:

- Understandings among the general public about harmful gambling definitions, understandings and behaviours: Gambling harm service provider and agency representatives highlighted a general lack of understanding among the general public about behaviours that constitute harmful gambling and when additional support may be required. One-third of the workforce survey respondents said that one challenge they face in delivering services and support to clients is 'educating clients about gambling harm'⁴⁵.

I wonder sometimes whether people out there in the community really recognise what a gambling problem is. At what point is this a serious problem that needs dealing with professionally? (Gambling agency 1)

⁴⁴ Ibid.

⁴⁵ See appendix 3

[Clients said] when they were at their worst, it would never have crossed their mind that they had a gambling problem and that they would never have thought to come to a counselling service...They can see it in others, they couldn't see it in themselves. So therein lies our predicament. It's not that people are not there. They are there. They don't know. (Gambling harm service provider 6)

We need to raise baseline community awareness of gambling as an issue and how it impacts all of society, not just the "very small percentage" of problem gamblers. (Gambling harm service provider – workforce survey)

- **Collective community connections and responsibility**

It's about raising that community understanding of what problem gambling is and joining people together...Create societal impact for people to have those conversations, and we [are] still unable to have those conversations talking about gambling harm as a society. (Lived experience representative)

- **Engaging in safe conversations about wellbeing (and harmful gambling)**

People need a drop-in space. They might not have an issue right then and there, but it needs to be able to be a space where you can come in and feel safe and have a conversation. You don't necessarily need to be counselled, some people just want to have a conversation, and that conversation can lead to other spaces...It's the connections you get....That's when you unravel the mamae (hurt) that's going on (Gambling harm service provider 8)

There's still a lot of work to be done so that people feel that they can openly talk about it, you know, because the stigma isolates. A lot of people will rather hide it. (Lived experience representative)

- **Mana-enhancing and destigmatising themes**

If you look at the prevalence estimates, they change rapidly.... In DSM 4, it was 2-3%. In DSM 5, it was 0.2-0.3%...it's harder to survey and find out [the] truth from people because there's so much stigma attached to it... [Gambling sector representatives are] not certain how well [they're] doing because [they] don't know what the size of the baseline is...[There is a need to] reduce the stigma in help-seeking and in disclosing what sort of problems that people have around their gambling... (Gambling agency 1)

It's the whole culture, you know, that shame. You know, we have our services available, yet our people [are] not coming forward. (Gambling harm service provider 7)

...because we don't use the word gambling, because if you translate the word 'Gambling' from English into ethnic-specific languages, it naturally becomes stigmatising. (Gambling harm service provider 1)

- **Whānau/family intervention services**

I think we should also change awareness-raising around services because our services also are there for family and affected members. But the general population don't know that...We offer the services, but we don't make them widely available. Yes, in the sector,

we all know about it, but the general public, I don't think [they] really know about it. (Gambling agency 2)

- Community funds and gambling industry marketing.

If people know only 23 cents or 23% of [every dollar], less than a quarter of their money actually goes to community causes, maybe they wouldn't buy a Lotto ticket. Maybe they'd actually just donate money to those causes or to other fundraising. I think we've become too reliant on fundraising, gambling fundraising. I mean, the gambling environments perpetuate that because of this charitable model. (Gambling Agency 2)

Public health and health promotion capacity and capability: Interviewed participants across gambling stakeholder groups noted that the public health and health promotion outputs, resources and activities led by Te Hiringa Hauora were variable and had fluctuated over the years.

I used to see them like two years ago. I used to see them at every different community event...promoting, talking about gambling. And they will definitely follow up if you filled in the form...two years ago, and I haven't seen them out in the community anymore. But I thought that was a great way of reaching out to people and making it just that a normal conversation that they could have at these community events. (Lived experience representative)

[Te Hiringa Hauora] actually stopped on the resources to the gambling providers...It's really hard when we've not got resources from [Te Hiringa Hauora] . Not enough, actually. And you know [ethnic-specific group], they need it, they need tangible things and take-home messages or things that they can take with them. (Gambling harm service provider 3)

Small numbers of participants also:

- Questioned whether capacity within Te Hiringa Hauora was adequate

Te Hiringa Hauora has been in the past a lot stronger than what they are presently...Even our engagement with Te Hiringa Hauora has dropped off...We tried to reach out, and there [was] only a part-time person [at the time]. (Gambling industry 2)

- Noted promotion of the Helpline and little resource promoting local and accessible intervention services

I know that, for example, our marketing leaders are always going "We just don't have budget to do it. We would love to be able to put money into actually promoting the service"...It would be amazing if we could actually have the ability to really promote our services because we would definitely, take a different approach than the [Te Hiringa Hauora] in how they have over the last while. (Gambling harm service provider 2)

- Contended that resources and merchandise no longer produced by Te Hiringa Hauora were still necessary for providing public health engagement with communities. Half of the workforce survey respondents said that one challenge they face in delivering

services and support to clients is 'having the right resource available to work with the clients'⁴⁶.

We do have evidence from evaluations that some of the big public health events like the Pasifika festival that some of the larger organisations go to, to talk about gambling and, and brief screens and things - then you see a spike in people attending, calling the gambling helpline or attending services. So that is some indication that raising awareness then gets people doing something, but it's too sporadic in my mind.
(Gambling agency 2)

Interviewed gambling harm service provider representatives noted they were unsure whether the frequency of training for venue staff around host responsibilities and exclusion was adequate given the high turnover and recruitment of staff in the hospitality industry – providers questioned whether online training was required to avoid delays training newly recruited staff.

9.9 Objective 11 - focus on research and evaluation

Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm

9.9.1 What does the evidence tell us?

Each Strategy to Prevent and Minimise Gambling Harm includes the Ministry's priorities for research and evaluation. Research and evaluation outcomes are *intended to inform policy and service development by government agencies, and appropriate activities in the sector*⁴⁷.

9.9.2 Progress against Objective 11

Interviewed participants from all gambling stakeholder groups and a quarter of the workforce survey respondents⁴⁸ noted some progress had been made against this Objective. However, many also said this occurred with limited planning and co-ordination.

...we haven't had a programme of research and evaluation to establish evidence to underpin all the activities. (Gambling agency 2)

From the last strategy [and on the Ministry] website...the intention [was] for the 2019 to 2022 calendar years is to have one funding round per annum...that the funding stream will support approximately five to seven projects...The Ministry is aiming to issue an RFP in August each year...The last time they issued an RFP was in 2019. (Gambling agency 2)

⁴⁶ See appendix 3

⁴⁷ <https://www.health.govt.nz/our-work/mental-health-and-addiction/addiction/gambling/gambling-research-and-evaluation/funding-opportunities-gambling-harm-reduction-research-and-evaluation>

⁴⁸ See appendix 3.

In relation to the latter quote, it is important to note that COVID-19 impacted on the release of the 2020 funding round. The Ministry has further informed that the impact of COVID-19 has resulted in delays to the delivery of some funded research projects and evaluations. This included the planned:

- Evaluation of services, interventions and pilots, including the new service and innovation pilots
- Research into reducing inequities in gambling harm, including how to address barriers to Māori, Pacific and Asian people use of gambling harm minimisation services, and the evidence for effective gambling harm minimisation service design for these population groups
- Research into how to prevent and reduce gambling relapse.

9.9.3 Participant's suggestions to address research and evaluation gaps and risks

Suggestions to address research gaps and risks as identified by all interviewed stakeholders included a need to ensure:

Adequate evidence is used to inform provider contracting and procurement: Participants noted that funding and service models do not currently measure service delivery and impacts in culturally responsive ways. For example, many ethnic-specific providers undertake additional work to ensure culturally safe engagement and outcomes that are not recognised in contractual agreements. Some providers also noted extensive compliance and reporting – and questioned whether the same level of inquiry was consistent across all providers.

So much stuff is not reported of the work that we do because it doesn't fit nice entirely into this very complex contracting arrangement for gambling contract services. (Gambling harm service provider 6)

[We] have the ability to or are expected to provide counselling in [ethnic-specific] language and cultural models...We're expected to translate information to simple and effective information for our people. And we're not recognised for that. (Gambling harm service provider 3)

Evaluation sits alongside all pilot projects and services:

The need for more evaluation... so often we don't know what effective services are. That evidence for effectiveness of services is pretty lacking in this country and also internationally as well. (Gambling agency 2)

...we know the gold standard services for gambling treatment are CBT and motivational interviewing and various variants of those that's been shown worldwide. But we don't insist that our services provide MI or CBT. And in fact, it might not work for Māori and Pacific and Asian and other ethnic groups or culture groups. So we don't really know what works. (Gambling agency 2)

The timing of research and evaluation outputs aligns with policy, practice and strategy:

Participants noted the importance of co-ordinating and aligning research and evaluation outputs and evidence with timing required to inform policy and practice development and strategy for gambling service providers and industry stakeholders.

Research [is] critical [but] sometimes not necessarily [done] in parallel [with services], so I think that is a challenge. As a Ministry, they do try their best to to have both so that they can inform the parties and bring all the parties together, but it's just the nature of [research] that it will take time. (Lived experience representative)

Everything's moving so quickly...By the time the studies are done and they get published...With all due respect to the Ministry, it does sometimes take quite a long time to come out...How can we get better access to data more quickly to help make us understand whether the responsible gaming things we're putting in place are working? (Gambling industry 5)

A commitment to action from the Ministry/Government in response to research

recommendations: Participants highlighted that while research outputs are produced the outcomes of this remain unknown. Many emphasised a need for government agencies to detail how research findings have/will be used to inform strategic thinking, practice and policy.

...The report goes to the Ministry of Health, and yes, it will be publicly available at some point when it's on their website...But then what happens to it?...The people who could benefit from it don't get to see it...Really good findings. Sometimes that could have a real impact. But then what happens to it? I just don't know, apart from the National Gambling Study, where the Ministry has used the prevalence data and the longitudinal data for informing decisions. (Gambling agency 2)

Research findings are disseminated and accessible to the entire gambling sector: Participants also noted a need to ensure findings are communicated in a way that resonates with different communities.

There needs to be some mechanism for that knowledge translation [and] exchange. The research and the research reports are written very academically and are not necessarily easy for non-academics to understand. There needs to be some mechanism of synthesising important findings and getting them out to the whole sector so that people can then see what could be built on, where are the gaps are, what needs to be done, what's good, what's bad. (Gambling agency 2)

Research and evidence gaps are addressed relating to:

- Gaming and gambling among young people to inform potential harm minimisation strategies for this new phenomena and health promotion and awareness-raising activities in schools

There's all these great programmes throughout schools, but not on gambling, and online gambling is becoming huge...I know it's a real issue. (Lived experience representative)

Gaming and gambling are becoming much more interwoven. As a result, it's hard to know when it's gambling...So we're dealing with things that we don't know the answers to...There's no host responsibility. There's no safety net. There's no harm minimisation stuff going on there. (Gambling agency 1)

- Clients who relapse, drop out or do not attend

We also don't know the outcomes which will help with relapse. Services struggle to do follow-ups with people, and when they do get them and do follow-ups, we're not collecting any outcomes data. So, we really don't understand the longer-term outcomes. And this could help with understanding relapse... (Gambling agency 2)

A huge proportion of people are dropping out...Why are they dropping out before they're turning up...If they've gone to that effort to contact and make an appointment? We need to understand why a majority of people who turn up for face-to-face services only attend one session and then don't go back anymore. Why are they dropping out so early? Is it the therapeutic relationship? We really need to understand these dropouts. (Gambling agency 2)

- Monitoring and managing mild to moderate gambling

We fully recognise that those presentation figures are kind of ambulance at the bottom of the cliff, that those are the people who are severely impacted by gambling harm. But I think that [what is] probably missing for us is, and what we've asked for before is 'What are the other data points that we should be monitoring'. (Gambling industry 5)

There's a lot of the research from responsible gambling historically based on looking at problem gambling and telling people what not to do...Trying to reframe responsible gambling into something that's more about encouraging positive play and healthy play behaviour...That becomes something for everybody who plays our games, as opposed to us looking at the people who are potentially experiencing harm. (Gambling industry 5)

- Gambling harm prevalence (Te Hīringa Hauora surveys are limited and do not explore details associated with online gambling and national surveys are infrequent)

Possibly not with all the online gambling, I would say that doesn't draw it out enough...I wasn't sure what's behind the questions...It's hard to know how much detail was given to the people that responded to it. (Lived experience representative)

The last proper big national gambling prevalence survey finished in 2015...The [Te Hīringa Hauora] healthy lifestyle survey, which is done every two years...very few gambling questions in that, and they're embedded within other healthy lifestyle questions around smoking and alcohol...We know from other international research that people answer gambling questions differently. They tend to be probably slightly more honest if it's a gambling survey, as opposed to a health survey. (Gambling agency 2)

Synthesis of multiple and conflicting databases and analysis: Several database systems were described to collect a range of data for reporting, research and evaluation, service outputs and delivery and continuous improvement of gambling harm prevention and minimisation approaches. Some were developed and utilised by the Ministry and gambling harm service providers and others by those in the gambling industry. Gambling industry representatives noted conflicting and opposing results and findings and limited access to up-to-date evidence.

Accessing up to date statistics is problematic. Currently, all available statistics are only available up to and including 2017/2018. (Gambling industry 1)

The details of all excluded players based on the MVE framework are recorded in the CONCERN database – a National database. These figures indicate that approximately 850 unique individuals have been excluded from venues throughout New Zealand. Consider this against the statistical information for gambling prevalence rates and figures pertaining to interventions [4478 in 2018] recorded by treatment service providers. How do these figures reconcile? (Gambling industry 1)

In relation to the latter quote, it is likely that the number of individual exclusions may not match not client because not all opt for exclusion and some exclusions are venue- rather than self-initiated. It is also important to note that the most up-to-date 2019/20 gambling statistics were released as Needs Assessment interviews were in progress.

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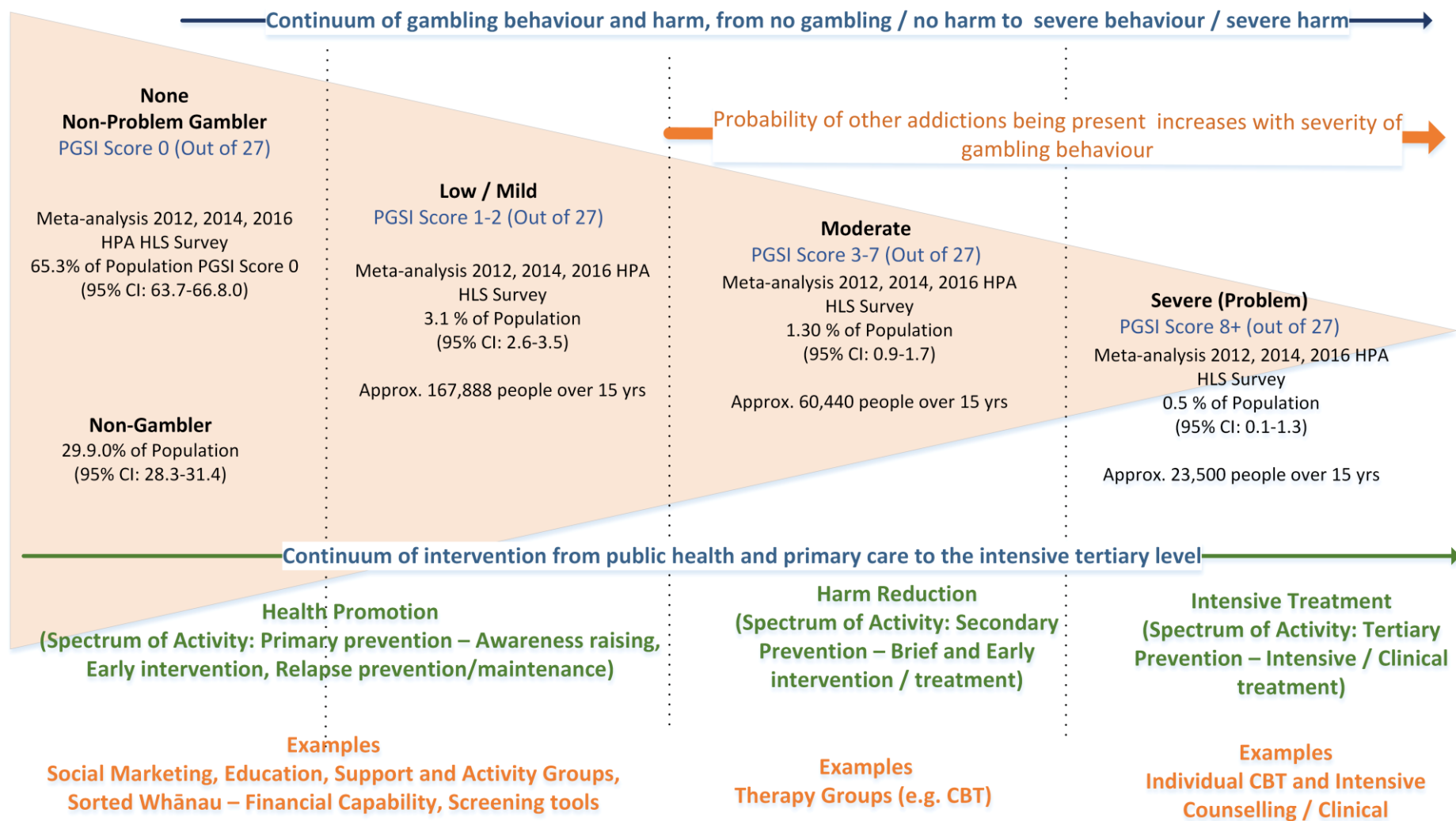
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Appendix 1: Gambling behaviour and harm: the continuum of prevention and harm reduction (Ministry of Health, 2019)



Appendix 2: Community and sports funding sub-categories – 2019

Community group sub-categories	Funding received
Community groups	\$37,838,195
Education	23,466,718
Arts	12,952,443
Health related	10,446,792
Community services	10,420,915
Faith based	6,819,355
Search and rescue (excluding surf clubs)	6,656,072
Māori	5,092,069
Kindergartens/Childcare/Plunket	2,452,638
Ambulance services	2,401,716
Council	1,516,343
Fire Services	748,819
Total	\$120,812,075

Source: (PGF Group et al., 2020)

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Sports group sub-categories	Funding received
Rugby	\$19,982,236
Other sports	\$19,861,454
Soccer	\$11,295,064
Cricket	\$8,908,166
Water sports	\$8,046,758
Racquets	\$6,012,940
Sports stadiums/academies/event centres	\$5,478,896
Hockey	\$4,757,123
Basketball	\$4,743,441
Netball	\$4,524,828
Surf lifesaving clubs	\$4,438,863
Bowling	\$3,431,502
League	\$3,179,766
Racing	\$2,861,218
Cycling	\$2,695,279
Special Olympics/sports for the disabled	\$2,433,512
Gym sports	\$2,341,199
Softball	\$1,766,541
Athletics	\$1,412,553
Equestrian/pony clubs	\$1,303,274
Motorsports	\$970,161
Total	\$120,444,774

Source: (PGF Group et al., 2020)

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Appendix 3: Online workforce survey

Workforce survey respondent profile:

- **Gender:** Higher proportions of females (64%) compared with males (31%) and gender diverse (4%) respondents completed the survey
- **Age:** Respondents represented a mature age group with many aged over 40 years: 60+ years (22%), 50-59 years (25%), 40-49 years (25%). Others were aged 30-39 years (16%) or 20-29 years (10%)
- **Ethnicity⁴⁹:** The most common ethnic group respondents identified with was NZ European (43%), followed by Pacific (30%), Māori (21%), Asian (18%) and Other (18%).
- **Region:** The majority of respondents were from the Auckland region (49%), followed by Wellington (16%) and Waikato (9%). Other regions represented included Canterbury, Hawkes Bay, Bay of Plenty, Manawatū-Wanganui, Otago and Gisborne.
- **Length of time working in the harmful gambling sector:** The highest proportion of respondents had worked for three to four years (41%), followed by five-ten years (20%), one to two years (17%), more than ten years (14%), and less than one year (9%)
- **Type of organisation:** Most respondents worked for a mainstream service provider (44%), followed by a Pacific provider (26%), Māori provider (15%) and Asian provider (12%). A small percentage (3%) said they worked for an Other type of service, for example, a Māori team within a mainstream service.
- **Type of role:** A high proportion of respondents worked in a Full-time role (86%), followed by half-time (5%) and Other (9%).
- **Type of support:** Respondents provided a range of services, including clinical interventions (33%), public health (21%), and both public health and clinical interventions (30%). Twelve percent of respondents were in managerial roles.

⁴⁹ Response percentages do not add to 100% as respondents were able to select multiple ethnicities.

Workforce survey – progress against Objectives in the Strategy

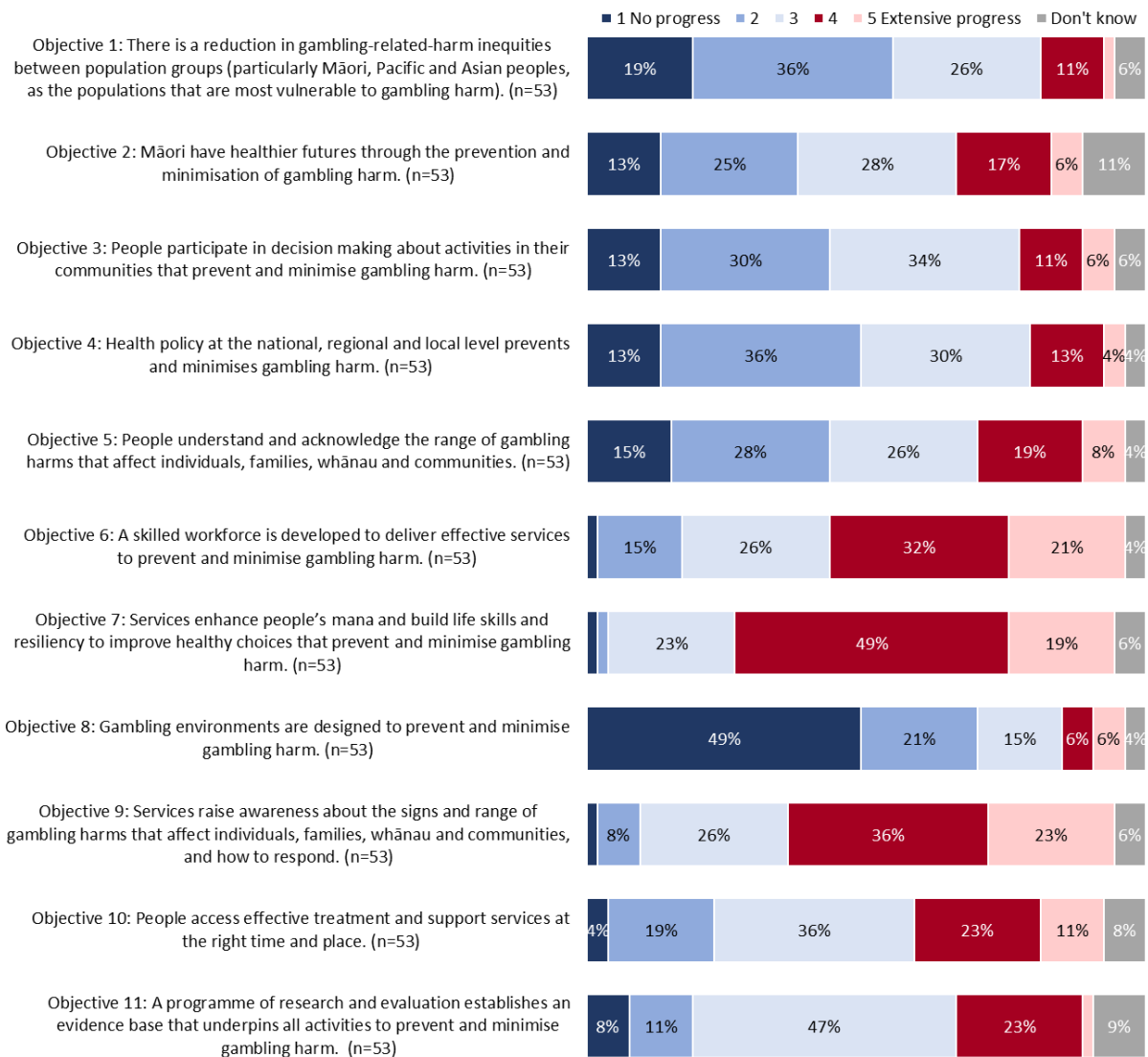


Figure 11: Respondent's views about progress made against Objectives in the Strategy.

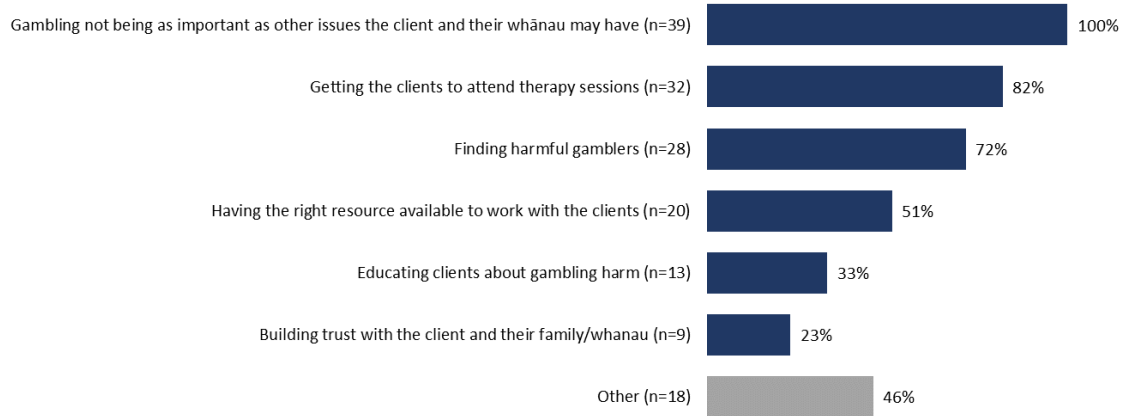


Figure 12: Respondents' views about challenges faced in delivering services and support to clients