



Draft Strategy to Prevent and Minimise Gambling Harm (2022/23 to 2024/25)

Submissions Analysis

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GLOSSARY

AUT	Auckland University of Technology
CPD	Continuing Professional Development
DHB	District Health Board
DIA	Department of Internal Affairs
FRT	Facial Recognition Technology
GMP	Gaming Machine Profit
HPA	Te Hiringa Hauora/Health Promotion Agency
The Ministry	The Ministry of Health
MVE	Multi-venue Exclusion
NCGM	Non-casino Gaming Machine
NCS	National Coordination Service
NGO	Non-government Organisation
NZQA	New Zealand Qualifications Authority
PGSI	Problem Gambling Severity Index
PMGH	Preventing and minimising gambling harm

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EXECUTIVE SUMMARY

Sixty-four submissions were received

Sixty-four submissions were received on the Ministry of Health's *Draft Strategy to Prevent and Minimise Gambling Harm (2022/23 to 2024/25)* (the draft strategy) consultation document. This is less than the number of submissions received during the 2018 consultation (82 submissions were received in the 2018 consultation).¹ Submissions were received from a range of stakeholders:

- sixteen service providers (12 clinical treatment providers, three other public health providers, and one advisory group)²
- sixteen Non-Casino Gaming Machine³ (NCGM) submitters (13 societies, two sector representatives, and one club)⁴
- sixteen health and social services submitters (seven health sector representatives, four District Health Boards [DHB], three health providers, one non-government organisation [NGO] representative and one social service representative)⁵
- five gambling industry (other) submitters (two casino operators, one gambling technology-related organisation, Lotto NZ and TAB NZ) ⁶
- four local government submitters⁷
- one central government submitters⁸
- six from individuals.⁹

Key themes at consultation hui

Culturally appropriate services

- Stakeholders considered it essential to have lived experience peer support from service providers who come from the communities that are suffering the most. People who are not from the communities have a harder time relating to and understanding the issues. In addition, people suffering harm struggle to reach out for help if they think that the person they are talking to will not be able to fully understand their cultural context.
 - This theme was raised in most hui, but came out particularly strongly in the Pacific and Asian-focused hui.
- 'For Pacific by Pacific' – stakeholders wanted to see services designed and implemented by their own communities. This would help with identifying

¹ <https://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2019-20-2021-22-proposals-document>.

² 6,7,8,9,13,18,25,27,29,34,41,46,47,50,54,C07.

³ Also known as Class 4 electronic gaming machines or 'pokies' - referred to as NCGM throughout this report.

⁴ 3,4,5,10,17,19,21,22,26,32,38,40,43,44,51,C01.

⁵ 02,11,23,24,28,33,35,37,39,45,48,49,52,53,C04,C08.

⁶ 20,30,31,36,42.

⁷ 12,15,C02,C05.

⁸ 55.

⁹ 01,14,16,C04,C06,C09.

community needs and responses much more effectively, as well as supporting more of a focus on prevention work.

- Stakeholders noted that at-risk groups should be engaged at the source of their harm. For example, young people could be engaged in schools by weaving gambling awareness into the curriculum. Another example was to address unhealthy gambling behaviours in the Pacific Islands where people begin developing harmful behaviours before arriving in New Zealand, where those behaviours are exacerbated.
- Some stakeholders noted that they could not 'see themselves' in the draft strategy and wondered why relevant groups had not been included in the drafting.
- Stakeholders noted the importance of growing the workforce by giving minority providers the chance to offer the same salary range as DHBs, so people within these communities can access culturally competent services.

Priority populations

- Stakeholders were pleased to see the additional focus on young people in the draft strategy.
- Stakeholders highlighted how young people are essentially a culture of their own, and therefore there must be a focus on a strategy, services and campaigns that are by young people, for young people.
- There was a desire from stakeholders to see more of a focus on the Asian community and retirees in the draft strategy.
- International students were well-represented at both the Lived Experience and Asian hui in particular. Stakeholders noted that international students often come from countries where gambling is illegal, and do not have support systems in place in New Zealand. Therefore, there should be additional focus on prevention (rather than just addressing harm once it has occurred) for these communities.

Effective implementation

- Stakeholders repeatedly mentioned the need for clarity in planning and implementation and asked for more detail on how the draft strategy would be implemented.

Education and training

- Stakeholders noted the importance of training and education being fit for purpose, culturally appropriate and reflected in the draft strategy. Stakeholders again emphasised that the best way to do this was to design and implement programmes with the communities involved.
- Stakeholders expressed a lot of interest in the Level 7 Qualification scholarships, and some support. Some stakeholders suggested that this could be a secondary school qualification (Level 2 or 3), to provide further-reaching opportunities.

Online gambling and gaming

- The concept of ‘gaming’ (more general than ‘gambling’) was raised in several hui by multiple stakeholders. Stakeholders were particularly concerned with ‘loot boxes’ and other forms of online games which require participants to spend money, and felt that more needed to be done to prevent harm in this area, particularly for young people.
- Some stakeholders expressed a desire for regulation/the levy to be extended to cover online gambling and gaming. They also noted that online gaming in the community should be tackled as part of the strategy.

NCGMs and de-stigmatisation

- Stakeholders in several hui focused on de-stigmatisation. In particular, they stated that there should be more visibility and awareness of how NCGMs work. This should include moving away from telling people that they have a problem controlling themselves and providing more information about how the design of NCGMs leads to addiction.
- Stakeholders also wanted to see a reduction in the number of NCGMs, particularly in poor communities.

Other issues

- Stakeholders expressed strong concerns about the decrease in the research budget.
- Stakeholders noted the importance of holistic services, and the recognition of gambling harm in conjunction with other types of addiction and mental health considerations.
- Stakeholders wanted to see more linking between gambling harm and other addiction and mental health services. Peer support is one thing that has worked well in mental health and alcohol and other drug addiction services that gambling can learn from.
- Host responsibility was a strong concern for many stakeholders (particularly those with lived experience), and it was suggested that training to recognise gambling harm could be linked to alcohol training.

Lived experience stories

The consultation hui were attended by a number of stakeholders who shared stories of their lived experience of gambling harm, either their own, or that of a whānau member. Some service providers also spoke on behalf of clients. Stories of lived experience are summarised below.

Stakeholders with lived experience wanted to see changes to policies to identify problem gamblers in venues. Stakeholders emphasised that staff in venues have an important role to play in identifying gamblers and that policies are not currently providing the mandate required. In particular, stakeholders were concerned about the perceived slowness of policy change, when it was so obvious that problems existed. Stakeholders discussed the consequences for venue owners on breaching alcohol licensing rules and considered that the consequences with respect to gambling harm could be much stricter.

In addition, stakeholders questioned why there was no formal training for bar staff, including bringing in people with lived experience to educate bar staff on what gambling addiction looks like, and how to identify and help people.

Stakeholders with lived experience also emphasised the risk of developing co-morbidities, with one stakeholder giving the example of being offered drugs at a casino. Stakeholders considered that a more comprehensive approach within drug and alcohol residence services could be adopted to address the manifestation of gambling harm with other addictions.

Many of the lived experience stakeholders came from migrant or international student backgrounds, and highlighted gambling as a particular risk area. International students are away from their families and often have limited support systems, which means that they can more easily fall into gambling harm, and struggle to get out of it.

Stakeholders also commented on the shame of gambling. Gambling was seen as a 'hidden disease', unlike something like alcoholism. Stakeholders noted that someone could be spending thousands of dollars a day, and it would be hard to see. In addition, some stakeholders considered that in monetary terms, problem gambling was a much bigger issue than alcohol abuse.

Some stakeholders also noted the warning labels on things like cigarettes and alcohol and wondered whether similar campaigns could be run for gambling. Stakeholders also wanted to see advertising and outside signage banned.

Lived experience stakeholders expressed strong support for including people with lived experience in the workforce, and noted that this could take a number of avenues:

- sharing stories in a peer capacity
- supporting someone who is trying to make changes in the context of their own experiences.

Lived experience stakeholders also strongly supported better involvement of whānau and 'affected others' in services, noting that gambling harm affects more people than just the person gambling.

Key themes from written submissions

Submitters considered equity to be an essential element of the draft strategy

Submitters from all sectors considered equity to be an essential element of the draft strategy, which ran through all aspects of the consultation document. The vast majority supported the focus on equity. However, many submitters were concerned that the draft strategy did not go far enough in outlining clear targets, structures and methods for actually achieving equity, and wanted to see more about how and where equity would be implemented.

Some submitters considered that the current strategy was not working

NCGM submitters and gambling industry submitters strongly considered that the current strategy was not working, as funding had been high, and the prevalence of problem gambling had not decreased.

Submitters from all sectors wanted to see greater focus on online gambling and gaming

Submitters from all sectors expressed concern about online gambling and gaming and noted that the draft strategy had a long way to go to appropriately address online gambling and gaming, and wanted to see increased focus on:

- research into the impacts of online gambling and gaming, particularly with respect to priority populations (Pacific, and rangatahi, and international students)
- specific service provision for online gambling.

Service providers considered that online service provision could be improved

Service providers saw a need to expand services into the online space. Providers referenced:

- the changing nature of face-to-face services due to COVID-19 and the associated increase in online gambling and stated that this has not been acknowledged in the draft service plan
- the need for more self-help groups or forums accessible face-to-face and online in New Zealand as these are scarce and push tangata whaiora to seek these forums on overseas websites.

NCGM submitters wanted to see an overhaul of service provision

NCGM submitters wanted to see an overhaul of service provision, including targets for service providers, and integration of addiction services. NCGM submitters commented that the strategy should include clear targets to be considered during the allocation of levy money.

NCGM submitters also commented on the need for more accessible face-to-face counselling and longer-term support.

NCGM submitters were critical of current preventing and minimising gambling harm (PMGH) service providers and considered that in spite of the funding available, current providers were not equipped or willing to travel to clients who cannot come to the office or see clients after hours/on weekends. These submitters stated that the Ministry of Health (the Ministry) must move away from funding services in set geographical areas Monday to Friday 9am-5pm, and instead require providers to be on call, provide afterhours and weekend support and travel to clients if necessary.

NCGM submitters also wanted the draft service plan to shift focus to long term treatment and support models and stated that the Ministry should require service providers to take reasonable steps to maintain contact with clients for a three-year period. These submitters stated that statistics show most clients receive less than 10 hours of support in total which is insufficient to prevent relapse.

Submitters from across sectors considered that more culturally appropriate services were required

Service providers, health and social services submitters, individuals and a local government submitter all considered that culturally appropriate services were required for Māori, Pacific, and Asian population groups.

Service providers considered that more culturally appropriate services were required for Māori, Pacific, and Asian population groups, and in particular, that the diversity of Pacific and Asian peoples should be recognised. Service providers specified issues with the National Gambling

Helpline for Pacific, and Asian communities. Submitters also called for the Asian Helpline run by Asian Family Services to be extended so it could run as a 24/7 service, while the others highlighted that having dedicated Pacific staff for the Pacific helpline is essential.

Service providers considered that more work should be done to ensure that general PMGH service providers were equipped to offer culturally appropriate services, as priority populations often access general services as well as culturally specific ones.

Service providers also commented on the need for more Kaupapa Māori services and support of alternative support staff in the form of kaiawhina/mataora or Māori approaches to treatment such as of wānanga.

Health and social services submitters also commented on the need for culturally appropriate services, and called for specific funding commitments for Kaupapa Māori, Pacific, and Asian services, and called for culturally mandated services as first referral options. Health and social services submitters also considered that the Ministry should ensure there is a culturally appropriate peer support workforce.

Two individuals also supported more culturally appropriate services. One of these submitters stated that consideration should be given to tikanga practices relative to iwi and hapū regions as Māori in isolated communities know their own and should therefore be supported in what they do within their communities.

NCGM submitters thought increased funding was inappropriate, while other submitters thought it would not be enough

NCGM submitters, service providers, health and social services submitters and a gambling industry submitter had mixed views on the increase in funding in the draft service plan.

NCGM submitters considered the increase in funding unwarranted for the following reasons:

- increasing the FTE rates is inconsistent with the government wage freeze
- money must be spent on preventing, minimising, treating or reducing harm, not paying existing providers more for office overheads or administration
- gambling participation and presentations to PMGH services have decreased, indicating a reduced workload for these services, thus making an increase to FTE rates unwarranted.

One gambling industry submitter commented that while they expected an increase in funding given trends in previous strategies, the size of this increase was surprising given the significant past investment from both the Ministry and the industry.

Service providers considered more funding and investment was needed to actualise the goals of the draft service plan, as current investments were insufficient to drive real change. One service provider commented that as a culturally specific service, they receive limited support from the National Coordination Service (NCS) and often have to fund their own culturally specific resources, meaning they are unfairly burdened compared to mainstream services.

One health and social services submitter commented that more investment is necessary to achieve set outcomes if we as a society are serious about equity and public health approached to gambling harm prevention and minimisation.

Submitters had a range of views on the proposed new services, innovation pilots and investments

NCGM submitters, service providers, health and social services submitters and gambling industry submitters had varying opinions on the proposed new services, innovation pilots and investments.

Most NCGM submitters suggested that additional to the proposed level 7 gambling harm qualification, funding should be allocated for a new NZQA qualification and harm leader minimisation leadership course, such as those proposed and run by Hospitality New Zealand.

NCGM submitters commented that the Ministry should consider whether a level 7 qualification would be a barrier to those the Ministry is trying to target with this initiative and whether there would be high uptake at this level. One NCGM submitter went on to say that few people would be likely to attempt a level 7 qualification, and even fewer would complete or pass. Another NCGM submitter suggested a level 5 or 6 qualification may have higher uptake and pass/completion rates.

Other NCGM submitters supported the new scholarships aimed at priority populations but suggested that access to scholarships should be extended to anyone that would like to provide help for problem gambling, including society and hospitality staff.

Some NCGM submitters commented that no detail is given as to what is proposed in the inequity pilots despite a budget of \$1.96 million and suggested an alternative use for this budget.

Two service providers commented that there was ambiguity around how and in what context the proposed qualification would benefit prospective students and raised concerns that this level of qualification may create further inequities for priority populations. Three service providers supported the creation of an entry-level Gambling Harm qualification (levels 1-4) to help build a pathway to and increase the accessibility of the NQZA level 7 qualification.

Service providers considered that rather than developing a standalone level 7 qualification on gambling harm and gambling intervention competencies, these should be embedded into current qualifications in the addiction space.

Three service providers commented that additional scholarships should be made available for the existing gambling workforce as well as lived experience Kaimahi in the workforce development area to upskill and develop their knowledge beyond the regional and national training forums.

Two service providers supported the intensive support pilot, stating that at present there are no contracted residential beds for people where their addiction does not include alcohol and/or other drugs or mental health issues despite the significant benefits this type of programme could have for those experiencing gambling harm.

Service providers were concerned that innovation pilots did not seem to be adequately resourced – for example, the total budget for the technology pilot across the strategy period is not enough when considering the infrastructure support needed to sustain technological innovations.

Service providers also considered that to address the challenges faced by the Asian community in this equity pilot, the nuances and many different cultures and ethnicities within the wider Asian population must be accounted for.

Health and social services submitters recommended:

- lived experience leadership to support the de-stigmatisation initiative

- those with lived experience moving into leadership roles including provision for scholarships to attain NZQA qualifications and these should extend beyond level 7
- rather than developing a standalone level 7 qualification on gambling harm and gambling intervention competencies, these should be embedded into current qualifications in the addiction space
- that scholarships should be attached to employers already committed to building the PMGH workforce and who have specific skills to support and mentor scholarship recipients and this could provide a way for providers to identify promising staff
- that priority populations should be prioritised in scholarship allocation, but if supply exceeded interest from other population groups, then this should be allowed and encouraged.

One gambling industry submitter supported the level 7 pathway as it was proposed, gave broad support for new scholarships, and supported the technology pilot in particular, stating that the technology-based innovation generally received universal support across the PMGH sector.

Submitters made suggestions for additional research priorities

NCGM and gambling industry submitters, service providers, health and social services submitters, and an individual generally agreed with research priorities but made other suggestions.

Service providers encouraged the Ministry to ensure all research with priority populations includes these groups not only as participants, but as leaders and co-leaders of research to allow for the voices of these populations to be captured and inform the development of appropriate supports. Comments included:

- research on Pacific peoples should be undertaken with and led by Pacific peoples
- there should be support for community lead projects, with funding earmarked for whānau, hapū, iwi and hāpori Māori and a fostering of acceptance of whānau, hapū, iwi and hāpori Māori centric knowledge, evidence and research
- support for qualitative research methods to aid in cultural responsiveness, and
- in future the Ministry may assess barriers to equitable service access and outcomes for subgroups e.g., those in the Asian community who are young and new migrants, and broader subgroups that intersect with the disability community.

Service providers suggested additional research priorities across NCGMs, multi-venue exclusions (MVEs), online gambling and online interventions as well as research into the effects of COVID-19, to understand gambling stigma.

One NCGM submitter expressed concerns that research underpinning Ministry strategies lacks long-term monitoring and reporting on NCGM societies and stated that the actions of these societies are largely ignored in research. This submitter called for better consultation with the NCGM sector, as well as research into the effectiveness of service providers alongside the NCGM sector to assess current performance.

One individual commented that there is a need for more effective research at a grassroots level, suggesting that researchers regularly cite NCGMs as the most harmful gambling product, but has never had a researcher visit a venue to understand the workings of one.

One gambling industry submitter commented that dedicated research, data collection and evaluation is required into unregulated offshore online gambling specifically, given the lack of harm minimisation controls in this area.

Health and social services submitters suggested additional research priorities across NCGMs, MVEs, online gambling and online interventions as well as research into the effect of loan sharks and what support works for affected others.

Health and social services submitters also encouraged research and evaluation to be targeted in areas where there were high rates of gambling to ensure data reflects the wider persistent impacts and disadvantages.

Most submitters favoured a 30/70 weighting

Most NCGM submitters favoured a 30/70 levy weighting. They argued a 30/70 weighting would:

- reflect the Gambling Act 2003's (the Act) wide definition of harm
- recognise help-seeking is not a good indication of gambling harm
- acknowledge that levy funding is used for research and evaluation
- recognise the NCGM sector has no online offering
- protect against adverse incentives
- recognise indicators of harm show reduced levels of harm.

Some NCGM submitters did not support a 30/70 weighting suggested further increasing the weighting towards expenditure, one suggested a 100 percent expenditure weighting.

Three NCGM submitters considered an increase in the levy rate to be inappropriate if it results in 'more of the same'. They did not support increasing the FTE rate of existing individual providers for their work, which they described as having not achieved the desired results.

Relatively few service providers commented on supporting a particular levy weighting. Those that did, supported different options but almost all argued the NCGM sector should contribute the most to the levy.

Service providers supported the proposed increase in the levy rate, many noted the need for further increases beyond this to fully recover the cost of developing, managing, and delivering the integrated problem gambling strategy. These service providers further discussed the need for targeted health services in relation to the levy.

Gambling industry submitters supported a return to the 10/90 levy weighting. They considered the shift to a 30/70 weighting as part of the previous strategy was unjustified and argued that the sectors which are the root cause to problem gambling should bear the largest proportion of the costs of the strategy. They considered a 10/90 weighting would best reflect the purpose of the levy.

Health and social service submitters commented on the levy weighting and proposed rates. Comments included:

- further increases to the levy rate beyond proposed levels were needed
- NCGMs are the most harmful form of gambling and should contribute the most to the levy

- the levy was no longer fit-for-purpose
- MVEs could be used as a proxy for harm.

1. INTRODUCTION

1.1. Background

The Ministry of Health (the Ministry) has responsibility under the Gambling Act 2003 (the Act) to develop and implement an integrated, public health-focused problem gambling strategy at least every three years (sections 317 and 318 of the Act refer). Through the Act, the Crown recovers the cost of developing and implementing the strategy by way of a 'problem gambling levy', set by regulation at a different rate for each of the main gambling sectors (i.e., TAB New Zealand, Lotto New Zealand, casinos and non-casino gaming machines [NCGMs]). The strategy must include:¹⁰

1. measures to promote public health by preventing and minimising the harm from gambling
2. services to treat and assist problem gamblers and their families and whānau
3. independent scientific research associated with gambling, including longitudinal research on the social and economic impacts of gambling, particularly the impacts on different cultural groups
4. evaluation.

The Ministry used insights from a Needs Assessment to outline proposed services to be delivered and indicative budgets for the next three-year period.

1.2. Consultation document

On 29 August 2021, the Ministry released a consultation document: *Draft Strategy to Prevent and Minimise Gambling Harm (2022/23 to 2024/25)* (the draft strategy). This document sought feedback on draft proposals for the:

- strategic plan, including a proposed strategic framework that sets out the population outcome, strategic goal, outcomes, objectives and priority areas for the strategy
- service plan for the three years from 2022/23 to 2024/25
- funding levels for the Ministry in relation to the gambling harm prevention and minimisation activities described in the draft strategy
- the problem gambling levy rates and weighting options per gambling sector for the three years from 2022/23 to 2024/25.

The consultation document included 13 questions to guide submitters' feedback in relation to these areas:

- Questions 1-4 asked stakeholders about the proposed strategic direction
- Questions 5-8 asked stakeholders about the proposed draft service plan and funding
- Questions 9-12 asked stakeholders about the proposed levy and weighting options

¹⁰ Gambling Act 2003, s 317.

- Question 13 asked if there was anything else that stakeholders would like to tell the Ministry about the draft strategy or preventing and minimising gambling harm more generally.

1.3. Purpose of this report

Allen and Clarke Policy and Regulatory Specialists (*Allen + Clarke*) was contracted by the Ministry to analyse the feedback provided at 10 consultation hui and the written submissions and provide all feedback in a narrative report.

This report summarises views submitted on the draft strategy both by thematic area and by category of submitter. Evidence provided by submitters is also described where relevant.

This report will be used by the Ministry to inform the development of the final direction of the strategy and its priorities. After considering the feedback in this report, and making any necessary revisions, the Ministry will submit the updated strategy and levy rates to the Gambling Commission in accordance with section 318 of the Act. The Gambling Commission will undertake an analysis, convene a consultation meeting, and provide its own advice to the responsible Ministers. Cabinet will subsequently make decisions on the shape of the strategy and the levy rates for the next three-year period (2022/23 to 2024/25).

1.4. Consultation process

The consultation process about the proposals to refresh the strategy and associated levy ran for six weeks from 29 August to 8 October 2021. Consultation focused on stakeholders from the gambling industry, service providers, affected communities and interest groups. Stakeholders were contacted via email, the Ministry's website and social media.

The Ministry held 10 consultation hui between 6 September and 28 September 2021, facilitated by *Allen + Clarke*. All hui were held via Zoom to accommodate the August 2021 COVID-19 Delta outbreak, and different stakeholder and interest groups were encouraged to attend. The purpose of the hui were to facilitate discussion about the Strategy, answer questions that stakeholders had, and to provide advice about preparing their written submissions. The hui were themed to hear Māori, Pacific peoples, Asian peoples, young people, people with lived experience and industry viewpoints and advice from the general public. Written notes of the verbal feedback received during the hui were taken by *Allen + Clarke*. Themes and comments from hui contained in this report are summarised from the full set of notes. Themes from the hui are included under the relevant heading throughout the report.

The analysis of the written submissions and verbal feedback during the hui is being considered by the Ministry and will inform the Ministry's response to the submissions.

1.5. Methodology

All submissions were supplied to *Allen + Clarke* in electronic format. Submissions were received by the Ministry via 'Citizen Space' (a cloud-based consultation software) and direct email submission, according to submitter preference. Submitters were asked to identify if they were an organisation (and if so, what type of organisation) or individual, and could choose from a standard set of possible options. This categorisation was supplemented by a Ministry assessment if the submitter type was not clear or not provided, or to determine a primary classification if the submitter had nominated multiple types. All submissions were collated and allocated a unique identifier before being provided to *Allen + Clarke*.

Once received by *Allen + Clarke*, submissions were uploaded to NVivo (version 1.5.1, a qualitative analysis software) and coded to a question-based coding framework. From this, specific reports by both theme and individual submitter were drawn and used to inform this report.

1.6. Summary of submitters

Section 1.6 summarises the submitters who commented on the draft strategy.

1.6.1. Number and type of submitters

A total of 64 written submissions were received:

- 58 submissions from organisations¹¹
- six submissions from individuals.¹²

The primary type of organisation (sector) and the number of submitters in each sector are described in Figure 1 (overleaf).

'NCGM submitters' includes NCGM societies, clubs and sector representatives.

'Service providers' are organisations that offer treatment to people who are experiencing harm from gambling. For the purposes of this analysis, Auckland University of Technology (AUT), and an advisory group, are counted as service providers.

'Health and social services submitters' include organisations such as DHBs, medical associations and social services organisations.

'Gambling industry' includes gambling-associated organisations, except those covered by NCGM sector, and technology providers.

'Local government' includes territorial local authorities.

'Government' includes independent Crown entities and government agencies.

'Individual' is the category of submissions received from private individuals.

¹¹02,03,04,05,06,07,08,09,10,11,12,13,15,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,C01,02,C04,C05,C07,C08.

¹² 01,14,16,C03,C06,C09.

Figure 1: Organisation submitters by sector type

Primary organisation type		Number of submissions received
 Service provider		16 submitters
 NCGM sector		16 submitters
 Health and social services		16 submitters
 Gambling industry		5 submitters
 Local government		4 submitters
 Central government		1 submitter

As well as the ability to self-identify from a range of different organisation types (as illustrated in Figure 1), submitters were able to identify one or more specific priority group/groups. Twenty-one organisations and individuals identified themselves as representing the interests of specific priority populations.¹³ These are described in Table 1 (below).

Table 1: Secondary category by priority group(s) represented

Priority group	Number of submissions identifying with priority group
Māori	Six submitters ¹⁴
Rangatahi (young people)	Five submitters ¹⁵
Pacific	Three submitters ¹⁶
Pacific, Rangatahi (young people)	Two submitters ¹⁷

¹³ 01,07,13,16,28,29,37,41,46,47,50,54,55,C01,C02,C03,C04,C05,C06,C07,C09.

¹⁴ 07,41,50,54,C06,C07.

¹⁵ 01,28,37,55,C02.

¹⁶ 29,46,47.

¹⁷ 16,C01.

Priority group	Number of submissions identifying with priority group
Asian	One submitter ¹⁸
Asian, Māori, Pacific	One submitter ¹⁹
Asian, Māori, Pacific, Rangatahi (young people)	One submitter ²⁰
Māori, Pacific	One submitter ²¹
Māori, Pacific, Rangatahi (young people)	One submitter ²²

1.7. General comments on submissions received

The comments received from submitters were diverse, focusing on a range of topics. Most submitters discussed those areas in which they had a specific interest and did not respond to the other questions posed by the Ministry.

Most submissions were unique, but 11 NCGM submitters drew on the submission drafted by the Gaming Machine Association of New Zealand (GMANZ),²³ at least in part and sometimes substantially, to develop their own submission.²⁴ Two further NCGM submitters commented that they supported the GMANZ submission in their own submission.²⁵

In addition, two service providers²⁶ provided nearly identical written submissions. One health and social services submitter²⁷ and a local government submitter²⁸ also provided nearly identical submissions.

One general service provider²⁹ summarised their points for priority populations based on feedback from more specialised service providers for Pacific communities³⁰ and Asian communities.³¹

Many of the comments about the draft strategic plan (part 2 of the draft strategy) and the draft service plan (part 3) were interrelated, with submitters commenting on aspects of both in their responses. Commentary presented by submitters that was relevant to multiple sections, for example factors that should be considered for priority populations and the mix of funding are

¹⁸ 13.

¹⁹ C03.

²⁰ C04.

²¹ C09.

²² C05.

²³ 05.

²⁴ 03,04,10,17,19,21,22,32,38,40,51.

²⁵ 43,44.

²⁶ 34,50.

²⁷ 35

²⁸ C05.

²⁹ 27.

³⁰ 29,

³¹ 13.

discussed in the relevant sections of this report. To ensure that comments were reflected to their best advantage, the analysis discusses submitters' points under the sections of the report that best align to what they indirectly recommended, which may be different to how the submitter categorised it in their submission. All original meaning intended by the submitter has been retained.

As was the case in previous consultations, a number of submissions referred to matters which affect gambling harm but which the strategy cannot address alone or in part (e.g., the legal and regulatory frameworks around gambling, online gambling, NCGM locations and advertising, or gambling policy). These matters fall under different processes and agency leads. Comments made by submitters which did not directly address the content of the draft strategy, but are still relevant to gambling harm in some way, are summarised in Section 5.

1.8. How to navigate this report

This report has been drafted and arranged thematically, based on the structure of the Ministry's consultation document. Where an answer to a question would better fit another section of the report, this has been noted and reflected in the analysis.

This report contains six sections.

1. Section 1 outlines the purpose and structure of the report, describes the methodology and provides an overview of submitters and their submissions.
2. Section 2 describes the submissions received on the draft strategic plan, including commentary about each of the four objectives, priority populations, and changes needed.
3. Section 3 describes the submissions received on the draft three-year service plan, including the proposed funding allocation and the key initiatives or programmes planned for 2022/23 to 2024/25.
4. Section 4 describes submitters' comments on the problem gambling levy rates, including the levy weightings and the method for calculating levy rates.
5. Section 5 draws on the analysis reported in Sections 2 to 4 to analyse the way the six sectors addressed the common themes that emerged through the submissions analysis.
6. Section 6 summarises stories of lived experience shared by stakeholders at the consultation hui.
7. Section 7 summarises the other issues raised by submitters, including issues with the consultation process and issues that fall outside the scope of the consultation.

Appendix A identifies submissions from individuals and organisations that provided a submission.

Appendix B provides a list of the 13 questions outlined in the consultation report.

Submitters are typically not identified in this report, except by organisation name in Appendix A, and by category of submitter in the body of the report. In a few cases, identifying an organisation was unavoidable.

2. THE DRAFT STRATEGIC PLAN

The consultation document set out the statutory requirements for an integrated problem gambling strategy and the aim for gambling harm minimisation. It specified four objectives, each containing three priority action areas. Section 2 outlines the commentary received from submitters on the draft strategic plan. It covers:

- agreement (or otherwise) with the proposed strategic goal, objectives and priority action areas
- discussion of whether the draft strategic plan adequately reflected changes in the gambling environment
- comments on priority populations and addressing inequities
- comments on ‘what needs to change’.

Four questions were asked, two of which included ‘Yes/No’ responses. Table 2 (below) shows the wording of those questions and the number of submitters who responded, by response. Sometimes the narrative response indicated that the support was qualified or conditional, in which case the ‘Yes’ response was altered to ‘Qualified Support’ for clarity.

Responses were received from across the seven sector groups, as detailed in Figure 2 (overleaf).

Table 2: Responses to questions about the draft strategic plan

Question	Yes	No	Qualified Support	Total
1. Do you agree with the proposed strategic goal, objectives and priority action areas?	18	20	13	51
2. Does the draft strategic environment adequately reflect changes in the gambling environment?	7	22	2	31
3. Do you have any comments to make on the priority populations, including how we will address inequities?	N/A			34
4. Do you have any comment to make on the matters under ‘what needs to change’?	N/A			39

Sixty-two submitters responded to at least some of the questions about the draft strategic plan, including 16 service providers, 16 health and social services submitters, 15 NCGM submitters, five gambling industry submitters, five individuals, four local government submitters and one government submitter.³²

³²01,02,03,04,05,06,07,08,09,10,11,12,13,15,16,17,18,19,20,21,22,23,24,25,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,C01,C02,C03,C04,C05,C06,C07,C08,C09.

Figure 2: Number of submitters, by sector, who commented on the draft strategic plan

Primary organisation type		Number of submitters
	Service provider	16 submitters
	NCGM sector	15 submitters
	Health and social services	16 submitters
	Gambling industry	5 submitters
	Local government	4 submitters
	Central government	1 submitter
	Individual	5 submitters

2.1. The degree of support for the draft strategic plan

Over half (31 out of 51) of the submitters who commented on the proposed strategic goal, objectives and action areas supported them to some degree.³³ Of those, 18 provided a simple “Yes” answer to Question 1. A further 13 expressed qualified support for the draft strategic plan (i.e., they supported the draft, but also commented on how it could be enhanced).

Comments on the draft strategic plan included:

- concern about the proposed strategic direction
- interest in seeing a bolder approach for the draft strategic plan
- interest in seeing more detail about how the draft strategic goal would be implemented
- interest in seeing more detail and tailored services to achieve the equity focus
- support for the Needs Assessment findings

³³ 02,08,09,11,12,13,15,16,18,23,24,27,30,31,33,37,,39,41,42,48,49,50,52,53,54,C01,C02,C04,C05,C07,C08.

- specific suggestions to strengthen the strategic goal
- constructive critique of all four objectives.

Each of these themes are discussed in the sections below.

2.1.1. Over half of the submitters who commented on the proposed strategic goal, objectives and action areas supported them to some degree

Submitters from almost all sectors expressed support for the overall draft strategic plan. Health and social services,³⁴ service providers,³⁵ and local government submitters³⁶ were the strongest supporters of the proposed draft strategy, with some support also reported from gambling industry submitters,³⁷ individuals,³⁸ and NCGM submitters.³⁹

In particular, submitters expressed support for:

- the draft strategy's alignment with other government strategic documents:
 - *Whakamaua: Māori Health Action Plan* and *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan* (six health and social services submitters, three service providers, one gambling industry submitter and one individual)⁴⁰
 - *Pae Ora – Healthy Futures* (two health and social services and two service providers)⁴¹
- the draft strategy's alignment with the current strategy (2019/20-2021/22), which was seen to be achieving the desired outcomes (one individual and one gambling industry submitter)⁴²
- the inclusion of a greater equity focus including explicit support for:
 - addressing the health status and outcomes of the most affected populations of Māori, Pacific peoples, Asian peoples and rangatahi (three health and social services submitters, two individuals, two service providers, one local government submitter⁴³ and one gambling industry submitter)⁴⁴
 - greater use of collaboration and co-design e.g., when commissioning dedicated Māori, Pacific and Asian public health and clinical intervention services (one health and social services submitter)⁴⁵
 - increasing use of services in different languages and supporting cultural awareness, and competency and safety training for the gambling harm workforce (one health and social services submitter)⁴⁶

³⁴ 02,11,23,24,33,37,39,48,49,52,53,C04,C08.

³⁵ 08,09,13,18,27,41,47,50,54,C07.

³⁶ 12,15,C02,C05

³⁷ 30,31,42.

³⁸ 16

³⁹ C01

⁴⁰ 11,16,18,23,24,27,37,39,42,49,52.

⁴¹ 13,34,37,C04.

⁴² 16,30.

⁴³ 15.

⁴⁴ 08,16,18,42,48,49,C03,C04.

⁴⁵ 11.

⁴⁶ 11.

- the strategic goal, which was seen to have a strong health promotion approach and the acknowledgement of the need for system change across sectors (two health and social services submitters)⁴⁷
- the draft strategy's strong focus on integrating public health approaches:
 - continued development of public health campaigns focused on priority populations (two health and social services submitter)⁴⁸
 - the situation of harm prevention and minimisation activities within the broader context of public health promotion and regulation of gambling (one health and social services submitter)⁴⁹
- the draft strategy's consideration of the financial impacts of service delivery such as:
 - increased budgeting to allow for workforce development (one service provider)⁵⁰
 - the proposal to introduce fair and equitable pay-scales with other addiction sectors (one service provider)⁵¹
 - better funding for public health (one service provider)⁵²
 - extra funding associated with the draft strategy and strategic plan (no further detail provided) (one health and social services submitter).⁵³

One NCGM submitter noted the positive changes within the industry over the life of the current strategy (not further specified) and supported all efforts to further minimise harm caused by gambling.⁵⁴

2.1.2. Submitters from across sectors had concerns about the proposed strategic direction

Submitters from across sectors also expressed concern about the proposed strategic direction, including concern that:

- the current strategy was not working (and that the draft was a repeat of the current approach) (noting that these comments came from industry submitters, while comments from other submitters were more explanatory)
- the draft strategy did not appropriately address the causes of gambling harm
- the three-year term does not provide enough flexibility to response to changes in the gambling environment
- a more nuanced understanding of risk should be incorporated into the draft strategy
- the draft strategy was not supported by enough research

⁴⁷ 24,48.

⁴⁸ 11,54.

⁴⁹ 23.

⁵¹ 54.

⁵² 54.

⁵³ 52.

⁵⁴ 51.

- the positioning of gambling harm as an equity issue.

Gambling industry submitters considered that the current strategy was not working: repeating the current approach was not valued by some

Eleven NCGM submitters and a gambling industry submitter commented that the current strategy was not working, and that the draft strategy repeated all prior strategies, which have been implemented without much success in terms of reducing gambling-related harm: funding has been high, and the prevalence of problem gambling has not decreased.⁵⁵ Comments included:

- the Ministry was proposing to do the same thing again, while expecting a different result, when it was clear (to these submitters) that a new approach was needed⁵⁶
- one NCGM submitter also noted that it was opposed to the continued funding of a service that has become “complacent, out-dated, and more of an anti-gambling advocacy service than a treatment service”⁵⁷
- one NCGM submitter supported the view that the current system has been successful to a degree in some respects (not further specified), but not in reducing ongoing gambling harm.⁵⁸

One service provider expressed concern about the current underutilisation of services, and presented a range of potential reasons for this, including:⁵⁹

- a lack of acceptable, culturally appropriate services - general services should be a choice for all users, and general services require support to attract and retain staff from a range of populations and to offer interventions and activities tailored to specific population groups
- insufficient promotion of specialist gambling harm services
- use of national telehealth services as the main promoted service as a first point of contact and which had an exceptionally low referral rate
- strong stigma associated with those affected by gambling harm and perpetrated by the gambling industry
- limited gambling services across Aotearoa.

Gambling industry submitters considered that COVID-19 was not responsible for the current strategy’s poor performance to reduce gambling-related harm

Five NCGM submitters did not accept that the COVID-19 pandemic was the cause of poor results related to underutilised services and the overall level of harm remaining the same year-on-year.⁶⁰ Two also commented that COVID-19 should have assisted with reducing the prevalence of harmful gambling and inequity, as all NCGM venues and casinos were closed (except online offerings).⁶¹ In addition, they submitted that there was considerable media attention regarding online gambling,

⁵⁵ 03,04,05,10,17,19,20,21,22,32,40,51.

⁵⁶ 03,19,40.

⁵⁷ 17.

⁵⁸ 43.

⁵⁹ 18.

⁶⁰ 5,21,38,40,51.

⁶¹ 05,40.

and the first level 4 lockdown lasted for only four weeks. They concluded that there had not been much change for the last 17 years, and a new approach was needed.⁶²

Ways to achieve change were suggested:

- technical machine changes (one NCGM submitter and one gambling industry submitter)
- the introduction of new harm minimisation technology including expanding the use of facial recognition software as a tool to promote treatment and improve monitoring and enforcement (one NCGM submitter and one gambling industry submitter)^{69,70}
- changes to the way treatment services are provided (one NCGM submitter)⁶³
- the development of a tool for persons to request multi-venue exclusions (MVEs) from home (self-help, without the need to visit venues or a counsellor) (one gambling industry submitter).⁶⁴

Submitters were concerned that the draft strategy did not address the causes of problem gambling

Health and social services submitters, service providers and one NCGM submitter expressed concern that the draft strategy did not go far enough to address the causes of problem gambling.

One service provider expressed a similar concern and in particular observed the broader Wairua of Aotearoa founding documents Te Tiriti o Waitangi/He Whakaputanga principles of Mana Tangata, Mana Whenua, Mana Moana and Mana Atua to be lacking.⁶⁵ This service provider suggested concentrating efforts on key public health activity such as minimising harmful endorsements of problem gambling (no further detail on how this could be done was provided).⁶⁶

Two health and social services submitters and one service provider noted although the draft strategy attributes inequity largely to the greater concentration of NCGMs in lower socioeconomic status and high deprivation areas, it fails to include any measures to address the location or density of NCGMs and other easily-accessible gambling venues.⁶⁷ The health and social service submitter expressed concern that the draft strategy's focus on support services and education campaigns aimed at countering harm, including pilot studies and research, would consume resource while not significantly changing outcomes.⁶⁸

One NCGM submitter commented that services should provide support beyond treatment and address the core reasons for excessive gambling.⁶⁹ Another NCGM submitter noted that previous strategies over the last 17 years have focused on the 'ambulance at the bottom of the cliff' and have done little or nothing to prevent and minimise the harm experienced by the minority of gamblers.⁷⁰ The submitter also commented that gambling services have failed to assist vulnerable problem gamblers, which was evidenced by the number of people returning to services.⁷¹ An individual also noted that the Ministry "funds ambulances at the bottom of the cliff" instead of

⁶² 05,21,51.

⁶³ 19.

⁶⁴ 20.

⁶⁵ 54.

⁶⁶ 54.

⁶⁷ 02,09,24.

⁶⁸ 02.

⁶⁹ 19.

⁷⁰ 38.

⁷¹ 38.

looking at the top, and should put processes in place that will slow the number of people needing to seek help.⁷²

One submitter considered that the three-year timeframe does not allow for nimbleness

One health and social services submitter noted that while it endorsed a large amount of the consultation document, strategic changes and a cross-agency strategy need to be implemented if gambling harm is to be prevented. It considered that the series of three-year strategies were too slow and are not nimble enough to respond to the changes within the gambling sector. For prevention to occur the regulation and legislation needs to be adjusted to bring in greater restrictions, and a better funding model.⁷³

One service provider considered that more nuanced understanding of risk could be incorporated into the draft strategy

One service provider did not fully support the proposed strategic goal, objectives and priority action areas, and noted that the draft strategy was based on a public health model outlined in the Act.⁷⁴ The service provider noted that although this was ground-breaking when the Act was introduced, significant progress has been made since then in the area of gambling-related harm since then, and not everyone can be treated as having the same level of risk of being affected by it.⁷⁵

One submitter considered that the strategy was not informed by enough research

One service provider commented that a limitation of the draft strategy was that it was informed by the Needs Assessment findings in a three-year period where ‘relatively little’ research was funded.⁷⁶ The submitter went on to say that this meant the local evidence which informed the draft strategy was incomplete. The submitter noted that the COVID-19 lockdown period would have been a good time to fund and conduct research on people’s inability to gamble in physical venues, behaviours on re-opening of venues, relapse and uptake of online gambling, and that this was an opportunity that was missed in Aotearoa.⁷⁷

One submitter disagreed with positioning gambling harm and prevention explicitly as an equity issue⁷⁸

One service provider considered that positioning gambling harm and prevention explicitly as an equity issue was problematic as it implied that other populations who experience gambling harm are not as important.⁷⁹ The submitter considered that this could contribute to maintaining the stigma associated with experiencing problem gambling and did not fit with the public health approach to minimise harms from gambling.⁸⁰

⁷² C09.

⁷³ 33.

⁷⁴ 06.

⁷⁵ 06.

⁷⁶ 27.

⁷⁷ 27.

⁷⁸ Note that this comment went against the general consensus, as outlined in Section 2.1.1.

⁷⁹ 09.

⁸⁰ 09.

2.1.3. Submitters from across difference sectors expressed interest in a bolder approach

Submitters from across all sectors expressed interest in a bolder approach, including:

- better integration and a more collective approach to preventing and reducing gambling harm
- better support for people trying to access services
- more inclusion of lived experience and the peer support workforce.

One individual and one local government submitter commented that the proposed strategy was not innovative or ambitious and needs to be looked at in a fresh way to minimise gambling harm.⁸¹ Other suggestions were that the draft strategy should be flexible, nimble, and adaptive: a bolder approach was needed from the Ministry, as well as a willingness to implement meaningful change, and an overhaul of the services provided to see a reduction in the problem gambling prevalence rate, a reduction in the relapse rate, and inequities addressed (one NCGM submitter).⁸² One service provider commented that preventing and minimising gambling harm would take at least:⁸³

- cross-agency support (not just the Ministry and the Department of Internal Affairs [DIA])
- expertise of specialist gambling-related harm services
- support from the entire mental health, addictions and social services sectors
- improved data collection and research to support decision-making and inform policy, legislation and regulation
- legislation/regulation, and a review and update of policy.

Submitters wanted to see better integration and a more collective approach to preventing and reducing gambling harm

Service providers, health and social services submitters and local government submitters wanted to see better collaboration across government agencies:

- one service provider and local government submitter commented that although DIA holds the role of regulating the gambling industry under the Act, measures for preventing minimising harm must also be included in the draft strategy, and the Ministry should take more proactive steps to prevent gambling harm⁸⁴
- one service provider and one health and social services submitter commented that addressing inequities and enhancing health and wellbeing requires a whole of government approach, including systemic and structural analysis; support and collaboration across the mental health, addiction, and social services areas; and specialist PMGH service knowledge, input, and support⁸⁵

⁸¹ 15,C09.

⁸² 17.

⁸³ 18.

⁸⁴ 15,45.

⁸⁵ 18,49.

- one health and social services submitter encouraged the Ministry to consider inclusion of the *Kia Manawanui Strategy* in the draft strategy, as it embraces a cross-agency approach.⁸⁶

Integration and collaboration were also seen as important for services. One service provider and one health and social services submitter wanted to see greater integration of public health and clinical roles as a way to innovate service delivery models.⁸⁷ Another service provider considered that collaboration across providers is valuable, but services are thinly spread across the country, and it was difficult for services to effectively prevent and minimise harm or to have the resources to collaborate effectively.⁸⁸

Two NCGM submitters wanted to see greater collaboration between venue operators and treatment providers, to facilitate referrals for treatment and a feedback loop to assist with ongoing monitoring and support.⁸⁹ One service provider also advocated for a collaborative approach that upholds the leadership, mana, and tino rangatiratanga of each priority population, and stressed that this should be done with the provision of transparent and timely host responsibility information from gambling providers and in collaboration with gambling treatment and public health services.⁹⁰

Submitters wanted better support for people trying to access services

One health and social services submitter commented that the draft strategy should include support for people experiencing gambling harm to access services, including provision for people to travel if needed.⁹¹ Another health and social service submitter commented on access and use of online tools to improve access, particularly for elderly people and people with disabilities.⁹²

Submitters wanted to see more inclusion of lived experience and workforce

Health and social services submitters and service providers submitters wanted to see more emphasis on lived experience throughout the draft strategy. Ideas to deliver on this included:

- amend the principle ‘people and whānau at the centre’ to include those with lived experience - the inclusion of people who have lived experience of gambling harm should be at the centre of service design and delivery (one health and social services submitter)⁹³
- listen carefully to the voices of people who have experienced gambling-related harm and incorporate their views into work that flows from the draft strategy (one health and social services submitter)⁹⁴
- include more references in general to the gambler and their whānau in the draft strategy, and state that gambling harm was wide-reaching (service provider).⁹⁵

⁸⁶ 39.

⁸⁷ 29,45.

⁸⁸ 18.

⁸⁹ 05,40.

⁹⁰ 27.

⁹¹ 48.

⁹² 48.

⁹³ 23.

⁹⁴ 48.

⁹⁵ 08.

One health and social services submitter commented that it should be clarified that ‘people and whānau at the centre’ includes the workforce.⁹⁶ This included:

- explicit reference to the participation of the workforce in service design
- acknowledging and supporting the existing problem gambling workforce across DHBs and community services
- enabling training and development of the workforce across DHBs, community services and other relevant agencies.

2.1.4. Submitters suggested rewording the draft strategic goal

The draft strategic goal was ‘to promote equity and wellbeing by preventing and reducing gambling-related harm’. Health and social services submitters, service providers and NCGM submitters suggested amendments to the strategic goal, including:

- being more ambitious with regard to eliminating harm:
 - ‘to promote equity and wellbeing by protecting against, preventing and **eliminating gambling-related harm**’ (submitter’s emphasis) (one health and social services submitter)⁹⁷
 - ‘to promote the prevention and reduction of gambling-related harm in a way that promotes equity and wellbeing’ (one health and social services submitter)⁹⁸
- using stronger language which prioritises and ensures that equity is a strategic reality rather than an aspiration – the strategic goal needs to look to ‘give effect to equity’ or ‘to action equity’ and then to promote wellbeing as an incidental outcome of equity-based strategy (one service provider)⁹⁹
- capturing the priority goal which should be to improve equity and to prevent gambling-related harm in the high deprivation communities of Aotearoa (one service provider and one health and social services submitter)¹⁰⁰
- having more critical inclusivity of the industry in focus - while the stated goal may well set a direction for the minimisation of harm related to gambling it was incorrect in its assertion that it is ‘system wide’, and the draft strategy fails to include the very organisations who own (the societies) and operate (the venues) the gaming machines (one NCGM submitter).¹⁰¹

2.1.5. Submitters from across sectors wanted the draft strategic goal to include more specific targets

Submitters from across all sectors expressed support for the strategic goal but wanted it to include more specific targets and tangible steps. Suggestions for additional information to be provided included:

⁹⁶ 28.

⁹⁷ 28.

⁹⁸ 23.

⁹⁹ 41.

¹⁰⁰ 07<35.

¹⁰¹ 44.

- proactive, measurable steps to minimise the occurrence of problem gambling (one local government submitter)¹⁰² or a SMART structure¹⁰³ (one health and social services submitter)¹⁰⁴
- specific reference to socioeconomic deprivation as it influences gambling harm inequities including research and effective data collection and analysis to inform evidence-based decision making (one service provider)¹⁰⁵ and where gambling-related harm is coming from (one service provider).¹⁰⁶

One service provider expressed particular concern for the implementation of the strategic plan for Asian communities, commenting that there was a failure (within the draft strategic plan) to recognise the needs of Asian populations, especially increased suicide rates.¹⁰⁷

2.1.6. Submitters from across sectors agreed with the equity focus, but wanted to see more detail and tailored services

Submitters from across all sectors agreed with the increased focus on equity but wanted to see more tailored services for different groups, and more detail about how the increased focus on equity would actually be achieved.

General statements about improving the equity component of the draft strategy included:

- reference to the how and where equity would be promoted (one service provider and one local government submitter)¹⁰⁸
- requiring tailored services, including targeted actions based on engaging with, listening to, and partnering with the most affected people (two service providers)¹⁰⁹
- noting that health equity cannot be achieved without recognising the micro and macro influences that brought about the inequities in the first place (e.g., discriminatory laws, policies and regulations enacted by the government) – it is important to explicitly recognise the legal, financial and political moves against Māori and their ways of living and knowledge to see how current settings have come to be and build a path to equity (one service provider)¹¹⁰
- including a broader poverty and structural inequality lens; addressing poverty and exclusion in poorest communities must sit alongside the public health measures proposed in the strategy (one health and social services submitter)¹¹¹
- recognising that ‘one size does not fit all’, and population-level interventions may not be designed to centre the specific contexts and needs of different communities within a rights-based framework: priority actions should be designed, resourced and implemented in partnership with communities, and enable tino rangatiratanga and mana motuhake (one health and social services submitter)¹¹²

¹⁰² 15.

¹⁰³ A ‘SMART’ goal is one which is Specific, Measurable, Achievable, Realistic and Time-bound.

¹⁰⁴ 02.

¹⁰⁵ 18.

¹⁰⁶ 27.

¹⁰⁷ 13.

¹⁰⁸ C05

¹⁰⁹ 34,50.

¹¹⁰ 18.

¹¹¹ 23.

¹¹² 49.

- needs of existing ethnic-specific services and peer support should be regularly reviewed, supported and solidified (service provider).¹¹³

Improving equity for Māori could include drawing on the special relationship that the Crown has with Māori under Te Tiriti where Māori are disadvantaged or harmed: this issue needs to be considered carefully and implemented well (two service providers)¹¹⁴. Another service provider noted that the draft strategy was not detailed enough or sufficient on its own to influence systemic and structural changes. Although there are references to various strategies that champion Māori health and description of the principles of Te Tiriti o Waitangi, the strategy lacks clarity about how it will meet its goal of ‘equity and wellbeing’ (one service provider).¹¹⁵ The role of the Māori Health Authority in the consultation on the draft strategy was queried.¹¹⁶

Specific suggestions for improving equity for Pacific peoples were identified, including:

- incorporating *Ola Manuia, Pacific Health and Wellbeing Action Plan 2020-2025* (three service providers and one health and social services submitter)¹¹⁷
- more detail about how the draft strategy will specifically address inequities and improve Pacific peoples’ health outcomes (three service providers).¹¹⁸

2.1.7. Submitters expressed support for the Needs Assessment findings, but had mixed views on whether the draft strategy sufficiently incorporates the Needs Assessment findings

NCGM submitters, gambling industry submitters, health and social services submitters and service providers commented on the Needs Assessment findings, and the perceived level of incorporation of those findings into the draft strategy.

Two service providers generally supported the findings and recommendations of the Needs Assessment findings.¹¹⁹

Submitters considered that the Needs Assessment showed that the current strategy had not delivered, particularly on equity grounds

Six NCGM submitters reproduced large portions of the Needs Assessment findings, and referred to it as ‘damning’ (i.e., the evidence supported their concerns about the amount of progress made over the past 17 years).¹²⁰ Three health and social services submitters considered that the current strategy progress was limited, and that the draft strategy required more focus on equity, service integration, workforce development and health promotion.¹²¹

One NCGM submitter noted that the Needs Assessment found that little to no progress had been made in relation to reducing gambling-related harm inequities for Māori, Pacific and Asian peoples.¹²²

¹¹³ 47.

¹¹⁴ 34,50.

¹¹⁵ 18.

¹¹⁶ 50.

¹¹⁷ 27,29,33,47.

¹¹⁸ 27,29,47.

¹¹⁹ 47,50.

¹²⁰ 05,21,32,38,40,51.

¹²¹ 23,37,52.

¹²² 51.

Submitters considered that more partnership with industry was needed

Four NCGM submitters noted that the draft strategy did not do anything to address the need for improved partnerships with industry (e.g., society staff, venue staff, and industry groups such as Hospitality New Zealand), as identified by the Needs Assessment findings, despite acknowledging that this was needed.¹²³

Submitters considered that the Needs Assessment showed that online gambling was an issue, and this was not addressed sufficiently in the draft strategy

One gambling industry submitter wanted to see more consistency between the Needs Assessment findings and the draft strategy in terms of how online offshore gambling was referenced¹²⁴

One gambling industry submitter considered that the Ministry had effectively utilised the Needs Assessment findings

In contrast to the points above, one gambling industry submitter that it was good to see the Ministry utilising the Needs Assessment findings [in the draft strategy].¹²⁵

2.1.8. There was constructive critique of all four objectives and the associated priority action areas

Twenty-six submitters commented on one or more of the proposed objectives, including 10 service providers, nine health and social services submitters, three NCGM submitters, two individuals, and one local government submitter.¹²⁶ Most provided comments about specific objectives.

Some submitters provided positive feedback on the four objectives and priority action areas generally, including:

- the reduction from 11 objectives (in the current strategy) to four (in the draft strategy) provided increased clarity (one service provider)¹²⁷
- there was support for the proposed priority action areas that would support each of the objectives, and a recognition that the action areas reflected the necessary contributions of DIA and Te Hiringa Hauora (one gambling industry submitter)¹²⁸
- it was noted that the gambling industry had an important role to play in relation to the priority action areas (one gambling industry submitter).¹²⁹

Only a small number of submitters provided explicit opposition to the draft objectives. One individual noted that although they agreed with the goal, they did not agree with the proposed objectives or priority action areas because these were just more of the same (which has not achieved anything, in the submitter's opinion).¹³⁰ This perceived lack of achievement was a consistent theme among those who did not strongly support the draft strategy.

¹²³ 05,21,40,51.

¹²⁴ 42.

¹²⁵ 36.

¹²⁶ 02,06,09,11,13,15,18,23,24,27,31,34,37,38,39,41,42,44,47,48,49,50,51,52,C06,C09.

¹²⁷ 09.

¹²⁸ 42.

¹²⁹ 42.

¹³⁰ C09.

Overarching changes to the draft objectives were suggested

While much of the commentary focused on specific objectives, there was also a range of proposed amendments that could apply across all four draft objectives. Ensuring meaningful connection between the objectives and the Crown's obligations to Māori was important to one service provider, who expressed concern about a perceived lack of connectivity between the strategic priority and the objectives, although they recognised that the objectives show a commitment to preventing and minimising gambling harm in Aotearoa.¹³¹ The submitter also acknowledged the note indicating that the objectives would look to align and enable the five Hauora principles determined by the Wai2575 claim.¹³² The submitter noted that the objectives should have the Hauora objectives embedded within them, not merely aligned or enabled.

Ensuring that the objectives could be measured was important to one health and social services submitter commented that there was sense that the objectives were not measurable and may not be achievable, that associated actions reflected the status quo (lack of ambition reflected by the absence of a meaningful measure for progress), and that there were no key performance indicators.¹³³ This view was similar to the ones expressed about the need for the draft strategic goal to be 'SMART' (above in Section 2.1.5.).

One health and social services submitter noted that objectives two and four aligned to the *Te Hiringa Hauora Strategy and Business Plan* to refocus resources and time to those communities where the need was greatest.¹³⁴ The submitter noted that it is vital to develop strong and strategic relationships to support a collective approach to improving health and wellbeing, and work with others who share the same ambitions and values.¹³⁵ Developing and investing in relationships with the minimising gambling-harm sector and communities was seen as key to optimising all of the objectives, including enabling and resourcing the sector.¹³⁶ The submitter noted that this would need to be supported by the Ministry and DIA so that service providers could meet their needs and goals.¹³⁷ One service provider also noted that under the four objectives, several priority action areas mentioned ensuring equitable participation in community decision-making and partnering with iwi and other Māori organisations.¹³⁸

Objective one: Create a full spectrum of services and supports

Twelve submitters commented on objective one, including eight service providers, three health and social service submitters, and one NCGM submitter.¹³⁹

Most submitters supported objective one.

Some submitters expressed support for the objective, without caveats because objective one address gaps in the spectrum of services and supports that are currently provided, particularly in the areas of peer support and residential treatment for specific groups (one service provider)¹⁴⁰ or because the hauora principles and outcomes address gaps in the spectrum of services and

¹³¹ 41.

¹³² 41.

¹³³ 02.

¹³⁴ 39.

¹³⁵ 39.

¹³⁶ 39.

¹³⁷ 39.

¹³⁸ 27.

¹³⁹ 06,18,23,27,34,37,38,41,47,48,49,50.

¹⁴⁰ 34.

supports provided, particularly in the areas of peer support and residential treatment and for specific groups (two health and social service submitters).¹⁴¹

Other submitters expressed support for objective one generally but outlined improvements that could be made to ensure that the objective was achieved. Suggested improvements included that:

- a broad range of information, support and targeted services should be made available (one service provider)¹⁴²
- more consideration be given of the impact of gambling harm on tamariki and services and supports for tamariki should be explicitly stated and the funding boost focus on supports and services should consider and address whānau impacted by problem gamblers (one service provider and one health and social services submitter)¹⁴³
- there should be more detail to explain how the objective should be interpreted (one service provider)¹⁴⁴
- there should be consideration as to whether the current service model was still fit for purpose and achieving equity (two service providers and two health and social services submitters), including:¹⁴⁵
 - face-to-face services are more appropriately termed ‘specialist gambling harm services’ and need to expand access modalities, particularly to meet COVID-19 lockdown challenges and improve access
 - action to address barriers to access should include increased funding and support for specialist PMGH services to implement online and remote interventions
 - the design and delivery of services must address the gaps identified for Māori, Pacific peoples, Asian peoples and young people, and meet the needs of these diverse groups
 - a holistic, Whānau Ora approach should be implemented to better support those affected by gambling harm as this would involve collaboration across the mental health and addiction sector and with other government agencies, such as the Ministry of Social Development for comprehensive care
 - stronger primary prevention efforts in place for those at low to moderate risk
 - linguistic and cultural knowledge should be better integrated across the system
 - documents and resources available in a range of accessible formats.
- the draft strategy should refer to a ‘culturally safe workforce’ rather than a ‘culturally responsive workforce’, as that would be consistent with the Medical Council of New Zealand’s framing and would ensure that the practitioner is working to address their own biases, assumptions and privilege, rather than continuing to

¹⁴¹ 34,50.

¹⁴² 47.

¹⁴³ 37,38.

¹⁴⁴ 06.

¹⁴⁵ 18,23,27,48.

position their patients as the “exotic other” (one health and social services submitter).¹⁴⁶

One service provider outlined a number of concerns that they had with objective one:¹⁴⁷

- the need to ensure that those who are “well” and “not well” are not compartmentalised
- those already working in the wider addiction and mental health field have their own experiences and history and it seemed unnatural to this submitter to have to sit within a ‘clinical’ role or a ‘lived experience’ role rather than adopting a mindset that acknowledges that they have multiple experiences influencing the work
- the submitter was ‘not convinced’ of the benefits of residential treatment for gambling issues if it would result in funding being diverted from community based/face-to-face services. In this submitter’s experience, those whose main presenting issue is gambling-related harm and who attend a residential programme find that current residential services are not ‘individualised’ enough for them
- it important to acknowledge the difficulties in addressing gambling-related harm (specifically NCGM venues) when the gambling industry is largely self-regulated.

One NCGM sector submitter called for wraparound services that were more flexible and responsive, provided anecdotal evidence that venue staff have been approached by problem gamblers who seek more help than service providers are ‘willing or able to provide’.¹⁴⁸ The NCGM submitter went on to describe the ‘common experience’ of gamblers receiving small amounts of initial face time with a counsellor, with no mechanism for follow-up- this means that there is often not effective rehabilitation.¹⁴⁹ The submitter also noted the need for a more collaborative approach and a move away from silos.¹⁵⁰ The submitter considered that the draft strategy did not adequately address the need to support a gambler fully through their journey to rehabilitation.¹⁵¹

One service provider noted that in creating this objective, there needed to be an ‘aggressive strategy’ which looked to consider the dependency that the gambling harm minimisation sector has on the gambling levy.¹⁵² The submitter urged the Ministry to further consider the role that public health has to play in the full spectrum of services and supports.¹⁵³

Objective two: Shift cultural and social norms

Seventeen submitters commented on objective two, including nine health and social services submitters, seven service providers, and one gambling industry submitter.¹⁵⁴

Objective two was widely supported, with recommendations provided for implementation and improvement.

Some submitters supported the objective without caveats because:

¹⁴⁶ 48.

¹⁴⁷ 06.

¹⁴⁸ 38.

¹⁴⁹ 38.

¹⁵⁰ 38.

¹⁵¹ 38.

¹⁵² 41.

¹⁵³ 41.

¹⁵⁴ 06,11,13,18,23,24,27,28,33,34,37,39,41,42,48,49,50.

- achieving the shift in cultural and social norms was a desirable outcome, and investment in de-stigmatisation initiatives and awareness campaigns would be a substantial leap forward in making services and supports more accessible (one health and social services submitter)¹⁵⁵
- increased awareness in the population would encourage help-seeking behaviours and support others to recognise the signs of harmful gambling (one health and social services submitter)¹⁵⁶
- the move away from personalising gambling harm to a focus on community and equity issues was supported (one health and social services submitter).¹⁵⁷

Submitters expressed support for objective two generally, but also expressed some concerns about the realities of implementing it.

The strategy should consider impacts on whānau/the community as a whole:

- one health and social services submitter and one service provider noted that any campaign to increase public awareness needs to focus on the drivers of harm and the impact of gambling across individuals, families and whānau, and communities and society as a whole, and that consultation on a campaign should include a range of stakeholders including social services, specialist and mainstream services, mental health and addiction services and people with lived experience¹⁵⁸
- one service provider noted that increasing public awareness was important, but how it was framed as a community and equity issue rather than an individual issue was essential, and that any future campaigns should focus on how gambling harm impacts all of society first, so that everyone buys into gambling harm prevention and stigma reduction¹⁵⁹

De-stigmatisation efforts were seen as essential to understand and address harm:

- two service providers supported the need to increase public awareness about the nature of harmful gambling and how to provide support for those with gambling issues, including de-stigmatisation, but noted that engagement with Māori in particular needed to improve, and not occur after decisions have been made¹⁶⁰
- one service provider supported the objective, particularly the strong public health approach outlined in the draft strategy, but noted that an equity response within in this objective would look to recognise the role that Te Ao Māori plays in understanding and addressing gambling harms and norms, in addition to addressing the wider determinants of health, as these form a critical part of informing social norms, in particularly, conversations about poverty, income and employment security, housing and wealth distribution and capability building¹⁶¹
- one service provider was supportive of continuing to improve de-stigmatisation strategies and approaches but were concerned that, like in the area of alcohol

¹⁵⁵ 24.

¹⁵⁶ 24.

¹⁵⁷ 23.

¹⁵⁸ 18,23.

¹⁵⁹ 18.

¹⁶⁰ 34,50.

¹⁶¹ 41.

control, education has largely seemed to be an ineffective strategy to affecting attitude or behaviour change (one service provider)¹⁶²

- one service provider was 'delighted' to see objective two and noted that they had witnessed first-hand the challenges of the stigma experienced by Asian communities in particular. They went on to comment that understanding that gambling harm and stigma are culturally based. is essential when designing an effective social marketing strategy, and provided some examples of specific ways in which Asian communities are harmed by, or respond to gambling, and noted that insight and in-depth cultural knowledge was essential for encouraging behavioural change¹⁶³
- one health and social services submitter recommended that awareness and education programmes, and the de-stigmatisation initiative be developed specifically for target population groups, noting that co-design with population groups would be essential in shifting cultural and social norms.¹⁶⁴

One gambling industry submitter commented that further consideration must be given to the effect that stigmatisation of general gambling participation has on the resulting stigma associated with gambling harm.¹⁶⁵ This submitter considered that its own role was most important in relation to objective two.¹⁶⁶

Prevention is better than a cure: submitters considered that a health promotion and environmental approach should be taken:

- one service provider strongly supported a public health approach focusing on building health environments through policy, health promotion and community engagement, however, believed that policy change was constrained by the Act¹⁶⁷
- one service provider considered that stronger primary prevention efforts are required for those exposed to mild gambling-related harm, and that this would help reduce the number of people developing and being affected by severe gambling harm in the first place¹⁶⁸
- one service provider commented that a focus on prevention would help address inequities, and therefore the priority action area to reduce the stigma attached to gambling was supported, however, it would be more effective to address inequities by changing the environment that people live in and further information about how this would be achieved was needed¹⁶⁹

Submitters repeated that implementation was key:

- one service provider commented that a focus on prevention would help address inequities, and therefore the priority action area to reduce the stigma attached to gambling was supported, however, it would be more effective to address inequities

¹⁶² 06.

¹⁶³ 13.

¹⁶⁴ 37.

¹⁶⁵ 42.

¹⁶⁶ 42.

¹⁶⁷ 18.

¹⁶⁸ 27.

¹⁶⁹ 27.

by changing the environment that people live in and further information about how this would be achieved was needed¹⁷⁰

Submitters considered equity considerations to be essential:

- one service provider noted that access to Lotto and the proliferation of new 'games' remained an issue, particularly in disadvantaged communities and considered that although the draft strategy outlined the increase in this area, it was unclear what approach the Ministry was planning to take to reduce the availability of games, particularly in disadvantaged communities¹⁷¹
- one health and social services submitter expressed their support of the objective, and recommended that the priority action areas be explicit in demonstrating how shifting cultural and social norms would be achieved for the priority population groups from prevention through to treatment¹⁷²

One health and social services submitter suggested additional actions that they wanted to see taken in relation to the objective:

- additional research should be undertaken to look at the community grants model in relation to NCGM gambling, and pointed out that while 1.3 percent of New Zealanders regularly use NCGMs, 50 percent of the NCGMs are in the most deprived communities, which means that the majority of the money being paid out by trusts and societies to community groups is coming from the poorest New Zealanders¹⁷³
- the current funding model was inequitable as the Boards are self-appointed and only accountable to themselves when deciding which groups receive the proceeds of NCGM losses, and suggested that NCGM losses be replaced with a government grants programme, which would, in their opinion, achieve:
 - community and sports funding being secured so services can continue to be delivered
 - losses from the most deprived communities would stop being diverted to national public programmes and national sports interests
 - transparency about who gets what money and what it is used for.¹⁷⁴

One health and social services submitter considered it to be “fundamental to acknowledge that gambling practices were introduced through colonisation and were not present in Te Ao Māori prior to the arrival of Europeans.”¹⁷⁵ The submitter also commented that information and support to make healthy choices about gambling should be widely available, barrier-free and accessible in many languages.¹⁷⁶

¹⁷⁰ 27.

¹⁷¹ 34.

¹⁷² 37.

¹⁷³ 11.

¹⁷⁴ 11,18,27.

¹⁷⁵ 49.

¹⁷⁶ 49.

Objective three: Strengthen leadership and accountability to achieve equity

Sixteen submitters commented on objective three, including six service providers, six health and social services submitters, two gambling industry submitters, one local government submitter, and one NCGM submitter.¹⁷⁷

In relation to objective three, submitters wanted to see much more collaboration between services, government departments and more inclusion of local government. Submitters acknowledged the separate roles of the Ministry and DIA and encouraged the Ministry to take a more active role in driving policy improvement.

Submitters wanted to see more support to improve the regulatory environment:

- the outcome of the *Online Gambling Review* would be fundamental to reducing the significant and increasing spend by New Zealanders on unregulated offshore online gambling websites, which have no mandatory harm minimisation controls (one gambling industry submitter)¹⁷⁸
- the priority areas under this objective should address gambling product design and environments, e.g., the *Gaming Machine National Standards* could be amended to reduce electronic gaming machine salience, and mandate for all machines to have in-built facial recognition so that exclusions can be properly monitored (one service provider)¹⁷⁹
- one service provider had collected questions from its community on objective three:¹⁸⁰
 - is there a plan to invest more into local government or an opportunity for councils to take on some of the regulatory tasks that DIA would usually undertake?
 - what changes can be made to align legislation and the Act to be more relevant?

Submitters considered that the Ministry had an important leadership role:

- objective three involves the Ministry and DIA working closely together, and it was recommended that the Ministry urge DIA to consider effective changes to the gambling environment (two service providers and one health and social services submitter)¹⁸¹
- strong leadership and accountability to achieve the outcomes intended would be essential (one health and social services submitter)¹⁸²
- the Ministry could use this objective to enact the most effective change to fulfil the strategic goal around addressing equity, prevention, and reducing gambling harm (service provider)¹⁸³

Submitters wanted to see more consultation and collaboration:

¹⁷⁷ 06,11,15,18,23,27,31,34,37,39,41,42,44,48,49,50.

¹⁷⁸ 31.

¹⁷⁹ 18.

¹⁸⁰ 50.

¹⁸¹ 11.

¹⁸² 23.

¹⁸³ 27.

- one service provider strongly supported improved leadership and accountability and noted that the priority action areas under objective three were strong. They considered that a component of the responsibility sat with the Ministry to improve communication and information sharing with the sector, other key stakeholders and the public, e.g., research summaries, feedback after reporting periods and intervention service data being supplied back to the sector in a more helpful way:¹⁸⁴
 - the submitter also wanted to see more proactive consultation and collaboration with the whole specialist PMGH service sector to reduce systemic barriers and support innovative and collaborative problem-solving
- two service providers acknowledged the Needs Assessment findings, and noted that the Ministry could do more to:¹⁸⁵
 - develop and maintain mutually respectful partnerships and relationships
 - consult and engage with gambling harm services, gambling operators, researchers and communities
 - create more decisive leadership in gambling harm minimisation and reduction.

Working with local government was seen as important:

- support for a collaborative approach between central government, local government, problem gambling service providers, the gambling sector and communities to prevent and minimise gambling-related harm and reduce gambling-related health inequities, but wanted to see more reference to the role local government plays in gambling harm prevention, and considered that given principles of community focus and collaboration, local government should be explicitly recognised as a strategic partner (one local government submitter)¹⁸⁶

Other submitters supported objective three, but considered that there were ways that it could be improved:

- one health and social services submitter noted that the action area to improve the legislative and regulatory framework was an opportunity to address the current gambling environment and explore policy levers outside of what currently exists and noted that effective policy levers will be different for each industry setting (e.g., Lotto, NCGM, casinos, sports betting, and online gambling)¹⁸⁷
- one service provider supported objective three and recommended that the objective gives effect to the concerns raised through the Needs Assessment, in addition to encouraging substantive action to ensure that there is an ecosystem of leadership and accountability working comprehensively towards achieving equity in gambling harm minimisation¹⁸⁸

¹⁸⁴ 18.

¹⁸⁵ 34,50.

¹⁸⁶ 15.

¹⁸⁷ 39.

¹⁸⁸ 41.

- one health and social services submitter supported the objective, and made the following suggestions:¹⁸⁹
 - people with lived experience should be in leadership roles
 - strong leadership of the equity framework is required.

One health and social services submitter agreed with the objective, but considered that the last two priority areas of the objective were not clearly translated in the draft service plan activities.¹⁹⁰

Gambling industry submitters wanted to see more recognition for the role of gambling operators. One gambling industry submitter noted this particularly in relation to supporting priority action areas.¹⁹¹ The submitter commented that consideration should be given to development of a priority action area to create a framework for ensuring that helpful and meaningful connection and consultation is maintained between the Ministry, DIA and gambling operators who wish to provide ongoing insight and information that can help shape this objective.¹⁹² A NCGM submitter commented that no consideration was given in this objective to the role the NCGM sector could play, or the benefits to be gained by their inclusion in a consultative and collaborative process.¹⁹³ This submitter noted that the NCGM sector and their representative body (GMANZ) have enacted a socially responsible approach to the safe operation of NCGMs.¹⁹⁴ The submitter considered that more collaboration with GMANZ and other sector representatives around programme development would be beneficial. In addition, a 'goodwill initiative' could include funding sector involvement in these initiatives.¹⁹⁵

One health and social services submitter noted that there were growing calls to address the funding of community projects and groups from the proceeds of gambling, and that the reliance of clubs and groups on trusts and societies grants results in the social acceptance of under-resourced communities funding the recreational pursuits of wealthier populations.¹⁹⁶

Objective four: Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples, and young people/rangatahi

Sixteen submitters commented on objective four, including seven health and social services submitters, six service providers, one local government submitter, one NCGM submitter, and an individual.¹⁹⁷

Detailed discussion on priority populations is also provided below in Section 2.3.

Submitters expressed strong support for objective four. One health and social services submitter suggested making this objective number one, to better acknowledge the increased risk of priority groups.¹⁹⁸ One service provider agreed with the identification of Māori, Pacific peoples, Asian

¹⁸⁹ 48.

¹⁹⁰ 37.

¹⁹¹ 42.

¹⁹² 42.

¹⁹³ 44.

¹⁹⁴ 44.

¹⁹⁵ 44.

¹⁹⁶ 49.

¹⁹⁷ 06,15,18,23,24,27,34,37,39,41,44,48,49,50,52,C06.

¹⁹⁸ 52.

peoples, and rangatahi as priority population groups.¹⁹⁹ One local government submitter strongly supported the objective four priority of improving host responsibility.²⁰⁰

Submitters expressed strong support for the focus on equity and commented on how the focus could be strengthened:

- objective four was endorsed with a focus on addressing and reducing health inequities, and it was noted that it aligned with *Te Hiringa Hauora's* approach of seeing gambling harm as an equity issue, and also aligned with the priority action areas in *Whakamaua: Tino rangatiratanga/self-determination, partnership, protection, options and equity* (one health and social services submitter)²⁰¹
- it was noted that the pace at which equity was being attained was not in step with the harms in the community, and that to overcome these harms, supporting services for Māori with Māori for Māori services must be a priority (one service provider)²⁰²
- more effort was required, as it seems that inequitable health outcomes are not improving (one service provider)²⁰³
- it was considered that all of the equity response was sitting within this objective, and shifts the strategy from being strategic into one in which victim blames those affected by gambling harm the most: it was suggested that the intentions with health and health equity be separated to give effect to the intended outcomes of each (one service provider)²⁰⁴
- the intention to tailor services to address inequities, explore innovations and invest in new services indicated that the draft strategic plan was cognisant of how the gambling landscape has changed (one health and social services submitter).²⁰⁵

Submitters highlighted the importance of co-design and leadership.

- Two service providers noted that it would be beneficial to get feedback on the strategy from the newly established Māori Health Authority- this ensures that Māori shapes a vital element of our future health systems in New Zealand through the strategic framework. This feedback is essential for Māori and ensures that under Te Tiriti o Waitangi, Tangata Whenua and Tangata Tiriti are working together in partnership to help resolve those equity issues.²⁰⁶
- One health and social services submitter agreed with objective four, and supported collaboration and co-design with priority populations, and accelerating and spreading Kaupapa Māori services and Pacific values-based services. However, the submitter cautioned that in order for this objective to be successful, the work needs to be well supported by workforce capabilities and funding.²⁰⁷

¹⁹⁹ 27.

²⁰⁰ 15.

²⁰¹ 39.

²⁰² C06.

²⁰³ 18.

²⁰⁴ 41.

²⁰⁵ 24.

²⁰⁶ 34,50.

²⁰⁷ 37.

- One health and social services submitter strongly supported the objective and encouraged the Ministry to involve people from these populations who have lived experience of gambling-related harm, in leadership roles.²⁰⁸
- Another health and social services submitter welcomed reference to lived experience in objective four, and noted that the quality and strength of solutions supporting the strategy’s continued implementation will build on the ability of the Ministry and its partners to listen and learn from the diverse experiences of people who have lived with gambling addiction or been impacted by gambling harm as a whānau member.²⁰⁹

Submitters wanted to see more information about how the objective would be implemented.

One service provider commented that more details on what objective four will actually mean are needed, and that based on the information presented, they did not agree with the objective.²¹⁰ This submitter commented that trying to define people accessing services by one ethnicity does not accurately define the importance of one ethnicity to them, the range of ethnicities that they may identify with, or the multiple other factors that contribute to why they may be experiencing gambling harm. The submitter commented that the objective implies that Māori, Pacific peoples, Asian peoples and young people are homogeneous groups who are best served by a specific services model.²¹¹ In this submitter’s opinion, the “majority of people presenting for support are Pakeha, and this approach does not provide a good picture on why it is that some priority populations are affected by gambling-related harm- e.g., it is likely to be due to multiple socio-economic factors which are not necessarily culturally-specific”.²¹²

One NCGM submitter strongly supported the emphasis on priority populations, but argued that the draft strategy was silent on direction for the NCGM sector and the role that it could play in implementing this aspect of the strategy.²¹³

2.1.9. Two submitters were unclear about the question or unsure about their answer

Two submitters seemed unclear or unsure about their answer:

- one individual noted that Pacific peoples and Asian peoples should also be included as priority populations (*note that Pacific peoples and Asian peoples are included as priority populations*)²¹⁴
- one NCGM submitter commented that they did not take a view on the appropriate detailed steps that would be necessary to create a system that can successfully deal with addiction.²¹⁵

²⁰⁸ 48.

²⁰⁹ 49.

²¹⁰ 06.

²¹¹ 06.

²¹² 06.

²¹³ 44.

²¹⁴ 16.

²¹⁵ 43.

2.1.10. Key themes from consultation hui

Comments from hui on the draft strategic plan

- Stakeholders commented that objective one (*Create a full spectrum of services and supports*) requires DIA to give iwi authority. Stakeholders noted that it would be hard to see how iwi voice was useful if there was no authority.
- Stakeholders questioned the Ministry’s strategy for achieving equity in terms of implementation and harm minimisation (with respect to objective three: *Strengthen leadership and accountability to achieve equity*) and emphasised that this work should involve Te Tiriti o Waitangi.

2.2. The degree of agreement that the draft strategic plan adequately reflected changes in the gambling environment

Most submitters did not agree that the draft strategic plan adequately reflected changes in the gambling environment: only nine out of the 31 who answered question two agreed that it did. Of those, seven provided a simple “Yes” answer to question two. A further two qualified their agreement (i.e. they supported it, but also commented on how it could better reflect changes).

Comments on the changes that could be made to better reflect the gambling environment included:

- increased prioritisation of online gambling throughout the draft strategy, including more emphasis on the harm from offshore gambling
- increased funding for and adoption of technology to prevent gambling harm
- changes to the way treatment providers are contracted so that service provision is more effective (including introduction of a cost pressure adjustment for service providers, introduction of harm minimisation ratings and the impact of COVID-19)
- increased support or training for venue staff and service providers.

Each of these themes are discussed in the sections below.

2.2.1. Two submitters qualified their agreement that the draft strategic plan adequately reflected changes in the gambling environment

One health and social service submitter agreed that the draft strategy includes appropriate changes, particularly shifting cultural and social norms, however, it considered that the draft strategy required more analysis in understanding the enablers of models and workforce capacity and capability.²¹⁶ One service provider commented that although they did not disagree that the strategic plan adequately reflects changes in the gambling environment, they considered that it did not propose anything significantly different from the current strategic plan.²¹⁷

²¹⁶ C04.

²¹⁷ 06.

2.2.2. Submitters from across sectors wanted to see increased prioritisation of online gambling

Twenty-three submitters (six health and social services submitters, six service providers, three gambling industry submitters, three NCGM submitters, two individuals, two local government submitters, and one government submitter)²¹⁸ wanted to see increased prioritisation of the harms of online gambling.

Generic comments about increased prioritisation of online gambling included:

- increased recognition of the growth of online offshore gambling and the 'gamblification' of sports and gaming, and information around how the harms would be mitigated (two service providers and two gambling industry submitters)²¹⁹
- more work to address the unregulated online gambling industry and the negative effects that this form of gambling has on the wider community (one NCGM submitter)²²⁰
- more work to assess need for those gambling in the online environment and to understand rangatahi engaged in gambling-related behaviours such as youth gaming (one health and social services submitter)²²¹
- the approach towards online gambling is too slow (one individual)²²²
- best practice would ensure that spend and time limits and exclusion orders are not subverted by players gambling online (one NCGM submitter)²²³
- the strategy does not reflect the increased needs from the online gambling sector, and is not nimble enough to adjust to the change in need over a three-year period (one health and social services submitter)²²⁴
- more discussion is needed about the increasingly blurred lines between online gaming and gambling – loot boxes are only one aspect of the issue, with other aspects of gambling relating to gaming including opportunities for gambling within online games (one individual).²²⁵

Submitters made a number of specific comments about what could be done to improve the approach to online gambling (much of it regulatory):

- a recommendation that the Ministry work with Māori from a Kaupapa Māori perspective to work with DIA to explore regulation of the emerging technologies that result in gambling harm or addictive behaviours such as in-app purchasing by young people in games and other online platforms, with a view to including them in the definition of gambling and seeking to obtain a levy (one government submitter)²²⁶

²¹⁸ 01,06,12,16,18,19,25,29,30,33,35,36,37,41,42,43,45,55,C01,C04,C07,C08,C09.

²¹⁹ 25,30,42,C07.

²²⁰ C01.

²²¹ 35.

²²² C09.

²²³ 19.

²²⁴ 33.

²²⁵ 01.

²²⁶ 55.

- clear intention is needed to understand the impact of online gambling and the reach of this to understand what it means (one health and social services submitter)²²⁷
- online gambling and the convergence of gaming and gambling needs to be more of a priority - the sector is struggling to respond with almost no data/information available to support decision-making (one service provider)²²⁸
- specialist services targeted specifically at harm created online need to be created and funded - with the current levy formula, only onshore online gambling provides funds for gambling harm prevention services (one service provider)²²⁹
- online gambling requires the strongest regulation possible - there is a concern that online platforms could lead to disproportionate harm for Pacific communities, particularly if the online gambling industry is allowed to grow and freely target Pacific communities (one service provider)²³⁰
- regulation needs to future-proof and consider the impact of COVID-19, and in particular the dramatic increase of online gambling during the pandemic – the ease of access in online gambling not only exposes gambling behaviour to tamariki at home but increases risk of child neglect (one health and social services submitter)²³¹
- there has been little effort put into how to navigate online gambling – this strategy needs to show leadership and outline how those who are operating under this strategy navigate the online gambling space (one service provider)²³²
- despite the evidence that online gambling is growing, there does not yet seem to be any focus on the identification and support of problem gamblers in this sector (one NCGM submitter)²³³
- there should be controls put on online gambling, including all banks following Kiwibank’s lead and putting voluntary blocks on customer’s access to online gambling sites (one health and social services submitter)²³⁴
- the strategy needs to be more agile and responsive to new emerging harms from technologies that mimic gambling – anything that triggers gambling should fit the definition of what the levy can be spent on, rather than limiting it to activities associated with levy funders (one government submitter).²³⁵

In contrast, one gambling industry submitter considered that a clearer distinction needs to be drawn between general participation in gaming (through playing, or watching Esports), and participation in real money risk-reward mechanics within gaming (i.e., loot boxes).²³⁶

²²⁷ C08.

²²⁸ 18.

²²⁹ 25.

²³⁰ 29.

²³¹ 37.

²³² 41.

²³³ 43.

²³⁴ 45.

²³⁵ 55.

²³⁶ 42.

2.2.3. Submitters from across sectors wanted to see more emphasis on the harm from offshore gambling in particular

Gambling industry and health and social services submitters commented on the growth of spending on offshore gambling products and recognised a need for more emphasis on the harm arising from offshore gambling. Mechanisms to address the harm from offshore gambling products were suggested.

- Increase regulation of online gambling by approving New Zealand-based operators and restricting or excluding offshore operators: this would give greater transparency to the impact of online gambling with the added benefits of preventing funds from going offshore, increasing the government tax income, holding online gambling operators to the same standard of host responsibility and inclusion in the levy contribution as other land-based operators (one NCGM submitter)²³⁷
- Accurately quantify the scale of the offshore online gambling spend, and incorporate strategic considerations that are specific to the harm associated with offshore online gambling (one gambling industry submitter and one local government submitter)²³⁸
- Develop a 'cybersecurity mandate' to ban offshore gambling sites (one health and social services submitter)²³⁹
- Actively advocate for regulation of the offshore online casino market (noting that this submitter was 'confident' in the robust player safety approach taken by their own domestic online gambling operations) (one gambling industry submitter).²⁴⁰

2.2.4. Submitters wanted to see increased funding for and adoption of technology

Gambling industry submitters and service providers were disappointed with the proposed funding and use of technology to minimise gambling harm.

One NCGM submitter commented that none of the technology fund should be used on technology that does not have a direct harm minimisation benefit (e.g., administration items used by treatment providers such as laptops).²⁴¹

Two service providers commented on technology specifically with respect to Pacific populations. One noted that more Pacific families are moving into the regions, which have limited services to provide the support they need – access to technology would reduce barriers for Pacific families.²⁴² Another service provider also commented that the ongoing COVID-19 lockdowns have shifted the way clients are supported online through apps such as Zoom. The submitter suggested that the Ministry provide a technology support fund for gambling clients and their families to be able to access remote support and counselling.²⁴³

²³⁷ 30.

²³⁸ 12,42.

²³⁹ 48.

²⁴⁰ 36.

²⁴¹ 51.

²⁴² 29.

²⁴³ 47.

NCGM submitters wanted the Ministry to spend money from the current technology fund

Three NCGM submitters commented that it was disappointing that no money from the current technology fund has been spent to date,²⁴⁴ and two went on to say that they did not accept that the COVID-19 pandemic was the only reason for this underspend.²⁴⁵

- increase the technology budget and actually spend the money, ideally on technology that will make a real difference: at least 10 percent of the budget should be allocated for technology, and the fund should then be used as a priority to meet the cost of facial recognition software and licensing fees at venues in high-deprivation areas (i.e. before any of the fund is used for new pilots) (five NCGM submitters, one gambling industry submitter)²⁴⁶
- how the technology fund is used should be decided using a consultative and collaborative approach with the industry (one NCGM submitter).²⁴⁷

One individual and one NCGM sector submitter wanted to see better monitoring of individual spends

One individual noted that there is no use of technology to assist in monitoring current gamblers, and that to stop harm there needed to be better monitoring in place to monitor spend per person via online products or systems in physical products to monitor player behaviour.²⁴⁸ In addition, an NCGM submitter considered that gaming machines should require some form of unique identifier to activate plan (e.g., wallet, card etc.) linked to Inland Revenue's records to set a maximum spend limit using artificial intelligence algorithms plus a maximum daily time limit and would prevent a player who is subject to exclusion from placing credit onto a machine and playing.²⁴⁹

Gambling industry submitters recommended funding for specific technologies

Facial recognition:

- more funding and emphasis should be placed on helping with the installation and operation of harm minimisation technology at gambling venues such as facial recognition (six NCGM submitters and one gambling industry submitter)²⁵⁰
- at least one percent of the levy fund should be allocated towards funding facial recognition licence fees (one NCGM submitter)²⁵¹

Self-help tools:

- fund self-help tools, such as a web-based tool that enables individuals to request that they be excluded- then they don't have to wait to see a counsellor to benefit from exclusion (four NCGM submitters and one gambling industry submitter)²⁵²

²⁴⁴ 21,40,51.

²⁴⁵ 21,51.

²⁴⁶ 04,05,20,32,40,51.

²⁴⁷ 51.

²⁴⁸ C09.

²⁴⁹ 19.

²⁵⁰ 03,04,10,20,21,22,51.

²⁵¹ 10.

²⁵² 10,19,20,22,32.

- investment in the CONCERN National Database (administered by the Salvation Army) (one NCGM submitter)²⁵³

MVEs:

- effective MVE is valuable for effectively treating gambling harm, and technological aids are required to assist with effective monitoring and enforcement of exclusion orders (two NCGM submitters and one gambling industry submitter).²⁵⁴

2.2.5. Submitters made comments about service providers and funding models

Two submitters commented generally on treatment services. Each presented different issues.

One NCGM submitter wanted to see less funding for treatment providers who are unwilling to 'work with' the gambling industry, and more funding for treatment providers who are willing to do so. They considered that society and venue staff should be included as part of the treatment services provided to those with gambling issues and should not be 'treated as the enemy'.²⁵⁵

One local government submitter commented that the draft strategy did not indicate how public health and clinical interventions will be allocated to areas of need rather than being funded by service providers.²⁵⁶

Two submitters suggested a cost pressure adjustment for service providers

One service provider and one health and social services submitter commented that organisations should have yearly general cost pressure uplifts worked into their contracts to maintain good quality services and meet growing demand.²⁵⁷

One NCGM submitter wanted to see harm minimisation ratings

One NCGM submitter considered that best practice would be for venues to have harm minimisation ratings, and rewards for venues with high standards.²⁵⁸ One of the requirements to reach the best rating could be to have a minimum number of staff who have undertaken an NZQA gambling-related qualification and undertaken a minimum number of hours each year of ongoing professional development.²⁵⁹

Services providers and health and social sector submitters commented on the impact of COVID-19

One health and social services submitter who represents the largest professional health workforce who predominately service the testing and vaccination centres for mate korona (COVID-19) commented that it is important that investment in improving the continued constraints that members are facing with minimal changes in cultural and work safe conditions,

²⁵³ 38.

²⁵⁴ 20,38,40.

²⁵⁵ 04.

²⁵⁶ 12.

²⁵⁷ 25,33.

²⁵⁸ 19.

²⁵⁹ 19.

unequal pay and limited access to necessary health and safety equipment and resources, remains topical when reflecting population needs.²⁶⁰

Another health and social services submitter acknowledged that COVID-19 was a factor in slowing down progress, however the prevalence of gambling harm remained the same.²⁶¹ The submitter was particularly concerned for the impact on priority population groups, and the ongoing detrimental effects on those most impacted by gambling harm, however noted that the strategy needs to be more ambitious and monitoring more rigorous if it is to reduce risks at an equitable level.²⁶²

One service provider commented that COVID-19 drastically changed the gambling landscape in Aotearoa.²⁶³ COVID-19 has exacerbated the psychosocial stressors which are impacting on whānau, which leaves communities more vulnerable and susceptible to predatory practices which act as a precursor for gambling harm (such as housing security, loan sharking and other such practices). The submitter considered that is critical to ensuring that the strategy is fit for purpose and that responsive measures are put in place to manage the interplay between the pandemic, emergency legislative measures and the impact that these have on whānau.²⁶⁴

One service provider commented that the recent COVID-19 pandemic highlighted the need for ongoing support for the Pacific community through consultations, engagement, and connecting with the community to come together to support one another.²⁶⁵

2.2.6. Some submitters wanted to see increased support or training

One NCGM submitter commented that the Ministry should develop and facilitate partnerships with gaming society staff and gambling venue staff, and that funding should be allocated for Hospitality New Zealand’s proposed NZQA gambling qualification and harm minimisation leadership course.²⁶⁶

One service provider commented that significant efforts and resourcing need to be directed towards ensuring that the workforce is fit for purpose and responsive to the emergent gambling issues in Aotearoa to best reach, engage with and support whānau who are engaging in harmful gambling.²⁶⁷ More support is needed to help Kaimahi bridge the cultural and linguistic divide to ensure gambling venues are supported.²⁶⁸

2.2.7. Key themes from consultation hui

<p style="text-align: center;">Comments from hui on key changes in the gambling environment</p> <ul style="list-style-type: none">Stakeholders strongly supported increased focus on online gambling, with some commenting that it was important to break down the different parts of online gambling e.g. Lotto, online scratchies, TAB, offshore casinos, etc. as this would

²⁶⁰ C04.
²⁶¹ 37.
²⁶² 37.
²⁶³ 41.
²⁶⁴ 41.
²⁶⁵ 46.
²⁶⁶ 05.
²⁶⁷ 41.
²⁶⁸ 41.

provide a better understanding of who is doing what online, and the harm being caused.

- Stakeholders at multiple hui discussed the need for interventions to prevent aggressive promotion of online gambling (e.g. pop-up adds on phones within other apps).
- Stakeholders discussed the need to ‘move into the future’ with service online such as online chat, apps and text, and noted that this sort of engagement would allow the sector to be more nimble, particularly in engaging young people online.

2.3. Priority populations

Stakeholders were asked whether they had any comments to make on the priority populations, including how inequities will be addressed. A total of 34 submitters commented on priority populations, including 12 service providers, ten health and social services submitters, four local government submitters, four individuals, two NCGM submitters, one government submitter, and one gambling industry submitter.²⁶⁹

There is also a discussion of priority populations above in Section 2.1.8., in relation to objective four.

Submitters made specific comments on each of the priority populations (Asian, Māori, Pacific and rangatahi), as well as general comments about the focus on priority populations. Some submitters also made suggestions for additional priority populations. Each of these themes are discussed in the sections below.

2.3.1. Submitters from across sectors made general comments about the focus on priority populations

Submitters from across all sectors made general comments about the focus on priority populations, many of them positive. Positive comments included agreement with the stronger focus on priority populations (three health and social services submitters, three service providers, one NCGM submitter and one gambling industry submitter)²⁷⁰ and support for an independent focus on restoring health and thriving aspirations for those populations most at risk (two health and social services submitters, one service provider).²⁷¹ One service provider specifically agreed with prioritising localised and ‘by X for X’ approaches and supporting priority populations into the workforce.²⁷² Other reasons for supporting a priority population approach were that priority populations are disproportionately affected by gambling harm and the intent to address inequity is important (one health and social services submitter).²⁷³ One health and social services submitter specifically supported the addition of rangatahi and Asian into priority populations.²⁷⁴

While there was strong support for the priority populations, there were also suggestions about how to strengthen the draft strategic plan. One service provider noted that there is significant cross-over in priority groups - Māori and Pacific populations are relatively young, and this

²⁶⁹01,06,08,09,11,12,13,15,16,18,24,25,27,28,29,31,33,35,37,39,41,43,45,46,47,48,55,C01,C02,C04,C05,C06,C07,C09.

²⁷⁰ 09,11,13,27,31,37,39,43.

²⁷¹ 25,33,C04.

²⁷² 18.

²⁷³ 24.

²⁷⁴ 33.

intersectionality needs to be considered when working with priority populations.²⁷⁵ Another service provider also noted that the Ministry should take a cross sector approach when it comes to undertaking gambling prevention with young Pacific people.²⁷⁶ Submitters also made specific suggestions.

Submitters wanted to see more accessible resources

- One local government submitter noted that the proposal to translate problem gambling resources into Te Reo Māori, Pacific and Asian languages is a positive step towards raising awareness and educating people.²⁷⁷
- One individual noted that the use of signage in different languages had been slow to roll out.²⁷⁸
- One individual commended the use of Pacific and Māori language material but noted that the growth of the number of Indian populations who gamble was not being represented in written materials.²⁷⁹

Submitters wanted to see engagement with priority population communities in all design and decision-making about gambling (including urban planning)

Submitters made a range of comments regarding better engagement with priority populations in design and decision-making:

- better use of the NGO and community sector to help address the inequities facing Māori and Pacific people was recommended (one service provider and one health and social services submitter)²⁸⁰
- when approaching priority populations make it a key focus to include iwi and Pacific people - this would strengthen the approach and delivery of the strategy (one local government submitter)²⁸¹
- consider regional town planning strategies that invest in economic development at a neighbourhood level critical to urban regeneration - cohesion in all aspects of community has a connection to new spaces, business development needs, proactive relationship engagement reflecting our Māori and Pacific communities (one individual)²⁸²
- the Ministry was recommended to involve the perspectives of the Lived Experience Advisory group to co-design positive, equity-enhancing statements (one health and social services submitter).²⁸³

²⁷⁵ 27.

²⁷⁶ 29.

²⁷⁷ 15.

²⁷⁸ C09.

²⁷⁹ C09.

²⁸⁰ 25,33.

²⁸¹ C02.

²⁸² C06.

²⁸³ 24.

Submitters wanted to see more research specific to priority populations

One health and social services submitter considered that further research should be done into vulnerable populations in terms of understanding the causes of gambling harm, and barriers to accessing services - combine research with evaluation into what works for vulnerable populations and how to improve services.²⁸⁴

Submitters wanted to see more acknowledgement of the complexity of priority populations

Health and social services submitters commented:

- priority populations needed to be considered not only as individuals but in the context of their tamariki, family and community and for Māori, their whānau, hapū and iwi²⁸⁵
- the draft strategy did not consider the complexities of groups within the Pacific and Asian ethnicities – access barriers to supports and services, such as language and cultural barriers are unique to these groups and continue to be a problem.²⁸⁶

One service provider disagreed with the focus on additional resources such as scholarships and noted that resource allocation should be based on need, not ideology, and clinical and public health practitioners should have a high degree of evidence-based training and be able to operate in a culturally appropriate manner.²⁸⁷

2.3.2. Asian populations

Submitters were generally supportive of the inclusion of Asian populations in the draft strategy. Comments about Asian populations focused on the need for early inclusion in the development of pilots and services, and more emphasis on the diversity of Asian populations, rather than a 'one-size-fits-all' approach.

Two service providers provided detailed feedback on the inclusion of Asian populations and encouraged the inclusion of Asian populations early in the development of pilots, technology-related innovation, intensive support pilot, and peer workforce pilot and expansion.²⁸⁸

One health and social services submitter commented that the use of the term 'Asian' is problematic, and there is risk in treating all Asian people as a single group.²⁸⁹ Being culturally aware was seen as being essential - it is not merely relaying the draft strategy to Asian communities but ensuring that unique cultural views are acknowledged so that messages are meaningful in an Asian context.²⁹⁰

Problem gambling and seeking help for addiction was noted as being severely surrounded by stigma in Asian cultures, and many Asians in New Zealand do not engage with 'mainstream' communities.²⁹¹ One service provider also noted that New Zealand's growth of Asian communities and linguistic groups, each with its own cultural traits and health profiles, presents a complex challenge to service providers to achieve equitable access. Current experience and research

²⁸⁴ 11.

²⁸⁵ 37.

²⁸⁶ 18,37.

²⁸⁷ 06.

²⁸⁸ 13,27.

²⁸⁹ 33.

²⁹⁰ 13.

²⁹¹ 13.

conducted in New Zealand showed that Asian people encounter difficulties accessing New Zealand health, mental health and addiction services. Other structural barriers experienced by new migrants/international students included unfamiliarity with the health and social system in New Zealand. Another health and social services submitter commented that the top three ways Asian people seek support are turning to family and friends, self-help, and support groups (face-to-face).²⁹²

There was a lack of culturally and linguistically appropriate information and resources to make informed decisions about living conditions, and some international students were being exploited through labour markets. To date, there is still only one dedicated mental health and addiction service providing culturally and linguistically appropriate services for Asians in New Zealand.²⁹³ This submitter considered that there was an overall lack of national strategy for Asian New Zealanders to achieve health and mental health equity.²⁹⁴

2.3.3. Māori populations

Submitters generally supported the discussion of Māori populations in the draft strategy, but considered that there should be further commitment to increase Māori inclusion in the design and delivery of PMGH services.

Focus on whānau and Kaupapa Māori services

Comments included a strong focus on whānau:

- interventions require strong consideration of whānau because the whānau as a whole is affected when an individual is affected by gambling harm (one health and social services submitter)²⁹⁵
- it is important that a variety of approaches and services are used to inform outcomes, including for Māori, a whānau-centred Kaupapa approach (one health and social services submitter)²⁹⁶
- life skills in whānau and community are the tools and resources that are acknowledged as a means of enhancing people's mana and Māori-developed Kaupapa programmes can co-exist as a co-designed programme with hapū and iwi and other services (one individual).²⁹⁷

There was support for increased Kaupapa Māori services. To deliver on Te Tiriti o Waitangi principles, there should be further commitment to increase the number and funding of kaupapa Māori gambling harm reduction services (one health and social services submitter, one service provider and one local government submitter).²⁹⁸ The service provider also considered that while the draft strategy effectively recognised the health inequities that Māori face, there was a gap between how Te Tiriti would be implemented and actioned, and how inequities would be addressed.²⁹⁹ This submitter commented that health inequities may also be addressed by established Māori pathways within general services to complement Kaupapa Māori services and

²⁹² 37.

²⁹³ 13.

²⁹⁴ 13.

²⁹⁵ 37.

²⁹⁶ C04.

²⁹⁷ C06.

²⁹⁸ 27,35,C05.

²⁹⁹ 27.

improved partnership and protection of Māori includes the Ministry's recognition of indigenous registered bodies for counsellors and social workers - this would help not only benefit by Māori, for Māori services, but such practitioners working outside of Kaupapa Māori services can also help achieve tikanga Māori within general services.

In addition, one individual encouraged the Ministry to provide services in rural communities that will engage, through their local resources, hapū and iwi to support PMGH programs.³⁰⁰ Tikanga and Kawa acknowledged as a mana enhancing 'best practice' of delivering either health promotion programmes or counselling 'kanohi me te kanohi'.³⁰¹

Recognition of the impacts of colonisation

One service provider commented that although the draft strategy championed Māori health and the principles of Te Tiriti, there should be more attempts to deconstruct the ongoing impacts of colonisation in the health sector and its effect on the lives of whānau, hapū and iwi Māori. An example of colonisation perpetuated was the continued high density of NCGM among high Māori populations. The submitter encouraged the Ministry to look at ways to establish partnerships with whānau, hapū and iwi, communities and the gambling sector.³⁰²

Te Tiriti o Waitangi

One government submitter gave some recommendations for Māori involvement in the governance and implementation of the strategy within the context of Te Tiriti o Waitangi:³⁰³

- Māori should be involved in the governance of the strategy
- Māori should be involved in governance of the research stream, and driving research and services to ensure mātauranga Māori is used and applied
- Iwi, hapū and Māori communities should have the ability to decide the strategy on preventing and minimising gambling harm within their communities, including having strong influence over the reduction of pokies machines in their rohe
- Māori health providers should be supported to develop a Māori workforce that can provide culturally appropriate supports and this workforce should also be trained specifically for youth work
- mental health services funded through the draft strategy to treat people with gambling addiction should include Māori providers with long-term contracts and resource to ensure sustainability of services.

A local government submitter supported the identification of Māori and young people as priority populations but queried how the Ministry would adequately address the inequities that these groups face in terms of accessing timely and appropriate support to address and minimise gambling harm.³⁰⁴

³⁰⁰ C06.

³⁰¹ C06.

³⁰² 41.

³⁰³ 55.

³⁰⁴ 12.

One service provider simply commented that targeted funding for Māori services was a positive step in support of Māori populations.³⁰⁵

2.3.4. Pacific populations

Submitters were supportive of the continued focus on Pacific populations, but wanted to see better acknowledgement of the diversity of Pacific peoples.

Three service providers noted that while the Ministry indicated that Pacific peoples were a priority, it remained unclear how the draft strategy would specifically work towards improving Pacific outcomes.³⁰⁶ To address inequities for Pacific peoples, systemic barriers need to be addressed at all levels of the health system, including facilitating and encouraging Pacific leadership, particularly in the gambling harm team at the Ministry.³⁰⁷

One service provider commented that Pacific peoples have distinct worldviews centred on spirituality, culture and family, and must be well understood in order for policy to be effective. Traditional communication, engagement and facilitation within communities is essential.³⁰⁸

Submitters made specific recommendations to improve services for Pacific peoples:

- stronger regulation (not specified) to better protect Pacific peoples from NCGMs and online gambling (one service provider)³⁰⁹
- extend coverage to Pacific Island nations, as for many Pacific families, gambling behaviour is normalised back home, and for some, the behaviour continues when they come to Aotearoa (one service provider)³¹⁰
- enable Pacific trainers with cultural competence and safety skills and expertise in clinical and public health, to address the barriers that Pacific peoples face in accessing high-quality health services (one service provider)³¹¹
- create career opportunities for Pacific peoples to undertake studies, paid internships and work in the PMGH space (one service provider)³¹²
- ensure presence of Pacific leadership at all levels of the health system and particularly in the gambling sector (one service provider).³¹³

2.3.5. Rangatahi/young people

There was support for the inclusion of rangatahi as a priority population (two service providers, one individual and one health and social services submitter).³¹⁴ One service provider agreed that rangatahi, and more broadly, children of gamblers also experience gambling harm and targeted support is required.³¹⁵ Another noted that through focusing prevention efforts earlier,

³⁰⁵ C07.

³⁰⁶ 27.

³⁰⁷ 27,29. /

³⁰⁸ 46.

³⁰⁹ 27.

³¹⁰ 29.

³¹¹ 29.

³¹² 47.

³¹³ 47.

³¹⁴ 01,27,29,37.

³¹⁵ 27.

strengthening protective factors and building resilience among rangatahi, greater impacts and lessened inequities can be achieved (one health and social services submitter).³¹⁶

Defining rangatahi

One service provider noted that rangatahi presenting as young as 11 are not captured because they do not meet the Ministry age requirement for gambling support (aged over 13 years old). It suggested that the Ministry revisit this age criteria, and that this impacts Pacific young people in particular.³¹⁷

Online gambling

Comments about rangatahi included a focus on the harm caused to rangatahi by online gambling/gaming. One service provider noted that gambling for young people can be seen as a new and exciting activity with the potential to make money - this is further expanded with the availability of online gambling and the 'gamification' of gambling (one service provider).³¹⁸

Three service providers considered that not enough is done to address the inequalities experienced by rangatahi, particularly in the online gambling and gaming space, where there is a lot of increased risk for rangatahi in particular (three service providers).³¹⁹ Two other submitters also recognised the impact of online gambling as a risk for young people and suggested that online gambling and gaming need to be better understood with appropriate data available to design and delivery quality interventions, including redesigning service delivery models to methods more suited to rangatahi (e.g., social media) (one service provider and one health and social services submitter).³²⁰

Specifically designed services are needed for rangatahi

One service provider noted that information about how rangatahi will actually be supported is vague.³²¹ Other submitters noted that there is a need for services to be designed with and for rangatahi. In particular, services for young people need to be targeted for rangatahi - what works for other groups might not work for the (one service provider).³²²

One service provider and one government submitter noted that the Ministry and service providers need to collaborate with rangatahi themselves to ensure that service delivery is appropriate. Collaboration would also involve recognising the dynamic needs of young people, and prevention efforts and campaigns should be developed alongside rangatahi to ensure that messaging is effective (one service provider).³²³

Specific steps and services were identified:

- understanding what gambling harm looks like among rangatahi is essential: this includes focusing more on relevant forms of gambling, such as online gambling and ensuring that research and services are informed by the voices of rangatahi

³¹⁶ 39.

³¹⁷ 47.

³¹⁸ 28.

³¹⁹ C07,27,28.

³²⁰ 18,48.

³²¹ 27.

³²² 28.

³²³ 27,55.

including Māori, Asian, Pacific, rainbow, disabled and immigrant communities (one health and social services submitter, one government submitter)³²⁴

- a gambling psycho-education and awareness programme introduced in secondary schools to help build Pacific youth capacity and coping skills in particularly around minimising gambling harm (one service provider).³²⁵

Some specific recommendations from one government submitter were that:³²⁶

- regulation should be improved to prevent rangatahi from accessing gambling
- education should be provided for parents and caregivers of rangatahi at risk of gambling harm.

2.3.6. Submitters considered that other priority populations should be included

Seven submitters commented that there were other priority populations that could be included:

- recent migrants because they are particularly vulnerable to gambling, and often do not seek early intervention (one local government submitter and one service provider)³²⁷
- New Zealand European/Pakeha as they make up a substantially larger portion of the community (one NCGM submitter)³²⁸
- people aged over 65 years, particularly given the impact of COVID-19 lockdowns on this population (one service provider)³²⁹
- tamariki to prevent intergenerational harm, including in particular, support for mothers who are gamblers, or mothers who are concerned significant others (one health and social services submitter)³³⁰
- people with disabilities because their increased vulnerability to gambling harm was not explicitly explained enough in the strategy (or the draft service plan) (one health and social services provider)³³¹
- rural populations who may have a different risk profile of needs than urban gamblers, and noted that small towns can miss out on specialised services (one health and social services submitter).³³²

One individual commented that the draft strategy should focus on all ethnic groups who are harmed by gambling, rather than just Māori, Pacific and Asian populations.³³³

³²⁴ 39,55.

³²⁵ 47.

³²⁶ 55.

³²⁷ 15,18.

³²⁸ C01.

³²⁹ 08.

³³⁰ 37.

³³¹ 37.

³³² 45.

³³³ 16.

2.3.7. Key themes from consultation hui

Comments from hui on priority populations

- Stakeholders at the Māori and Pacific-focused hui commented that although priority populations were consulted with on the draft strategy, there was a feeling that they had not been included in the development, and noted the importance of having an indigenous advisory group.
- Stakeholders wanted to see more information about what would actually be done to cater for different ethnic communities, particularly within the priority populations of Asian peoples and Pacific peoples.
- Stakeholders wanted to see a detailed action plan for young people to ensure that future gambling harm would be prevented.
- Stakeholders wanted to see more work being done for other priority populations, such as the rainbow community.
- Some stakeholders also wanted to see more research and focus on retirees, and noted that there are a high number of people of retirement age experiencing gambling harm, particularly during lockdowns, when they are more vulnerable and isolated.
- Stakeholders commented that trusts and societies should also shoulder more of the responsibility for reducing harm in priority populations, and gave the example of Christchurch Casino, where services and industry stakeholders had partnered to reduce harm.
- Stakeholders wanted to see specific data on the rates of gambling harm for Pacific against non-Māori and non-Pacific people, and commented that the data shows non-Pacific (including Māori) as the comparison group, when it is well-recognised that Māori are above Pacific peoples in terms of harm rates. Stakeholders were concerned that this presentation of data could pull the comparison group rate close to Pacific populations and potentially downplay the harm – Pacific groups wanted to see Māori removed from the comparison group so that a true picture of Pacific harm could be observed.
- Stakeholders noted that the Gambling Helpline was particularly inaccessible to Pacific populations in terms of linguistically and culturally appropriate services.
- Stakeholders wanted to see dedicated strategies for Pacific peoples and rangatahi.
- Stakeholders noted that there needed to be more consideration of the languages being used by the Ministry, particularly for the diversity of Asian and Pacific populations.
- Stakeholders also wanted to see more focus on the specific factors for different populations, for example in Pacific communities, the main contributors to gambling harm are stigma, poverty, finances and neglect, and a range of different methods, led by Pacific communities, need to be used.
- Stakeholders noted the importance of addressing gambling behaviours in the Pacific Islands, as behaviours were amplified once people moved to New Zealand.

- Stakeholders at the Pacific hui emphasised the need for:
 - support for Pacific peoples by Pacific peoples
 - culturally appropriate, and culturally-specific services, with a move away from the collective culture of ‘Pacific’
 - clarity for funding and leadership in the new health sector
 - upskilling and training for Pacific peoples in gambling harm
 - an emphasis on multi-skilled roles, maximising areas like the unregulated workforce
 - micro-credentialling could be used to build up professional skills in Pacific communities that have a lot of other talents (e.g. life experience).
- Rangatahi commented on the role of social media as a crucial element when trying to communicate with young people. Stakeholders discussed the use of a large social media campaign to help spread awareness and de-stigmatise problem gambling, and suggested a slogan or catch phrase (e.g. drink driving ads).

2.4. What needs to change

Question four asked stakeholders if they had any comments on ‘what needs to change’. Thirty-nine submitters commented on question four, including 12 service providers, 12 health and social service submitters, 12 NCGM submitters, one government submitter, one local government submitter, and one gambling industry submitter.³³⁴

Comments on matters under ‘what needs to change’ included:

- removal of the silos in the addiction space
- better access to and sharing of information
- the need for more research on gambling harm and more effective use of evidence
- the need for more education
- more of a focus on de-stigmatisation
- opportunities for co-design
- development of a peer support workforce
- stronger commitment to developing a skilled workforce
- express commitment to supporting priority populations
- introduction of targets for service providers.

Note that much of what was discussed in answer to this question is repeated elsewhere in this document (e.g. research priorities, de-stigmatisation, silos). Content may be repeated here for completeness, and to ensure that all comments are fairly represented.

³³⁴03,/04,05,07,08,09,10,11,13,17,18,19,21,24,25,27,28,29,32,34,35,37,38,39,40,41,42,43,44,45,46,48,49,51,52,55,C04,C05,C08.

One health and social services submitter strongly agreed with three changes listed in particular:³³⁵

- recognition of specialist skills
- recognition that the causes of harmful gambling are complex
- a commitment to address gaps in the spectrum of services and supports that are currently provided.

2.4.1. Submitters from all sectors wanted to see silos in the addiction space removed

NCGM submitters and health and social services submitters expressed strong support for a move away from dedicated gambling and towards addressing of comorbidities.

NCGM submitters strongly supported the consolidation of gambling-related work with other comorbidity issues such as alcohol harm, mental health and budgeting needs, and commented:

- a treatment service that can only deal with one addiction, when comorbidity is so common, is not fit for purpose³³⁶
- consolidation of services would provide better outcomes for people with comorbidities, and is also more efficient³³⁷
- the problem gambling levy should only fund gambling-related counselling and support, however, the Ministry could develop a fair and workable system which monitors the treatment provided and part-funds a consolidated service in proportion to the gambling work undertaken (legislative change is not required)³³⁸
- there should be a move away from a technical approach to funding, to an outcome-focused approach³³⁹
- treatment contracts should be awarded to agencies that can address a range of addictions, with funding allocations made on the basis of a client's addictions³⁴⁰
- gambling treatment that is currently provided is not a comprehensive, wraparound service, and is largely unavailable for people with work commitments or childcare obligations (no face-to-face services available after hours or for clients who live outside major cities)³⁴¹
- contracts with existing gambling-only treatment providers need to be wound down, and new contracts entered into with mental health and general addiction services that are able to provide a full range of support, including gambling addiction treatment³⁴²
- consolidation would also enable smaller regions to have gambling services (as part of a range of services available), and eliminate some of the barriers to accessing treatment³⁴³

³³⁵ 52.

³³⁶ 05,10,19,32,51.

³³⁷ 03,05,10,19,40,43,44,51.

³³⁸ 03,04,05,21,40,44,51.

³³⁹ 05,51.

³⁴⁰ 05,10,19,32,51.

³⁴¹ 04.

³⁴² 04,05,10,51.

³⁴³ 05,21,44,51.

- moving away from the silo system will also reduce the relapse rate, as comorbidities will be treated as well.³⁴⁴

In addition, one health and social services submitter commented that silos need to be broken down and integrated care provided to give clients holistic care.³⁴⁵

Service providers took a different approach to consolidation, commenting that social determinants of health such as employment, education or housing are also important factors to consider when developing an effective strategy to eliminate gambling - the collective nature of public health activities is crucial to success.³⁴⁶ One service provider commented that an important reason that the current health system is fragmented is that there is no cooperation between different providers and DHBs. Breaking down silos and ensuring worker participation will require culture shift towards cooperation and away from competition in the health system.³⁴⁷

One health and social services submitter commented that responses to gambling harm should be coordinated across government, particularly across the mental health and addiction sector, child and youth well-being and family violence sectors.³⁴⁸ If equity is a key goal, then the lack of consideration for intersectionality is a concern - clear acknowledgement and complexities should be important, as gambling is often present alongside mental health problems, alcohol and drug abuse and/or family violence.³⁴⁹ One health and social services submitter commented that greater action is needed to address the co-occurrence of gambling behaviour and use of alcohol and other drugs.³⁵⁰

One health and social services submitter commented that the key shifts could be strengthened by adopting a life course approach and acknowledging that gambling harm inequities do not exist within a vacuum - communities, whānau and individuals that experience gambling harm often also experience poor health outcomes in other areas and greater inequities related to the broader social determinants of health.³⁵¹

One health and social services submitter commented that there is little in the strategy that addresses the intersectionality of gambling and alcohol and other drugs.³⁵² Interventions need to understand addiction, mental health and substance use, and social determinants of health as contributing drivers to these health outcomes.³⁵³

One government submitter commented that the levy should be directed more holistically to address harms that result from gambling addictions and recommended that contracts for clinical interventions be adequately flexible to treat the whole person holistically.³⁵⁴

³⁴⁴ 05,10,21,51.

³⁴⁵ 52.

³⁴⁶ 28.

³⁴⁷ 28.

³⁴⁸ 37.

³⁴⁹ 37.

³⁵⁰ 49.

³⁵¹ 39,49.

³⁵² 49.

³⁵³ 49.

³⁵⁴ 55.

2.4.2. Service providers wanted to see better access to and sharing of information

Two service providers agreed that there should be more active and timely sharing of information and evidence from research and evaluations to gain maximum utility from the evidence and noted that in the past most research has not been widely disseminated or used.³⁵⁵

A service provider considered that the wider workforce needs to have access to information about specialised organisations such as the Problem Gambling Foundation, to refer gamblers and their families to for information and advice.³⁵⁶

2.4.3. Submitters wanted to see more research

One service provider wondered why ongoing research and evaluation would only be ‘encouraged’ and considered that it should be mandated and funded.³⁵⁷ Another service provider commented that there needs to be more research and education around the dangers of gaming in relation to gambling. One health and social services submitter supported the continued investment of a health promotion programme to raise awareness and educate people about harmful gambling - further investment could lift the profile of this messaging.³⁵⁸

One health and social services submitter commented that one area where the Ministry has not ‘been responsive’ is advocating for a national policy on the location and density of NCGMs.³⁵⁹ The submitter noted that consideration should be given to national management of NCGMs so that there is more national consistency and an overall decrease in NCGMs.³⁶⁰

One service provider agreed with the greater use of evidence to target investment decisions but noted that it is important that evidence is independently obtained and robust.³⁶¹

2.4.4. Health and social services submitters and gambling industry submitters wanted to see more of a focus on de-stigmatisation

One health and social services submitter commented that including gambling as an addiction issue is imperative, as treating it separately has been shown to be unsuccessful.³⁶² One health and social services submitter agreed with the focus on de-stigmatisation³⁶³ and another supported a clear focus on reducing stigma related to gambling and gambling harm, as well as a shift towards co-design and putting communities at the centre.³⁶⁴ However, one of these submitters noted that there are other barriers (other than stigma) which also need to be understood.³⁶⁵

One gambling industry submitter considered that further consideration needs to be given to the effect that stigmatisation of general gambling harm participation has on the resulting stigma associated with gambling harm.³⁶⁶ This submitter considered that initiatives which may have the

³⁵⁵ 07,09.

³⁵⁶ 28.

³⁵⁷ 09.

³⁵⁸ 11.

³⁵⁹ 11.

³⁶⁰ 11.

³⁶¹ 09.

³⁶² 24.

³⁶³ 37.

³⁶⁴ 39.

³⁶⁵ 37.

³⁶⁶ 42.

effect of creating general gambling stigmatisation should be avoided, and that ‘consideration should be given as to how this is positioned’ throughout the strategy.³⁶⁷

One NCGM submitter agreed with the focus on de-stigmatisation, but that by limiting the focus of de-stigmatisation to the level of the individual, no further progress will be made in achieving the objective to connect people with problem gambling issues to service providers.³⁶⁸

2.4.5. Service providers highlighted opportunities for co-design

One service provider commented that more effective collaboration across the services is required, and that online gambling self-help and support tools should be co-designed and available within PMGH services.³⁶⁹ Another service provider strongly supported the inclusion of the workforce and emphasised that it is crucial to highlight that people who gamble, family, and whānau and the workforce are at the centre of any activity that intends to protect against, prevent and eliminate problem gambling.³⁷⁰

One service provider commented that Māori solutions should have “the same rigour as other ‘pilots’” and that it should be ensured that Māori providers have the freedom to design solutions that work for whānau.³⁷¹

One service provider commented that creating conditions for community and clinical workers to work more effectively together should involve them all having a collective voice in designing services, ideally across sectors and institutions.³⁷²

2.4.6. Submitters supported the development of a peer support workforce

Submitters largely supported the shift to developing the workforce to include peer support:

- one service provider and one health and social services submitter supported expanding the gambling harm peer support workforce in clinical and public health services, and also urged the Ministry to include increasing the leadership of lived experience³⁷³
- one local government submitter and one health and social services submitter supported the strategic shift to developing the workforce to include peer support from those with lived experience of gambling harm³⁷⁴
- one service provider welcomed the ability to utilise the available peer support research, which is seen as being able to assist with de-stigmatising the experience of gambling harm³⁷⁵
- one service provider considered that the peer support workforce should be a key focus and should be linked to the proposed scholarship programme - people with

³⁶⁷ 42.

³⁶⁸ 44.

³⁶⁹ 18.

³⁷⁰ 28.

³⁷¹ 41.

³⁷² 28.

³⁷³ 13,48.

³⁷⁴ 35,C05.

³⁷⁵ C08.

lived experience should be trained and mentored to become leaders in their own communities³⁷⁶

- one service provider recommended that the development of a lived experience workforce include support for PMGH services to build both consumer advisor and peer worker capacity³⁷⁷
- one service provider supported funding the Lived Experience Advisory Group to improve lived experience input into Ministry decision-making, but suggested that further funding be provided to PMGH services to build capacity within existing services to use potential lived experience³⁷⁸
- one health and social services submitter advocated for the investment in the peer workforce: ideally ethnically balanced, with recognition of lived experience³⁷⁹
- one service provider commented that peer support is important, but there need to be specific raining modules for peer support workers, and professional supervision³⁸⁰
- one service provider noted that Pacific peoples need to be able to fully participate in decisions that determine solutions for Pacific populations- a concern for this submitter was the decision to give leadership for the Peer Support Pilot to a non-Pacific, non-Māori provider³⁸¹
- one health and social services submitter recommended developing lived experience leadership potential and welcomed the provision of targeted scholarships to include people in priority populations and people with lived experience³⁸²
- one health social services wanted the strategy to better address the spectrum of services and supports that are currently provided, particularly in areas of peer support and residential treatment for specific groups³⁸³
- one service provider commented that peer support workers and the introduction of lived experience should not substitute or fill the gaps of existing professional workforces³⁸⁴
- one service provider supported funding for the Lived Experience Advisory Group but suggested additional training for service providers who would be working alongside those with lived experience to keep services accountable, ensure manaaki and provide support so as not to compromise their recovery journey.³⁸⁵

2.4.7. Submitters wanted stronger commitment to developing a skilled workforce

One health and service submitter strongly supported the Ministry's intention to enable a skilled and culturally responsive workforce and commented that this should include supporting the

³⁷⁶ 08.

³⁷⁷ 18.

³⁷⁸ 18.

³⁷⁹ 24.

³⁸⁰ 25.

³⁸¹ 29.

³⁸² 48.

³⁸³ 52.

³⁸⁴ 28.

³⁸⁵ 27.

ability for innovations to enable local communities to develop workforces responsive to community need.³⁸⁶ This submitter added that:³⁸⁷

- as it relates to workforce this strategy should seek to improve access and to make it easier for people to join the problem gambling workforce
- the current focus on funding an entirely clinical workforce is not adequately responsive to the needs of different types of problem gamblers, their whānau and communities
- they supported any intention to build a workforce that is responsive to the needs of whai ora and their whānau and is representative of their diversity - this includes the provision of peer support, cultural and support worker positions
- they represented practitioners skilled at delivering addiction competencies, and it was their position that generic counselling skills should not be privileged over the ability to deliver addiction interventions for this group and should be considered when contracting for workforce
- level 5 qualifications are useful for Continuing Professional Development (CPD) points, but most current practitioners are already qualified to work in this area
- the Ministry should consider that those working with problem gambling populations are well-suited to working with people with gaming disorders/addiction and are an important resource
- additional workforce is required to address current and increasing presentations in this area especially those able to work with rangatahi
- gaming often introduces young people to gambling and sometimes pornography, so interventions focused on gaming is something that is required in the short-term.

Two service providers endorsed the change to grow a stronger gambling harm prevention workforce, including improving workforce capacity and capability.³⁸⁸ Addiction training should incorporate gambling-specific training and people should be enabled to develop their skills through paid time for training and development and related appropriate funding.³⁸⁹ Another service provider commented that language skills are essential, and the contractual requirement is an important indicator to consider when strengthening service delivery in qualified, registered and cultural workforce alliance.³⁹⁰

One NCGM submitter noted that more funding should be allocated to providing workforce development for those working on the front line in venues where the evidence of addiction is present but not always easy to recognise.³⁹¹

One service provider commented that gambling harm could be taught in schools as part of the health and wellbeing curriculum.³⁹²

³⁸⁶ C04.

³⁸⁷ C04.

³⁸⁸ 25,28.

³⁸⁹ 28.

³⁹⁰ 46.

³⁹¹ 43.

³⁹² 34.

2.4.8. Submitters wanted to see more explicit commitment to supporting priority populations

Submitters were encouraged by the changes to better recognise inequities, but emphasised that these changes should be more clearly committed to by:

- explicitly considering the complexities and diversity of Pacific peoples and Asian peoples (one health and social services submitter)³⁹³
- committing to work in true partnership with Māori (one service provider)³⁹⁴
- creating an agency staffed by experts tasked with identifying the appropriate treatment for all addictions, and the appropriate method of delivery, including cultural considerations (two NCGM submitters)³⁹⁵
- giving Māori and Pacific peoples the ability to limit access to harmful gambling in their own communities (one health and social services submitter)³⁹⁶
- being more specific about the funding for priority populations (one health and social services submitter).³⁹⁷

2.4.9. NCGM submitters wanted to see the introduction of targets for service providers

Eleven NCGM submitters commented that the strategy should include clear targets, and that when allocating levy money, the question should be about how money can be best allocated to achieve the targets.³⁹⁸ Targets suggested by NCGM submitters were:

- fifty percent reduction in the relapse rate for persons who identify NCGM as their primary gambling mode
- twenty-five percent increase in the number of people seeking help
- twenty percent reduction in the prevalence of harmful gambling among adults
- prioritisation of service providers who can treat comorbidities
- prioritisation of research projects that look at how to reduce the relapse rate
- prioritisation of services and innovation that involve technology to prevent relapse
- prioritisation of projects that train and support gambling venue staff
- people that seek face-to-face counselling have their first session in the town nearest to them within 48 hours of the request.³⁹⁹

2.4.10. Key themes from consultation hui

Comments from hui on changes that are needed

- Stakeholders advocated strongly for more holistic service provision to promote health and wellbeing, particularly with regard to addictions and mental health

³⁹³ 37.

³⁹⁴ 41.

³⁹⁵ 43,44.

³⁹⁶ 45.

³⁹⁷ 48.

³⁹⁸ 03,04,05,10,17,21,32,38,40,43,51.

³⁹⁹ 03,04,05,10,17,21,32,38,40,43,51.

issues. Stakeholders noted that a lot of people who have issues with gambling have other addictions and mental health issues, and it was seen as important to be able to provide services to people to deal with their health needs more generally.

- Stakeholders wanted the Ministry and DIA to focus more on co-designing and co-commissioning supports and services with priority populations, particularly Māori, and focusing closely on equity and implementation around the country, especially at a grassroots level.
- Stakeholders with lived experience considered that a more comprehensive approach within drug and alcohol residence services could be adopted to address the manifestation of gambling harm with other addictions.

3. THE DRAFT SERVICE PLAN

Section 3 of this report outlines feedback received from submitters on the service plan. It covers:

- satisfaction (or otherwise) with the direction and overall content of the service plan
- the proposed funding mix for services and support, and opinions about the proposed new services including:
 - the de-stigmatisation initiative
 - innovations pilots and investments
- the priorities for research and evaluation.

Four questions were asked, all of which included ‘Yes/No’ responses. Table 3: Responses to questions about the draft service plan (below) shows the wording of those questions and the number of submitters who responded, by response. Sometimes the narrative response suggested that support was qualified or conditional, in which case the ‘Yes’ response was altered to ‘Qualified support’.

Responses were received from across the seven sector groups, as detailed in Figure 3 (overleaf).

Table 3: Responses to questions about the draft service plan

Question	Yes	No	Qualified Support	Total
5. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of service and activities?	12	15	4	31
6. Do you consider the proposed funding mix for services and supports appropriate?	10	7	4	21
7. Do you agree with the proposed new services (including the de-stigmatisation initiative), innovations pilots and investments?	11	8	12	31
8. Do you agree with the priorities for research and evaluation that have been outlined in the draft service plan?	10	4	8	22

Fifty-three submitters commented on the draft service plan, including 15 NCGM submitters, 14 service providers, 13 health and social services submitters, four gambling industry submitters, four individuals, two local government submitters, and one government submitter.⁴⁰⁰

⁴⁰⁰03,04,05,07,08,09,10,11,12,13,16,17,18,19,21,22,23,24,25,26,27,29,30,31,32,32,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49, 50,51,52,55,C03,C04,C05,C06,C07,C08,C09.

Figure 3: Number of submitters, by sector, who commented on the draft service plan

Primary organisation type		Number of submitters
	Service provider	14 submitters
	NCGM sector	15 submitters
	Health and social services	12 submitters
	Gambling industry	4 submitters
	Local government	2 submitters
	Central government	1 submitter
	Individual	4 submitters

3.1. The degree of support for the draft service plan

Around half (16 out of 31) of the submitters who commented on the draft service plan supported it to some degree. Of those, 12 provided a simple “Yes” answer to Question 5. A further 5 expressed qualified support for the draft service plan (i.e. they supported it, but also commented on how it could be enhanced).

Submitters who did not support the draft service plan wanted to see:

- more inclusion of culturally appropriate services
- better and more accessible face-to-face services
- better performance of the National Gambling Helpline/Homecare Medical
- services providing longer term support
- alternative approaches to the service plan.

Each of these themes are discussed in the sections below.

3.1.1. Half of the submitters who commented on the draft service plan supported it to some degree

Seven submitters including four service providers, two gambling industry submitters and one health and social services submitter offered further comments in support of the draft service plan.⁴⁰¹ The health and social services submitter⁴⁰² and one service provider⁴⁰³ supported the service plan in its proposed focus and investments for priority populations, stating the importance of continuing with this progression of change in order to reach and improve health benefits for all.

One service provider who did not support the draft service plan commented that it was not explicit as to how the Ministry would achieve its commitment to improving service access to all people affected by gambling harm. This provider also stated that they supported continued funding for the National Coordination Service (NCS) but noted that the NCS was not always a key support for PMGH services, as while they provide alerts for significant developments, they do not always do so in a timely manner.⁴⁰⁴

Submitters expressed qualified supported for the draft service plan

Four submitters expressed qualified support for the draft service plan.⁴⁰⁵ These submitters supported the draft service plan with the following conditions:

- the draft service plan would benefit from further information and indication as to which types of technology would be enabled and accessed via the Technology fund (one gambling industry submitter)⁴⁰⁶
- Health Improvement Practitioners or Health Coaches could be an access point to seek help for gambling-related harm in primary care settings (one health and social services submitter)⁴⁰⁷
- the opportunity to provide clinical intervention services within prisons and youth justice facilities should also come with early identification and interventions to those with gambling problems in Te Whare Whakapiki Wairua and community corrections services (one health and social services submitter)⁴⁰⁸
- the proposal in the draft service plan to collaborate and co-design with priority population groups and people with lived experience was good but the Ministry should include specific consideration of the action areas in a whānau context, including the involvement of tamariki (one health and social services submitter).⁴⁰⁹

3.1.2. Submitters from across sectors wanted to see more culturally appropriate services

Twelve submitters including six service providers, three health and social services submitters, two individuals and one local government submitter commented on the need for more culturally

⁴⁰¹ 27,33,36,39,42,50,C04.

⁴⁰² C04.

⁴⁰³ 39.

⁴⁰⁴ 18.

⁴⁰⁵ 37,42,48,52.

⁴⁰⁶ 42.

⁴⁰⁷ 48.

⁴⁰⁸ 52.

⁴⁰⁹ 37.

appropriate services, including culturally appropriate services for Māori, culturally appropriate peer support and cultural safety in general PMGH services.⁴¹⁰ Submitters made the following general comments about culturally appropriate services:

- in addition to the strategy's greater investment in culturally appropriate services and approaches, there should be culturally mandated services as first referral options (one health and social services submitter)⁴¹¹
- there should be specific funding commitments for Kaupapa Māori, Pacific, and Asian services (one health and social services submitter)⁴¹²
- a service provider queried what modelling data would be used in the proposal to spread the development of Kaupapa Māori services (one service provider).⁴¹³

Submitters wanted to see culturally appropriate services for Māori

Five submitters commented specifically on the development of culturally appropriate services for Māori.⁴¹⁴

Two service providers, one local government submitter and an individual wanted to ensure that Kaupapa Māori services would be delivered to communities in need first, in alignment with services and support already operating in these areas.⁴¹⁵ One service provider cited the fact that NCS service utilisation data from Te Matau-a-Maui Hawke's Bay show around double the pro rata population size, showing a greater need for Kaupapa Māori services in the region and a need for this to be taken into account when allocating FTE to regional services.⁴¹⁶ One service provider recommended an increased use of alternative support staff such as kaiawhina/mataora as smaller regions face recruitment challenges in recognising these roles despite them playing a vital support role for these communities.⁴¹⁷ Another service provider called for clearer information about how services and programmes would be implemented to best achieve primary prevention and address inequities, and made some suggestions:⁴¹⁸

"For awareness and education programmes, we encourage the Ministry to adopt creative and innovative approaches when working with priority populations. For example, public health activities undertaken with Māori are often in the form of wānanga, which covers a range of Kaupapa and can vary over time. We highlight that there needs to be an acknowledgement of this tikanga which is reflected in the financial support of such culturally appropriate activities. These activities create deeper and more meaningful connections and will ultimately help shift cultural and social norms around gambling."

Submitters wanted to see culturally appropriate peer support services

Four submitters, including two service providers and two health and social services submitters commented specifically in support of ensuring peer support services are culturally appropriate:⁴¹⁹

⁴¹⁰ 07,12,13,18,27,34,41,48,52,C03,C04,C06.

⁴¹¹ C04.

⁴¹² 48.

⁴¹³ 07.

⁴¹⁴ 07,12,27,34,C06.

⁴¹⁵ 07,12,34,C06.

⁴¹⁶ 07.

⁴¹⁷ 34.

⁴¹⁸ 27.

⁴¹⁹ 13,47,52,C08.

- those in the Asian community who experience gambling harm often do so at casino tables rather than NCGMs, so peer support in the context of the Asian community needs to match not only by culture but by gambling mode and setting (one service provider)⁴²⁰
- the development of the peer support workforce should be extended to the development of support workers and cultural support positions (one health and social services submitter)⁴²¹
- there need to be more Māori and Pacific peer support workers within the Peer Support Advisory Group (one service provider)⁴²²
- the Ministry should look into funding and creating Peer Support, Consumer Advisor and Family Advisor FTE positions and services across the gambling workforce development space to better support and enhance the care of clients and families affected by gambling harm (one service provider).⁴²³

Submitters wanted better support to develop cultural safety in general PMGH services

Four service providers commented on strategies to improve cultural safety in general PMGH services.⁴²⁴

One service provider recommended the Ministry work with service providers to customise their service delivery specifications in order to address the needs of whānau, hapū, iwi and hāpori Māori.⁴²⁵ This submitter considered that this would allow for a more targeted approach to minimising and preventing gambling harm, as well as creating a sector that would be more responsive to whānau.⁴²⁶ Another service provider commented that advice and feedback between the Ministry and NCS seemed to focus mostly on Māori, Pacific, and Asian services, and stated that while they understood this as part of the broader goal to reduce inequities, general services work with priority populations as well and need support to do so in a culturally appropriate way.⁴²⁷

3.1.3. Service providers and NCGM submitters agreed that better and more accessible face-to-face support services were needed

Eleven submitters including nine NCGM submitters and two service providers discussed the role of face-to-face services in the PMGH sector.⁴²⁸

The nine NCGM submitters commented that despite the funding available (which they considered to be “vast”), many townships outside of major cities do not have PMGH face-to-face counselling services, and that current PMGH services are either not equipped or “not willing” to travel to clients who cannot come to the office or see clients after hours or on the weekend.⁴²⁹ These submitters all cited the fact that GMANZ had made an inquiry with a large service provider as to whether a counsellor could make a 44-minute drive from Hamilton to Ōtorohanga on the weekend

⁴²⁰ 13.

⁴²¹ C08.

⁴²² 47.

⁴²³ 47.

⁴²⁴ 18,32,33,34.

⁴²⁵ 41.

⁴²⁶ 41.

⁴²⁷ 18.

⁴²⁸ 04,05,10,17,18,19,21,22,25,40,51.

⁴²⁹ 04,05,10,17,19,21,22,40,51.

to see a client but were told the only option they could offer was remote support. These submitters stated that when people reach out for help, they are usually in crisis, and cannot afford to wait till business hours.⁴³⁰ One NCGM submitter considered that current services are too complacent and are focused on anti-gambling advocacy rather than treating gambling harm.⁴³¹

These NCGM submitters suggested the Ministry move away from the current service model and instead have treatment providers reduce set office hours and be on call.⁴³² The NCGM submitters also considered that the Ministry's contract with these providers should include a requirement to provide counselling afterhours/on weekends and for these providers to be fully mobile.⁴³³ These submitters suggested that now would be the perfect time to negotiate these requirements, given the proposed increase in FTE rates.⁴³⁴

Two service providers commented on the need to expand services into the online space.⁴³⁵ One service provider raised the changing nature of traditional face-to-face services due to factors such as COVID-19 and an increase in online gambling, stating that this had not been acknowledged in the draft service plan.⁴³⁶ This service provider considered that more funding was needed to support and develop online interventions in PMGH services alongside social media marketing and campaigns to introduce and normalise such online interventions.⁴³⁷ The other service provider commented that there needed to be more self-help groups both face-to-face and accessible online, as tāngata whaiora were accessing online overseas Gamblers Anonymous groups due to the paucity of such forums in New Zealand.⁴³⁸

Gambling industry submitters considered that services funded by the Ministry need to be held accountable as to whether they are effective

Two NCGM submitters⁴³⁹ and one gambling industry submitter⁴⁴⁰ wanted to see greater transparency around the effectiveness of the services funded in the current and draft service plan. Two of these submitters stated that with the proposed increases in funding, services should be expected to be transparent about the effectiveness of the programmes they are running so as to not be “rewarded for complacency”.⁴⁴¹

One NCGM submitter suggested the Ministry regularly monitor services via a quality assessment team, who should test the Gambling Helpline as well as make contact with treatment providers to test the urgency and willingness with which they see to clients at short notice.⁴⁴²

One service provider noted that there did not seem to be funding for service audits in the draft service plan and queried whether these would still be required.⁴⁴³

⁴³⁰ 04,05,10,17,19,21,22,40,51.

⁴³¹ 17.

⁴³² 04,05,10,17,19,21,22,40,51.

⁴³³ 04,05,10,17,19,21,22,40,51.

⁴³⁴ 04,05,10,17,19,21,22,40,51.

⁴³⁵ 18,25.

⁴³⁶ 18.

⁴³⁷ 18.

⁴³⁸ 25.

⁴³⁹ 17,32.

⁴⁴⁰ 36.

⁴⁴¹ 17,36.

⁴⁴² 32.

⁴⁴³ 18.

3.1.4. Submitters agreed that the National Gambling Helpline/Homecare Medical was not performing well

Nine submitters including seven service providers⁴⁴⁴ and two health and social services submitters⁴⁴⁵ raised concerns around the efficacy and cultural competence of and communication with the National Gambling Helpline.

Four service providers commented on the need for better transparency and communication between the Gambling Helpline and the broader PMGH sector.⁴⁴⁶ Another service provider criticised the Gambling Helpline for its lack of leadership in facilitating communication with the sector and for the lack of participation in PMGH Consultation Hui.⁴⁴⁷

Two service providers⁴⁴⁸ commented that specialist PMGH services do not receive significant referrals from the helpline, and this was seen by one service provider⁴⁴⁹ as a significant cause of low service utilisation. These two service providers⁴⁵⁰ acknowledged their support for funding for national telehealth services generally, but one service provider⁴⁵¹ did not agree that the Gambling Helpline was the only service providing information about self-help, peer-to-peer support options and assessment guides or referral and access to intervention services as PMGH services have had to pick this up due to the poor performance of the Gambling Helpline.⁴⁵²

Three service providers⁴⁵³ and one health and social services submitter⁴⁵⁴ considered the Gambling Helpline to be a barrier to people experiencing gambling harm from accessing and receiving help when they need it. Two of these submitters referenced feedback from people who had experienced gambling harm and tried to use the Gambling Helpline, with both describing it as less helpful than expected, noting long wait times and/or a lack of connection with the person on the phone.⁴⁵⁵

Service providers were concerned about the cultural accessibility of the Gambling Helpline

Four service providers raised issues with the cultural accessibility of the Gambling Helpline for priority populations.⁴⁵⁶ Three of these service providers expressed concerns with the Gambling Helpline's levels of cultural competency and professional development when dealing with the Pacific community and were concerned further that these issues contribute to barriers and unmet needs for Pacific peoples experiencing gambling harm.⁴⁵⁷ These service providers stated that dedicated Pacific staff for the Pacific Gambling Helpline was essential, while one of these providers suggested outsourcing the Pacific Gambling Helpline to an experienced Pacific service provider.⁴⁵⁸

Two service providers raised further issues about the cultural accessibility of the Gambling Helpline with specific reference to the Asian community, especially in terms of language

⁴⁴⁴ 07,13,18,27,29,33,47.

⁴⁴⁵ 45,48.

⁴⁴⁶ 07,13,18,27.

⁴⁴⁷ 13.

⁴⁴⁸ 07,18.

⁴⁴⁹ 18.

⁴⁵⁰ 07,18.

⁴⁵¹ 18.

⁴⁵² 18.

⁴⁵³ 13,29,47.

⁴⁵⁴ 48.

⁴⁵⁵ 13,48.

⁴⁵⁶ 13,29,33,47.

⁴⁵⁷ 29,47,33.

⁴⁵⁸ 29.

barriers.⁴⁵⁹ These service providers wanted to see the Asian helpline extended and funded to be a 24-hour service, as the Asian Helpline is currently taking a comparable amount of annual phone calls as the National Gambling Helpline despite running only as a 9am-8pm service.⁴⁶⁰

3.1.5. NCGM submitters wanted services to provide longer term support

Seven NCGM submitters wanted the draft service plan to shift its focus to long term support and treatment.⁴⁶¹ These submitters cited statistics from *Problem Gambling Intervention Services in New Zealand 2007 Service-user statistics: Public Health Intelligence Monitoring Report No. 18* which they considered to show that gambling harm was not being dealt with appropriately such as low treatment hours, lack of follow up and high relapse rates. Additionally, one health and social services submitter stated that evidence suggested over half of all problem-gambling cases are relapsed, and that these people need to be considered and offered different services when they seek help for relapse.⁴⁶²

These seven NCGM submitters⁴⁶³ called for a system reorientated towards providing long term support and treatment:⁴⁶⁴

“To achieve the target of reducing relapse, the MOH should require the treatment providers to take reasonable steps to maintain contact with their clients for a 3-year period. The providers should regularly check in with their clients and provide ongoing support/monitoring. Initially this could include fortnightly visits at the client’s home. Towards the end of the 3-year period, the support could be reduced to a monthly text exchange or phone call.”

One NCGM submitter suggested an approach similar to the support Plunket provides after childbirth, with a minimum of eight core visits at a location that best suits the client, followed by ongoing contact/check-ins via informal short visits/phone calls and monthly text messages.⁴⁶⁵

3.1.6. Service providers and health and social services submitters wanted to see more funding for services

Four service providers and one health and social services submitter considered that more funding and investment was needed to actualise the goals of the service plan.⁴⁶⁶ Two of these service providers considered that the increase of \$7 million, given that much of this would be re-invested for new services delayed in the current service plan, was insufficient to drive significant change or progress beyond current achievements.⁴⁶⁷ One service provider explained:⁴⁶⁸

“...without significant investment in the whole gambling harm sector, including increased investment in public health services, and relevant, adequate research and development investment, will not produce significant results... We believe, that to bring about significant change, a major increase in local clinical and public health service provision is needed across the board. The level of impact we can achieve as a sector is proportional to the investment in

⁴⁵⁹ 13,33.

⁴⁶⁰ 13,33.

⁴⁶¹ 05,19,21,22,32,40,51.

⁴⁶² 45.

⁴⁶³ 05,19,21,22,32,40,51.

⁴⁶⁴ 05.

⁴⁶⁵ 19.

⁴⁶⁶ 09,13,18,23,25.

⁴⁶⁷ 09,18.

⁴⁶⁸ 18.

preventing and minimising harm – which is less than [five] percent of overall gambling expenditure. Trying to prevent and minimise gambling harm with that proportion of expenditure is like trying to stop a river overflowing its banks with a bucket.”

One service provider commented that as a culturally specific provider, they received limited benefits or tangible support from the NCS and often have to fund their own resources and provide extra support for the funded national coordination support in order to navigate the gaps experienced by the Asian community, something not experienced by mainstream services.⁴⁶⁹

3.1.7. Submitters from across most sectors suggested alternative approaches for the service plan

Fourteen submitters including six NCGM submitters, four health and social services submitter, two service providers, one local government submitter and one individual offered alternative approaches to the service plan.⁴⁷⁰

Health and social services submitters wanted more focus on prevention and the needs of those experiencing gambling harm

Three health and social services submitters were critical of the focus or approach proposed for the service plan for the following reasons:⁴⁷¹

- there was too much focus on minimising gambling harm, and there needed to be a greater, more balanced focus on prevention⁴⁷²
- the service plan had too little focus on the needs of gamblers, and supports for psychological effects of gambling were not well described in the service plan⁴⁷³
- the Ministry should support a suite of services in a new approach for those experiencing gambling harm, including:⁴⁷⁴
 - residential services for people experiencing moderate to severe harm, with day or evening programmes for people who are maintaining their employment
 - support services for whānau/those impacted by another’s gambling harm
 - the use of social media to engage and support people experiencing gambling harm, particularly to engage rangatahi, and increasing programmes that focus on awareness of rangatahi issues such as online gaming.

NCGM submitters highlighted the need for better communication between service providers and the NCGM sector

Three NCGM submitters suggested that there needed to be better liaison between service providers and venue staff:

⁴⁶⁹ 13.

⁴⁷⁰ 16,17,19,21,22,25,26,35,37,38,41,45,48,51,C05.

⁴⁷¹ 25,37,48.

⁴⁷² 37.

⁴⁷³ 48.

⁴⁷⁴ 25.

- treatment providers, with consent of the client, should have an active role in the team that monitors and supports the person⁴⁷⁵
- treatment providers could visit venues where the client has been gambling, meet with venue staff and (with client permission) share the client’s status and intended treatment plan so that venue staff could assist with monitoring and enforcement of things like reduced spend or self-exclusion⁴⁷⁶
- given that venue staff are at the “coalface” of the problem, more investment should be given to those that operate there⁴⁷⁷
- funding should be given for third party accredited harm minimisation training, and while venues should not be able to ‘contract out’ of harm minimisation training obligations, training by an accredited provider would be beneficial to the industry.⁴⁷⁸

On a similar note, one service provider noted that the service plan had moved away from previous focuses on having the health sector work with the industry on fronts such as safer gambling environments, host responsibility and effective screening, and queried whether this was by design or omission.⁴⁷⁹

Two NCGM submitters commented that the use of medical tools to treat gambling harm needs to increase.⁴⁸⁰ These two submitters both suggested the use of Naltrexone, while one submitter stated that treatment providers funded under the service plan do not currently include staff who can prescribe prescription medicines, and that this should change.⁴⁸¹

A local government submitter⁴⁸² and one health and social services submitter⁴⁸³ recommended that the proposed and future service plans and allocated budget should be based on modelling for at risk populations and gambling harm data e.g., NCGM rate, gaming machine profits (GMP) spend and service usage, and that FTE rates should be aligned with this modelling.

3.1.8. Key themes from consultation hui

Comments from hui on the draft service plan	
<ul style="list-style-type: none"> • Stakeholders raised the need for culturally appropriate services for priority populations, highlighting that people experiencing harm will be reluctant to reach out for help if they think the person, they are talking to does not understand or relate to their cultural context. number of hui but came out particularly strongly in the Pacific , Rangatahi and Asian-focused hui. • Stakeholders raised issues with, and criticisms of the National Gambling Helpline and Homecare Medical, citing a lack of referrals, a lack of cultural competence and general poor performance. These themes were particularly strong at Pacific, 	

⁴⁷⁵ 19,21.
⁴⁷⁶ 19.
⁴⁷⁷ 38.
⁴⁷⁸ 38.
⁴⁷⁹ 41.
⁴⁸⁰ 17,19.
⁴⁸¹ 19.
⁴⁸² C05.
⁴⁸³ 35.

Asian and Rangatahi hui, where some stakeholders who had personal experience using the helpline shared their criticisms and general feedback.

- Stakeholders called for the integration of current Māori voices into the Kaupapa of this draft service plan, and implementation of Mātauranga Māori into both the service plan and service provision was a strong theme at both general and the Māori-focused hui.
- Stakeholders at the Industry-focused hui raised the need for more well-rounded support from service providers, particularly in after-hours/weekend support and greater accessibility for people in rural settings. This comment received some push back from service providers who considered they were doing the best they could with the resources available.
- Stakeholders discussed the partnership between service providers and the industry at both the Industry-focused and general hui, with attendees from both parties acknowledging a need for more collaboration. Industry stakeholders commented that they were invested in having a limited impact on the communities in which they operate and were keen to work in partnership with service providers; while some service providers iterated it was less about partnership, but about the industry referring as many people experiencing gambling harm as they can.
- Stakeholders at the general hui were supportive of a mix of clinical and non-clinical staff, e.g., health coaches, to support people experiencing gambling harm.

3.2. The degree of support for the proposed funding mix

Two-thirds (14 out of 21) of the submitters who commented on the proposed funding mix supported it to some degree. Of those, 10 provided a simple “Yes” answer to Question 6. A further 4 expressed qualified support for the proposed funding mix (i.e. they supported it, but also commented on how it could be enhanced).

Comments on the proposed funding mix included:

- support for the proposed increase to FTE rates for clinical intervention roles
- concern that technology had been overlooked in the funding mix
- mixed views on the decrease in research funding
- concern that the increase in funding was inappropriate if there was to be more of the same
- the need for sustainable funding note based on industry profits.

3.2.1. Two-thirds of the submitters who commented on the proposed funding mix supported it to some degree

Seven submitters answered yes and provided further comment in support of the proposed funding mix.⁴⁸⁴ Specific support for the proposed funding mix included support for:

⁴⁸⁴ 07,26,31,35,39,50,C05.

- the funding around clinical and public health services (two service providers, one health and social services submitter and one local government submitter)⁴⁸⁵
 - one service provider and one local government submitter commented that this investment reflected the greater intensity and resource required for clinical support compared to community work with groups⁴⁸⁶
- the proposal to carry over the \$5.6 million of underspend appropriation into the next levy period (one service provider)⁴⁸⁷
- the adoption of cost-effective harm minimisation tools that would target problem gamblers without having a negative impact on recreational gamblers who are not at risk of harm (one NCGM submitter)⁴⁸⁸
- all investment area actions:
 - the period of 2022/23 to 2024/25 would be challenging and this submitter stated that they would work to update and develop new resources to align with the new strategy and reflect both the submitter's Te Tiriti dynamic approach as well as the *Safer Gambling Aotearoa* campaign (one service provider).⁴⁸⁹

Submitters expressed qualified support for the proposed funding mix

Four service providers expressed qualified support for the proposed funding mix.⁴⁹⁰ Qualification centred on submitters suggesting changes to the funding mix, with a focus on ensuring that the funding mix better supports equitable outcomes:

- culturally appropriate and competent training to be provided to the workforce: partnering with organisations like Te Wānanga o Aotearoa to access the suite or training, expertise and kaitiaki to better guide clinicians around Māori tikanga in their work (one service provider)⁴⁹¹
- funding parity between public health and intervention services: there should be a redirection of funding to both Māori specific clinical and public health services so that the funding mix is proportionate to the burden of harm and the communities impacted by those harms (one service provider)⁴⁹²
- include an equity package to provide intervention to reduce inequalities amongst whai ora service users, for example, the provision of mobile phones with six months data to whai ora in need during the latest COVID-19 response. Providers having the flexibility to offer these kinds of interventions would help reduce inequities at a grassroots/community level (one service provider)⁴⁹³

⁴⁸⁵ 07,18,35,C05.

⁴⁸⁶ 07,C05.

⁴⁸⁷ 50.

⁴⁸⁸ 26.

⁴⁸⁹ 39.

⁴⁹⁰ 07,18,27,41.

⁴⁹¹ 27.

⁴⁹² 41.

⁴⁹³ 07.

- continued funding for the MVE administration service and database but queried whether the increase in funding cover associated audit and testing costs as well as further technical development and evaluation (one service provider).⁴⁹⁴

3.2.2. Submitters expressed general support for the proposed increase to FTE rates for clinical intervention roles

Thirteen submitters including eight service providers,⁴⁹⁵ two NCGM submitters,⁴⁹⁶ three health and social services submitters⁴⁹⁷ and one local government submitter commented on the proposed increase to FTE rates for clinical intervention roles.

Eight submitters supported the increased clinical FTE rates.⁴⁹⁸ Reasons for supporting the increased clinical rates were that the proposed increase would:

- have a positive impact on recruitment and retention of staff into the PMGH sector (one health and social services submitter and one service provider)⁴⁹⁹
- enable the development of a sustainable and high-quality workforce, including attracting a high calibre of Asian social workers, especially in Auckland where living costs are high (one service provider).⁵⁰⁰

One service provider commented that they would prefer to see an increase in the FTE rate for public health staff, as they considered upstream approaches to have a greater impact on preventing and minimising harm in a broader context:⁵⁰¹

“To effect significant change, we recommend that public health FTE be increased, as it is difficult to achieve impact when we have lone, part-time workers spread thinly across the country. There are currently not enough public health workers to meaningfully support local community action, raise awareness, support safer gambling environments, promote healthy public policy and advocate for effective screening environments to prevent and minimise gambling harm. Pivoting to working with high priority populations alone is not enough to effect change. We also need to develop specialists across certain areas of public health such as policy development, social marketing, and media, to attract younger people, data analysts, researchers, etc.”

Submitters expressed conditional support for the proposed increase to clinical FTE rates

Four submitters (two NCGM submitters, two service providers) conditionally supported the proposed increase to clinical FTE rates.⁵⁰² The two NCGM submitters considered that the proposed FTE rate increase should only move forward if service providers could:⁵⁰³

- provide face-to face counselling without restriction (e.g., being on call, after hours support, travel, etc.)

⁴⁹⁴ 18.

⁴⁹⁵ 08,13,18,25,27,29,47.

⁴⁹⁶ 10,32.

⁴⁹⁷ 35,39,52.

⁴⁹⁸ 08,13,27,29,35,39,52,C05.

⁴⁹⁹ 08,13.

⁵⁰⁰ 13.

⁵⁰¹ 18.

⁵⁰² 10,25,32,47.

⁵⁰³ 10,32.

- travel to meet with clients
- diversify their skillset and treat comorbidities
- increase their workload to match increased presentations.

The NCGM submitters commented that if these requirements were not supported, they would object to the increase, as they considered it inappropriate to increase funding to what they considered to be poor-quality services, with decreasing presentations.⁵⁰⁴

Two service providers supported the increase but raised concerns about how effectively this would address recruitment and retention of staff in the PMGH sector.⁵⁰⁵ One service provider commented that the proposal ignores pay parity and relativity issues and thus further funding increases are needed.⁵⁰⁶ The other service provider recommended permanent contracts for clinical and public health FTEs as opposed to the current fixed term contracts, as the fixed term contracts leave employees uncertain of long-term employment in the gambling workforce, leading to difficulties with both recruitment and retention.⁵⁰⁷

3.2.3. NCGM submitters, service providers and individuals considered that more of the proposed funding mix could focus on technology

Ten submitters including five NCGM submitters, three service providers and two individuals commented on the funding for technology in the proposed funding mix.⁵⁰⁸

Three NCGM submitters highlighted the importance of investing in technology to prevent and minimise gambling harm and called on the Ministry to allocate 10 percent of the current budget to fund technology-based harm minimisation initiatives.⁵⁰⁹ These submitters suggested the Ministry fund tools to assist with self-enrolment in multi-venue exclusion, and the monitoring of this exclusion via facial recognition. Two NCGM submitters recommended working with the sector to identify areas that would benefit from the use of Facial Recognition Technology (FRT), and funding venue-based harm minimisation technology to foster industry partnership and improve outcomes.⁵¹⁰

Service providers and individuals offered other suggestions for funding technology:

- more funding should be supplied to upgrade the Client Information Collection (CLIC) database, as although the database had not changed in eight years, the sector had moved on considerably and thus adjustment to the data collection categories was necessary (one service provider)⁵¹¹
- the demand for digital services is here now due to the changing landscape of service provision due to COVID-19, and the sector cannot afford to wait another three-year period for appropriate funding to come in (one service provider)⁵¹²

⁵⁰⁴ 10,32.

⁵⁰⁵ 25,47.

⁵⁰⁶ 25.

⁵⁰⁷ 47.

⁵⁰⁸ 17,18,22,26,33,37,40,51,C03,C09.

⁵⁰⁹ 17,22,26.

⁵¹⁰ 40,51.

⁵¹¹ 18.

⁵¹² 33.

- the growth in online gambling shows cause for the development of a New Zealand-based online gambling blocking tool and commented that in theory the Concern database could be expanded to include this function (one service provider)⁵¹³
- one service provider collected questions from their community, and one of them was “Is there an opportunity to create a Safer Gambling App?”⁵¹⁴
- the funding mix did not include anything towards the development in the use of technology to monitor gambling “live” behaviour (one individual), and⁵¹⁵
- the current MVE system operates well for those who identify/self-identify as having a problem with NCGMs but relies on busy venue staff to recognise those who should be excluded but may not be regulars at that particular venue, and so facial recognition should be included in every machine - if trusts are expected to pay for this then it would become standardised, and costs would reduce (one individual).⁵¹⁶

3.2.4. Submitters had mixed views on the decrease in research funding

Ten submitters, including four service providers, three health and social services submitters, two NCGM submitters and one gambling industry submitter commented on the proposed decrease in research funding.⁵¹⁷

Two service providers and one health and social services submitter commented that research and evaluation were underfunded in this proposed funding mix, noting that that research and evaluation are critical for evidence-based decision making as well as advocacy and public health work in the PMGH space.⁵¹⁸ One service provider considered that the proposed budget would not allow for any large scale or new longitudinal projects to be conducted, and the reduced level of research funding meant that some initiatives would be implemented without a robust evidence base, thus hindering their effectiveness.⁵¹⁹

Two NCGM submitters, one health and social services submitter and one service provider supported the proposed decreased investment into research and evaluation.⁵²⁰ The two NCGM submitters considered that recent research funded by the Ministry had been of low quality and failed to assist in reducing gambling harm or addressing inequities.⁵²¹ The service provider recommended that funds be reallocated to fund frontline and service delivery in light of delays in procurement due to COVID-19.⁵²²

One health and social services submitter raised concerns about the reduction and stated that they did not understand why the underspend could not be boosted into funding for this financial year.⁵²³ This submitter stated that the proposed reduction in funding and previous underspend indicated that there needed to be clearer direction in research areas. This view was shared by an

⁵¹³ 18.

⁵¹⁴ 50.

⁵¹⁵ C09.

⁵¹⁶ C03.

⁵¹⁷ 05,09,11,25,27,31,37,39,47,51.

⁵¹⁸ 09,27,39.

⁵¹⁹ 09.

⁵²⁰ 05,35,47,51.

⁵²¹ 05,51.

⁵²² 47.

⁵²³ 37.

NCGM submitter, who stated that the Ministry should ensure that the funded research was more focused.⁵²⁴

One service provider commented that while they understood the push from researchers/universities to undertake research to understand the impacts of offshore online gambling, this should not come at the cost of services for people experiencing gambling harm now.⁵²⁵ This service provider considered research to be time-consuming and stated that the PMGH sector did not have the luxury of waiting years for verified results to inform service delivery when people are experiencing harm in real time.⁵²⁶

In addition, one health and social services submitter recommended that funding for future research not be derived from the gambling industry, in order to ensure that academic integrity is not compromised.⁵²⁷

There is further discussion about research priorities and funding below in Section 3.4.

3.2.5. Gambling industry submitters considered that the increase in funding was inappropriate if there was to be more of the same

Five NCGM submitters and one gambling industry submitter commented on the increase in funding for services, stating that this increase was inappropriate for numerous reasons.⁵²⁸

These submitters cited the following reasons:⁵²⁹

- increasing the FTE rates was inconsistent with the public sector wage freeze
- money must be spent on preventing, minimising, treating or reducing harm, not paying existing providers more for office overheads or administration
- gambling participation and presentations to PMGH services have decreased, indicating a reduced workload for these services, thus making an increase to FTE rates unwarranted.

The gambling industry submitter stated that an increase in cost was to be expected given trends in previous strategies, but the quantum of increase in this service plan was surprising given the significant investment by both the Ministry and the industry towards preventing and minimising harm.⁵³⁰ This submitter expected that the Ministry would be able to demonstrate consequential increase in measurable outcomes to reflect this increase in funding.⁵³¹

3.2.6. Submitters considered that there was a need for sustainable funding that was not based on industry profits

Five submitters including four health and social services submitters and one service provider commented on the need for sustainable funding opportunities and highlighted the need to move away from relying on industry profits.⁵³²

⁵²⁴ 05.

⁵²⁵ 25.

⁵²⁶ 25.

⁵²⁷ 11.

⁵²⁸ 05,21,30,38,40,51.

⁵²⁹ 05,21,38,40,51.

⁵³⁰ 30

⁵³¹ 30

⁵³² 24,25,37,49,C04.

One health and social services submitter commented that existing and new contracts should steer away from 12–18-month terms and accommodate long-term contracts of three to five years, to produce more equitable and positive outcomes for the workforce capability including for whānau they support.⁵³³

Two health and social services submitters commented that community reliance on funding from the proceeds of gambling was unethical and stated that funds derived from gambling in high deprivation communities are often translated into community assets elsewhere.⁵³⁴ One of these submitters commented that an alternative funding solution was needed.⁵³⁵ The other health and social services submitter recommended a pathway to introduce sustainable funding opportunities to reduce reliance of community organisations on grants from trusts and societies⁵³⁶ This submitter considered there to be significant scope to review the distribution of gaming machine proceeds.⁵³⁷

One health and social services submitter encouraged the provision of secure funding to community grants and sports clubs that are currently funded by money from NCGMs, including a robust review of distribution of NCGMs to ensure stronger regulations, and eliminating NCGMs in high deprivation areas to minimise gambling harm, and ensure that community groups are no longer dependent on funding from money lost to NCGMs by the most vulnerable communities.⁵³⁸ One service provider stated that funding across the board needs to increase, and a funding model implemented that ensures organisation sustainability.⁵³⁹

3.2.7. Key themes from the consultation hui

Comments from hui on the proposed funding mix

- Stakeholders expressed their support for the increase in clinical intervention FTE rates across several hui. However, many stakeholders also called for an increase to public health FTE rates. This came out strongly at the Asian-focused hui, where stakeholders iterated that limited public health FTE for Asian communities makes it difficult to tackle the big issues in the PMGH space, especially as public health work in the Asian community looks very different to the general and other priority populations.
- Stakeholders emphasised that FTE covers everything from leadership, human resources, supervision, research, monitoring etc., and that nobody gets paid the actual FTE in wages.
- Stakeholders commented on funding for technology across a few of the hui. At the Industry-focused hui, stakeholders wanted to ensure that the technology fund would only be used for harm minimisation tools and not for administrative equipment for service providers. Service providers at general hui alternatively stated that they did not think the Industry should receive funding from the Ministry for facial recognition technology/other venue hardware.

⁵³³ C04.

⁵³⁴ 24,49.

⁵³⁵ 24.

⁵³⁶ 49.

⁵³⁷ 49.

⁵³⁸ 37.

⁵³⁹ 25.

- Stakeholders highlighted the need for more technology focused support, given that traditional in-person support is not always feasible in current times given the risk of lockdowns, and service providers need resources to support this move.
- Stakeholders expressed concern across all hui at the reduction in research funding. This was especially prevalent at the Asian-focused hui, where attendees were concerned as gambling harm in the Asian population is already under-researched in Aotearoa. At general hui, stakeholders discussed how research, prevalence data and New Zealand specific evidence are fundamental in supporting policy and service provision in the PMGH space.

3.3. The degree of support for the proposed new services, innovation pilots and investments

Over two-thirds (23 out of 31) of the submitters who commented on the proposed new services, innovation pilots and investments supported them to some degree. Of those, 11 provided a simple “Yes” answer to Question 7. A further 12 expressed qualified support for the proposed new initiatives (i.e., they supported them, but also commented on how they could be enhanced).

Comments on the proposed new services, innovation pilots and investments included:

- conditional support for the de-stigmatisation initiative
- a range of views on the purpose and efficacy of developing an NZQA level 7 qualification
- conditional support for scholarship funding
- general support for the innovation pilots.

3.3.1. Over two-thirds of the submitters who commented on the proposed new services, innovation pilots and investments supported them to some degree

One local government submitter and one health and social services submitter supported the proposed new services, innovation pilots and investments, stating that it would be important to apply the lessons from the pilots in particular to continue to expand approaches to preventing and minimising gambling harm.⁵⁴⁰ Two service providers and one health and social services submitter supported the proposed de-stigmatisation initiative in particular.⁵⁴¹

Submitters expressed qualified support for the proposed new services, innovation pilots and investments

Three service providers and a health and social services submitter made general comments in qualified support of the proposed new services, innovation pilots and investments.⁵⁴² They noted that:

⁵⁴⁰ 35,C05.

⁵⁴¹ 13,33,C04.

⁵⁴² 07,35,41.

- funding opportunities need to be open to the market to enable regional service providers to develop initiatives with their own priority communities (one service provider and one health and social services submitter)⁵⁴³
- proposed new services need to be developed with commitment to work in true partnership with Māori (one service provider)⁵⁴⁴
- the focus remains individual (i.e., on the person with a problem gambling behaviour) rather than a broader public health approach (one service provider).⁵⁴⁵

3.3.2. Service providers and health and social services submitters conditionally supported the de-stigmatisation initiative

Five submitters including three service providers and two health and social services submitters expressed conditional support for the proposed de-stigmatisation initiative.⁵⁴⁶ Some of the challenges they saw with the de-stigmatisation initiative were that:

- there should be lived experience leadership to support the de-stigmatisation initiative (one health and social services submitter)⁵⁴⁷
- it should be broadened to include other addictions and mental illnesses as different comorbidities often have a compounding effect (one service provider)⁵⁴⁸
- the proposed de-stigmatisation initiative did not reflect a public health approach, but a continued focus on gamblers as individuals with problems, rather than understanding why and how people with gambling problem become stigmatised (one service provider).⁵⁴⁹

Funding for the initiative was seen as a potential issue

Use of funding for this initiative was seen as a potential issue, especially in relation to the funding of other services to reduce harm. One health and social services submitter considered that funding for grassroots support services would be more effective in generating meaningful change, rather than expensive anti-stigma campaigns.⁵⁵⁰ Funding services was also important for one service provider, who commented that while it supported the increased funding for the new initiatives, the proposed funding for the de-stigmatisation initiative would not be enough to drive significant change.⁵⁵¹ This submitter stated that it seemed the funding for this initiative would go to Te Hiringa Hauora; the service provider acknowledged that Te Hiringa Hauora provide much-needed national campaigns and resources, but iterated that PMGH services also require increased funding to support this initiative at the local level.⁵⁵²

⁵⁴³ 07,35.

⁵⁴⁴ 41.

⁵⁴⁵ 09.

⁵⁴⁶ 09,18,39,48,C07.

⁵⁴⁷ 48.

⁵⁴⁸ C07.

⁵⁴⁹ 09.

⁵⁵⁰ 48.

⁵⁵¹ 18.

⁵⁵² 18.

Submitters considered that the de-stigmatisation initiative must be fit for purpose for priority populations

Two service providers and one health and social services submitter discussed their conditional support in reference to the focus of the de-stigmatisation initiative on priority populations.⁵⁵³

One service provider noted that there should be a balance between investing in initiatives focused on priority populations compared to initiatives for the general population that have increased focus for priority populations.⁵⁵⁴ Striking the right balance avoids risks that non-priority populations then see problem gambling as a problem of the priority populations only, which may have the unintended consequence of increasing stigma and/or discrimination.

Conversely, there was also concern that a single national de-stigmatisation campaign for all New Zealanders would potentially not resonate with the identified priority populations (one service provider and one health and social services submitter).⁵⁵⁵ Ways to improve resonance were identified:

- ensure extensive consultation with communities in the identified priority populations to co-design the initiative to be fit for purpose (one health and social services submitter)⁵⁵⁶
- acknowledge that priority populations also access general services and engage with general PMGH services to have more reach and be more effective than the previous *Choice Not Chance/Safer Gambling Aotearoa* campaigns (one service provider)⁵⁵⁷
- customise campaign efforts for each priority population, with the following as potential campaign topics (one service provider):⁵⁵⁸
 - electronic gaming machines design that encourages continuous playing
 - the relationship between online gambling/gaming and harms for rangatahi
 - de-colonisation programmes to better understand cultural stigma around gambling to shift mindsets and encourage help-seeking behaviour.

3.3.3. Submitters expressed a range of views on the purpose and efficacy of developing an NZQA level 7 qualification

Twenty-one submitters including nine NCGM submitters, eight service providers, three health and social services submitters and one gambling industry submitter had various views on the purpose and efficacy of the proposed NZQA level 7 qualification.⁵⁵⁹

Two service providers and one gambling industry submitter supported the level 7 pathway as it was proposed.⁵⁶⁰ One of these service providers queried what would be done to attract people to these qualifications.⁵⁶¹

⁵⁵³ 09,18,39.

⁵⁵⁴ 09.

⁵⁵⁵ 09,39.

⁵⁵⁶ 39.

⁵⁵⁷ 18.

⁵⁵⁸ 18.

⁵⁵⁹ 03,04,05,08,10,13,18,19,21,27,29,34,38,39,40,42,46,50,51,C08.

⁵⁶⁰ 18,42.

⁵⁶¹ 08.

Eight NCGM submitters suggested that, in addition to the proposed qualification, funding should be allocated for a new NZQA qualification and harm leader minimisation leadership course (like those proposed and run by Hospitality New Zealand).⁵⁶² Such qualifications would be aimed at hospitality and society staff and focus on NCGM compliance and operational components alongside harm minimisation and addiction components. Three service providers supported the creation of an entry-level gambling harm qualification (levels 1-4) to help build pathways to and increase the accessibility of the NQZA level 7 qualification.⁵⁶³

Other views included:

- to support those with lived experience moving into leadership roles, provisions for scholarships to attain NZQA qualifications should extend beyond Level 7 (one health and social services submitter)⁵⁶⁴
- good treatment providers do not necessarily need a university qualification and so the proposed qualification should be replaced with a programme that enables semi-qualified lived experience mentors to work with, and next to fully qualified persons, including:
 - training in safety, self-protection, and basic addiction training
 - movement to formal academic qualifications supported by the treatment provider if desired by the individual (one NCGM submitter)⁵⁶⁵.

Some submitters questioned whether setting the qualification at level 7 was suitable

Seven NCGM submitters commented that the Ministry should consider whether a level 7 qualification would be a barrier to those whom the Ministry was trying to target with this initiative and whether there would be high uptake at this level.⁵⁶⁶ One went on to say that few people would be likely to attempt a level 7 qualification, and even fewer would complete or pass.⁵⁶⁷ Another NCGM submitter suggested a level 5 or 6 qualification may have higher uptake and pass/completion rates.⁵⁶⁸

Two service providers commented that there was ambiguity around how and in what context the proposed qualification would benefit prospective students and raised concerns that this level qualification may create further inequities for priority populations.⁵⁶⁹ One commented that the strategy for training and youth psychosocial programmes start in school similar to alcohol and other drugs education, and that exposure to these pathways would be best pitched at NCEA level 1.⁵⁷⁰ This service provider stated that the psychosocial education development for Pacific students should be Pacific-led in both design and delivery.

One health and social services submitter commented that a level 5 qualification may be useful for CPD points, as most practitioners are already qualified to work in this area.⁵⁷¹ However, this submitter still saw it as a useful pathway for the peer support, cultural or support worker

⁵⁶² 03,05,10,19,21,38,40,51.

⁵⁶³ 34,37,50.

⁵⁶⁴ 48.

⁵⁶⁵ 19.

⁵⁶⁶ 03,04,05,10,21,51.

⁵⁶⁷ 04.

⁵⁶⁸ 03.

⁵⁶⁹ 27,29.

⁵⁷⁰ 29.

⁵⁷¹ C08.

workforce.⁵⁷² This submitter, along with three service providers and another health and social services submitter considered that rather than developing a standalone level 7 qualification on gambling harm and gambling intervention competencies, these should be embedded into current qualifications in the addiction space.⁵⁷³

3.3.4. Submitters from all sectors expressed conditional support for scholarship funding

Thirteen submitters including six NCGM submitters, four service providers, one health and social services submitter, one gambling industry submitter and one individual commented on the proposed funding for scholarships to enable priority populations to undertake tertiary study to enter the PMGH workforce.⁵⁷⁴

One gambling industry submitter and one service provider supported the new scholarships.⁵⁷⁵

Two submitters were concerned about uptake. One individual supported the provision of scholarships focused on priority populations but suggested that this initiative may not be effective as many young people who experience gambling harm do so at the same time that they are studying or choosing a career pathway.⁵⁷⁶ They suggested that rather than 'sugar-coat' new initiatives for positive attention, efforts should be focused on listening to the needs of these communities.⁵⁷⁷ One NCGM submitter considered that the scholarships would not make a difference, as very few people would take up these scholarships, and of those, very few would go on to work in the gambling workforce.⁵⁷⁸

The scholarships should be extended/additional scholarships should be made available

Extending who could apply for the scholarships was proposed with the following extensions suggesting:

- anyone that would like to provide help for problem gambling, including society and hospitality staff (five NCGM submitters)⁵⁷⁹
- existing gambling workforce (three service providers)⁵⁸⁰
- lived experience Kaimahi in the workforce development area to upskill and develop their knowledge beyond the regional and national training forums (three service providers)⁵⁸¹
- employers already committed to building the PMGH workforce and who have specific skills to support and mentor scholarship recipients and could provide a way for providers to identify promising staff (one health and social services submitter)⁵⁸²

⁵⁷² C08.

⁵⁷³ 13,27,29,39,C08.

⁵⁷⁴ 03,04,05,13,16,21,32,34,42,47,50,51,C08.

⁵⁷⁵ 13,42.

⁵⁷⁶ 16.

⁵⁷⁷ 16.

⁵⁷⁸ 04.

⁵⁷⁹ 03,05,21,32,51.

⁵⁸⁰ 34,47,50.

⁵⁸¹ 34,47,50.

⁵⁸² C08.

- priority populations should be prioritised in scholarship allocation, but if supply exceeded interest from other population groups, additional scholarships should be allowed and encouraged (one health and social services submitter).⁵⁸³

3.3.5. Submitters provided general support for the innovation pilots

Nine submitters including four service providers, three NCGM submitters, one health and social services submitter and one gambling industry submitter commented on the proposed innovation pilots.⁵⁸⁴ Some of these submitters indicated general support for particular pilots:

- the intensive support pilot: at present there are no contracted residential beds for people where their addiction does not include alcohol and/or other drugs or mental health issues despite the significant benefits this type of programme could have for those experiencing gambling harm, and community organisations could hold a flexi-fund to allow access to the most appropriate service to ensure continuity of care for tangata whaiora (two service providers)⁵⁸⁵
- the technology pilot, as technology-based innovation generally receives universal support across the PMGH sector (one gambling industry submitter).⁵⁸⁶

Two submitters had concerns over the resourcing and implementation of the innovation pilots

One health and social services submitter commented that while they supported the concept of the peer support pilot to develop a peer workforce, they had concerns that the model was not meeting the needs of communities.⁵⁸⁷ This submitter considered that the peer support and support workforce should mirror the current alcohol and other drugs workforce structure, and the pilot should be based in a service that offers peer support, clinical treatment, whānau and clinical interventions where possible to allow peer support and clinical teams to build understanding of each other's Kaupapa.⁵⁸⁸ This submitter commented further, stating that the current model was likely to be under-serving the needs of Kaupapa Māori services significantly, and the funding of cultural support positions was required.⁵⁸⁹

One service provider was pleased to see the proposed investment into innovation pilots but noted that they did not seem to be adequately resourced – for example, the total budget for the technology pilot across the strategy period was not considered to be enough when taking into account the infrastructure support needed to sustain technological innovations.⁵⁹⁰

NCGM submitters and service providers gave conditional support for pilot programmes to address inequity

Four NCGM submitters commented that no detail was given as to what was proposed in the equity pilots despite a budget of \$1.962 million and suggested that “money should be spent making

⁵⁸³ C08.

⁵⁸⁴ 05,13,18,21,25,27,41,42,51,C08.

⁵⁸⁵ 25,33.

⁵⁸⁶ 42.

⁵⁸⁷ C08.

⁵⁸⁸ C08.

⁵⁸⁹ C08.

⁵⁹⁰ 13.

current services fit for purpose (by expanding them to enable comorbidities to be addressed) and by extending their reach”.⁵⁹¹

Two service providers commented that they supported the pilot to address inequity, but:

- these pilots should include improvement of client engagement and access to all PMGH services⁵⁹²
- it was unclear how funding would be divided between public health and intervention services.⁵⁹³

One service provider referenced a *Youth 2000* survey series for East Asian, South Asian, Chinese and Indian students, which highlighted misleading information when grouping these populations together as “Asian”; this provider stated that in order to address the challenges faced by the Asian community in this equity pilot, the nuances and many different cultures and ethnicities covered in the Asian population must be accounted for.⁵⁹⁴

3.3.6. Two NCGM submitters did not support the proposed initiatives

Two NCGM submitters did not support the proposed new services, innovation pilots and investments.⁵⁹⁵ One commented that it had no objections to funds being allocated to address inequity but stated that the proposed new services, initiatives and innovation pilots were modest and insufficient to achieve the objectives of the strategy.⁵⁹⁶ The other NCGM submitter commented that the proposed initiatives in the service plan were unlikely to make a difference, and a radical change in focus and entirely new approach was needed.⁵⁹⁷

3.3.7. Key themes from the consultation hui

Comments from hui on the proposed new services, innovation pilots and investments

- Stakeholders supported the peer support pilot at both the lived experience and general hui, as well as expressing qualified support specifying the need for culturally appropriate peer support services and supervision/safe spaces for these lived experience peers.
- Stakeholders generally supported the introduction of scholarships to support the expansion of the PMGH workforce, but suggested additional scholarships to be funded:
 - scholarships for Pākehā/European groups
 - scholarships for Level 2-3 qualifications, to target priority populations who may not reach higher levels otherwise
 - additional funding for apprenticeships rather than purely academic courses.

⁵⁹¹ 05,21,40,51.
⁵⁹² 18.
⁵⁹³ 27.
⁵⁹⁴ 13.
⁵⁹⁵ 10,51.
⁵⁹⁶ 10.
⁵⁹⁷ 51.

- Stakeholders questioned what the de-stigmatisation initiative would look like in a public health space and questioned whether it would be extended to other priority populations.
- Stakeholders discussed the need for culturally specific de-stigmatisation initiatives, particularly at the Asian hui. These stakeholders were concerned that a 'one-size-fits-all' campaign would not meet the needs of priority populations.
- Stakeholders discussed whether Level 7 was the appropriate level for a gambling harm qualification across most of the hui, with mixed views across the board. Some stakeholders felt that while Level 7 was aspirational, it may be out of reach for many people and suggested introducing Level 3 or 4 training. Level 7 was seen as a barrier in particular for people with lived experience who may not have been brought up in the mainstream education system. Stakeholders at the Lived Experience hui also suggested bridging courses, particularly for Māori trying to enter the PMGH workforce.

3.4. The degree of support for research and evaluation draft priorities

Most (18 out of 22) submitters who commented on the draft research and evaluation priorities supported them to some degree.⁵⁹⁸ Of those, 10 provided a simple “Yes” answer to Question 8. A further eight expressed qualified support for the proposed research and evaluation priorities (i.e., they supported them, but also commented on how these priorities could be enhanced). Comments included suggestions for additional research priorities.

3.4.1. Most submitters who commented on the research and evaluation draft priorities supported them to some degree

Some submitters expressed qualified support for the research and evaluation priorities

Eight submitters supported the research priorities and suggested additional research priority areas for the Ministry to consider.⁵⁹⁹ Additional research priorities are summarised in Section 3.4.2 (overleaf). Three service providers had general comments about research and evaluation related issues, raising concerns about:

- access to content: people must find relevant and recent research and it can be difficult to do this⁶⁰⁰
- a need for local research and access to research funding:
 - topics include online gambling, the efficacy of public health interventions for gambling, and socio-economic cost/benefits of gambling to communities to counter industry narratives⁶⁰¹
 - research deferred from the past levy period must be prioritised, particularly research into “reducing inequities in gambling harm, including how to address barriers to Māori, Pacific people and Asian people using gambling-

⁵⁹⁸ 07,09,12,13,16,18,27,31,35,37,39,41,52,C01C02,C05,C06,C09.

⁵⁹⁹ 07,09,13,18,27,31,37,41.

⁶⁰⁰ 18.

⁶⁰¹ 18.

harm minimisation services and the evidence for effective gambling harm minimisation service design for these populations”⁶⁰²

- access to research funding: the annual researcher-initiated research round appears to have been removed and topical research priorities change quickly: by only updating these priorities every three years without annual rounds there is risk of missing key research opportunities.⁶⁰³

Service providers emphasised that research must be culturally safe and inclusive

Five service providers encouraged the Ministry to ensure all research with priority populations includes these groups not only as participants, but as leaders and co-leaders of research to allow for the voices of these populations to be captured and inform the development of appropriate supports.⁶⁰⁴ Three providers specified that research about Pacific people should be undertaken with and led by Pacific people.⁶⁰⁵ Other suggestions to improve cultural safety in research were:

- encouraging the use of qualitative research methods to aid in cultural responsiveness (two health and social services submitters)⁶⁰⁶
- providing support for community led projects, with funding earmarked for whānau, hapū, iwi and hāpori Māori and a fostering of acceptance of whānau, hapū, iwi and hāpori Māori-centric knowledge, evidence and research (one health and social services submitter)⁶⁰⁷
- targeting research in areas where there were high rates of gambling to ensure data reflects the wider persistent impacts and disadvantages (one health and social services submitter)⁶⁰⁸
- assessing barriers to equitable service access and outcomes for specific population (e.g., those in the Asian community who are young and new migrants, and broader subgroups that intersect with the disability community (one service provider).⁶⁰⁹

3.4.2. Submitters from most sectors suggested additional research priorities

Eighteen submitters including nine service providers, five health and social services submitters, two NCGM submitters, one government submitter and one individual submitter suggested other or additional research priorities to those proposed.⁶¹⁰

Submitters wanted more research into NCGMs and MVEs

Submitters wanted to see more research into NCGMs and MVEs, including research into:

⁶⁰² 41.

⁶⁰³ 09.

⁶⁰⁴ 27,29,41,46,47.

⁶⁰⁵ 29,46,47.

⁶⁰⁶ 27, 41.

⁶⁰⁷ 41.

⁶⁰⁸ C04.

⁶⁰⁹ 13.

⁶¹⁰ 07,09,13,23,27,29,37,40,41,44,45,46,47,48,52,55,C07,C09.

- how modifications to NCGMs can reduce the risk of problem gambling (e.g.. stop the machines working after a certain amount of money has been lost on them) (one health and social services submitter)⁶¹¹
- NCGM prevalence and use at a grassroots level including how to prevent harm (one individual)⁶¹²
- the efficacy of MVEs as a harm reduction tool – this submitter stated that they would be willing to facilitate this research on the basis that they consider MVEs to be the most effective treatment intervention for NCGM addicted players, but some providers do not provide this service, despite some tangata whaiora just wanting MVEs and no further counselling (one service provider)⁶¹³
- long-term monitoring and reporting on NCGM societies and the actions and current performance of these societies (one NCGM submitter)⁶¹⁴
- research into the concentration of gambling machines and products in socio-economically deprived communities (one health and social services submitter)⁶¹⁵

Submitters wanted more research into online gambling and online interventions

There was cross-sector interest in more online gambling and interventions research, including:

- artificial intelligence or algorithms used by the industry to manipulate user behaviour – this is a personalised, data-driven strategy to profile users and maximise profit that is inherently harmful to problem gamblers (one service provider)⁶¹⁶
- online gambling:
 - how to best regulate online gambling (e.g., website bans, regulation of payment methods, and restrictions on ‘paysave cards’) (one service provider)⁶¹⁷
 - identifying and reducing harms of online gambling-like activities that young people participate in, specifically recognising gaming as a potential problematic gambling behaviour (one government submitter)⁶¹⁸
 - impact of online gambling product advertisements that encourage gambling and related harm (one health and social services submitter)⁶¹⁹
- unregulated offshore online gambling specifically, given the lack of harm minimisation controls in this area (one gambling industry submitter)⁶²⁰

⁶¹¹ 45.

⁶¹² C09.

⁶¹³ 07.

⁶¹⁴ 44

⁶¹⁵ 23.

⁶¹⁶ 13.

⁶¹⁷ C07.

⁶¹⁸ 55.

⁶¹⁹ 52.

⁶²⁰ 31.

- research into effective gambling harm interventions digitally/online considering COVID-19 impacts and tele-health (one service provider)⁶²¹
- assessment of the relationship between gaming and gambling, especially the investigation of “loot boxes” (one health and social services submitter).⁶²²

Submitters made other suggestions for research priorities

Submitters made additional suggestions for research and evaluation priorities. This included research to understand the:

- stigmatisation of problem gambling from both general and specific population perspectives (one service provider)⁶²³
- effect of loan sharks on financial harm from problem gambling (the effects of which were of particular concern to members of a lived experience group) (one health and social services submitter)⁶²⁴
- effective supports for affected others to make sure services are whānau-inclusive (one health and social services submitter)⁶²⁵
- impact of COVID-19 on gambling trends, practices, culture and the resulting long-term harm and psychosocial impacts (one service provider).⁶²⁶

3.4.3. Key themes from consultation hui

Comments from hui on the research and evaluation priorities

- Stakeholders strongly supported more research into online gambling, particularly the unbundling of different elements of online gambling to capture who was experiencing harm and where. This was a strong theme at the general and Asian-focused hui.
- Stakeholders supported research on Pacific populations to be done by Pacific peoples at the Pacific-focused hui.
- Stakeholders expressed support for alternative research priorities, including:
 - gambling prevalence in the Rainbow community, considering they are at high risk of experiencing harm from other addictions
 - gambling harm for senior and elderly populations, due to the ease of online gambling
 - regional breakdowns of barriers in accessing services to help local government develop policies
 - priority population monitoring measures for gambling providers and host responsibility.

⁶²¹ 47.

⁶²² 48.

⁶²³ 09.

⁶²⁴ 48.

⁶²⁵ 48.

⁶²⁶ 41.

4. LEVY AND ALTERNATE LEVY WEIGHTINGS

Section 4 outlines submitters' comments on the levy and levy weightings. It covers:

- the levy and whether it provides a reasonable way to reflect relative harm
- player expenditure forecasts for each gambling sector
- preferred weightings for expenditure and presentations
- the estimated draft levy rates for each sector.

Four questions were asked about the levy, two of which included 'Yes/No' responses. Table 4 shows the tally of responses by question.

Table 4: Responses to questions about the levy

Question	Yes	No	Total
9. Are the player expenditure forecasts for each gambling sector (D) realistic?	12	4	16
10. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?	13	2	15
11. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please keep in mind that the levy weighting options only affect the proportion of levy to be paid by each gambling sector and do not affect the total amount of the levy.	N/A		24
12. Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set out in legislation and is not under consideration in this consultation?	N/A		15

The levy was addressed at least in part by 34 submitters from across the six sector groupings, as illustrated in Figure 4 (overleaf).

Figure 4: Numbers of submitters, by sector, who commented on the levy

Primary organisation type		Number of submitters
	Service provider	11 submitters
	NCGM sector	11 submitters
	Health and social services	5 submitters
	Gambling industry	4 submitters
	Local government	1 submitter
	Individual	2 submitters

4.1. The degree of support for player expenditure forecasts

Eight submitters including three service providers, two gambling industry submitters, one health and social services submitter, one NCGM submitter, and an individual commented on whether the player expenditure forecasts were realistic.⁶²⁷

4.1.1. Submitters considered the forecasts were unrealistic because they did not include offshore and online gambling

Five submitters commented about offshore or online gambling in relation to the expenditure forecasts. They broadly considered it necessary to include online gambling expenditure within the forecasts.⁶²⁸

Three submitters (one service provider, one health and social service sector submitter and an individual) argued for including offshore and online operators within the sector and the problem gambling levies.⁶²⁹ The local government submitter and individual wrote this was necessary “to fund gambling treatment and research”.⁶³⁰ The service provider questioned whether there would be any scoping work undertaken during this service plan period to understand the shifting

⁶²⁷ 07,18,30,31,35,41,C01,C06.

⁶²⁸ 07,18,35,41,C06.

⁶²⁹ 18,35,C06.

⁶³⁰ C06.

gambling environment and presentations associated with online gambling.⁶³¹ They described increasing presentations “outside the four main forms of gambling” and questioned how this might influence future decisions about the levy.⁶³²

One service provider described the need to include offshore gambling in the dataset, noting the high level of gambling losses, and associated harm, for individuals in this environment.⁶³³ Similarly, a service provider described the absence of an adequate mechanism to account for expenditure going offshore due to online gambling.⁶³⁴

4.1.2. Submitters considered that decreased gambling expenditure was realistic given COVID-19 uncertainty and restrictions

One service provider described the decreased expenditure forecasts as realistic due to COVID-19; however, they added this decrease would “likely be offset by expenditure increasing to near-normal levels once restrictions ease”.⁶³⁵ A gambling industry submitter described the difficulty of predicting expenditure during the COVID-19 pandemic, noting it had no alternative to the conservative approach advocated for in the discussion document.⁶³⁶

One NCGM submitter considered the expenditure forecast to be “as realistic as it can be, all things being considered”.⁶³⁷ They also supported the indication in the draft strategy to include live data in the expenditure forecasts.⁶³⁸

4.1.3. Lotto NZ suggested the Ministry adopt their Statement of Intent expenditure forecast

Lotto NZ argued DIA’s forecasts in the consultation document were “significantly higher than the corresponding values from our 2022-25 Statement of Intent (SOI) prepared earlier this year”.⁶³⁹ Lotto NZ argued the stated reason for higher expenditure in 2019/20 (growth of online players) was not correct and was instead the result of a rare Powerball-Must-be-Won draw.⁶⁴⁰ They suggested the Ministry adopt Lotto NZ’s SOI forecast, which had been reviewed by the Treasury and approved by the Minister of Internal Affairs.⁶⁴¹

4.2. The degree of support for the various weighting options

Twenty-four submitters including twelve NCGM submitters, four gambling industry submitters, four service providers, two health and social service submitters, one individual, and one local government submitter commented on the various weighting options or whether there were any realistic alternatives.⁶⁴²

Table 5 below shows the level of support for each weighting preference.

⁶³¹ 18.
⁶³² 18.
⁶³³ 07.
⁶³⁴ 41.
⁶³⁵ 41.
⁶³⁶ 30.
⁶³⁷ C01.
⁶³⁸ C01.
⁶³⁹ 31.
⁶⁴⁰ 31.
⁶⁴¹ 31.
⁶⁴² 03,04,05,07,09,10,15,17,22,26,27,30,31,32,33,35,36,38,40,41,42,51,C01,C06.

Table 5: Level of support for each weighting preference, by number of submitters

5/95	10/90	20/80	30/70	Other
4	4	0	13	3

4.2.1. Submitters supported a 30/70 weighting and almost all NCGM submitters preferred this weighting

Thirteen submitters including ten NCGM submitters, two service providers, and one local government submitter supported a 30/70 weighting.⁶⁴³ They noted this was the highest weighting of expenditure being considered. Support was due to the Act’s wide definition of harm and the increasing prevalence of online gambling options. They described presentations as a subjective measure of help-seeking behaviour. Submitters further comments are summarised below.

30/70 weighting best reflects the Act’s wide definition of harm

Nine submitters including eight NCGM submitters and one local government submitter⁶⁴⁴ argued 30/70 was the most appropriate weighting given the Act’s wide definition of harm. It was appropriate that high-quality services be readily available to acute problem gamblers,⁶⁴⁵ but described the levy funding as having much wider ramifications than for just this proportion of problem gamblers.⁶⁴⁶ They described presentations as not reflecting low and moderate risk gamblers, and one submitter added this “means that the New Zealand Lotteries Commission’s share of the levy is underestimated when a high weighting is placed on the presentation data”.⁶⁴⁷

One NCGM submitter noted “the Ministry has acknowledged that it is inappropriate to place a high weighting on presentations given the wide definition of harm”, citing the 2018 consultation document.⁶⁴⁸

Three NCGM submitters added that a 30/70 weighting better reflects a user pays model which they considered appropriate given the wide definition of harm and the benefits of the strategy.⁶⁴⁹

30/70 weighting is appropriate as help-seeking is not a good indication of the amount of gambling harm

Eight NCGM submitters,⁶⁵⁰ two service providers⁶⁵¹ and a local government submitter⁶⁵² argued that presentations are a subjective measure and the level of help-seeking associated with each mode of gambling does not mean more people are suffering harm from that type of gambling. These submitters described any higher weighting of presentations beyond 30/70 as inappropriate.

⁶⁴³ 03,04,05,09,15,22,26,27,32,38,40,51,C01.
⁶⁴⁴ 03,04,05,15,22,26,32,38,51.
⁶⁴⁵ 05,51.
⁶⁴⁶ 05,22,26,40,51.
⁶⁴⁷ 05.
⁶⁴⁸ 05.
⁶⁴⁹ 03,05,51.
⁶⁵⁰ 03,05,22,26,32,38,40,51.
⁶⁵¹ 09,27.
⁶⁵² 15.

Conversely, expenditure was considered less subjective and more easily measurable, and two NCGM submitters argued it was appropriate to place a larger weighting on expenditure as it can be measured exactly.⁶⁵³ They added, that Inland Revenue can advise the Ministry of the exact spend accruing in each sector.⁶⁵⁴

One service provider agreed with placing greater emphasis on expenditure as this would better represent the harms of gambling.⁶⁵⁵ They argued using presentations as a proxy for gambling harm was not a true public health approach and noted that “it is well accepted that the majority of people harmed by gambling do not present for treatment”. They supported a 30/70 weighting which they described as reflecting the monetary losses to each sector.⁶⁵⁶

One service provider, arguing in favour of a 5/95 weighting, considered presentations to be an inaccurate reflection of gambling harm, and described expenditure as providing a better picture of “how much is being spent and which communities may be most affected”. They concluded “NCGMs are the most harmful form of gambling in New Zealand and expenditure has only been increasing, we argue that a stronger weighting towards expenditure is needed”.⁶⁵⁷

30/70 weighting acknowledges that levy funding is used for research and evaluation

Seven NCGM submitters considered a 30/70 weighting appropriate as it would ensure that all gambling sectors contributed to gambling research and evaluation funded by the levy.⁶⁵⁸

30/70 weighting is fair given the NCGM sector has no online offering

Seven NCGM submitters highlighted the seriousness of online gambling issues and noted they were the only sector without an online gambling offering.⁶⁵⁹ They argued a levy weighting should be chosen that results in providers with online offerings bearing a larger share of the costs related to online gambling.⁶⁶⁰

One NCGM submitter added that Lotto could afford to pay the additional levy rates given its increased annual revenue and being able to trade during COVID-19 lockdowns.⁶⁶¹

30/70 weighting protects against adverse incentives

Four NCGM submitters argued that host staff and gambling organisations should be encouraged to support problem gamblers to seek help.⁶⁶² These submitters considered that a levy with high presentation weighting financially penalised diligent gaming societies, punishing their proactive harm-minimisation efforts.⁶⁶³

⁶⁵³ 04,22.

⁶⁵⁴ 04,22.

⁶⁵⁵ 09.

⁶⁵⁶ 09.

⁶⁵⁷ 27.

⁶⁵⁸ 03,04,05,22,26,32,51.

⁶⁵⁹ 04,05,26,32,38,51,C01.

⁶⁶⁰ 04,05,26,32,38,51,C01.

⁶⁶¹ C01.

⁶⁶² 05,26,32,51.

⁶⁶³ 05,26,32,51.

4.2.2. Submitters from across sectors supported a 5/95 weighting, so the NCGM sector would contribute the most to the levy

Four submitters (two health and social services submitters, one service provider, and an individual) preferred a 5/95 weighting.⁶⁶⁴ These submitters argued that the gambling sector which causes the most harm should contribute the most to the levy. Four submitters specified the NCGM sector should have the highest levy payments.⁶⁶⁵

Three submitters (one service provider, one health and social services submitter, and an individual) described presentations as the more effective proxy for serious gambling harm.⁶⁶⁶ One service provider described expenditure as a subjective measure of harm.⁶⁶⁷

A health and social services submitter argued that while the levy was no longer fit-for-purpose, it preferred a 5/95 weighting, as evidence suggests the NCGM sector causes the most harm to the most vulnerable communities.⁶⁶⁸

4.2.3. Four gambling industry submitters advocated for returning to the 10/90 weighting

Four gambling industry submitters advocated for a return to the 10/90 weighting.⁶⁶⁹ They considered presentations a “better proxy of the financial costs associated with the strategy”. One argued that “the purpose of the levy is to allocate proportional funding on the basis of where harm is occurring withing the sector... anything less than a 90 percent presentation weighting moves too far from the purpose of the levy”.⁶⁷⁰

One gambling industry submitter argued that “the sectors which are the root cause to the problem gambling behaviour should bear the largest proportion of costs associated with the prevention and treatment of that gambling harm”.⁶⁷¹ Two gambling industry submitters⁶⁷² considered the casino sector’s share of presentations to be inflated. One wrote “Casino-excluded patrons are required to undertake a minimum of six counselling sessions before applying to re-enter [a venue]. These six sessions are recorded as six presentations in Ministry statistics instead of one individual or one presentation”.⁶⁷³

One gambling industry submitter detailed their disagreement with the arguments in favour of a 30/70 weighting, writing “any shift away from the established 10/90 split was not justified within materials provided in relation to the previous consultation period, and that the 30/70 split ultimately implemented is not consistent with the objectives of the Act, or the object of the levy mechanism”.⁶⁷⁴

One gambling industry submitter argued the casino sector “may be being penalised for our proactive efficacy in excluding actual and potential problem gamblers”, as a result of identifying problem gamblers earlier and mandating counselling.⁶⁷⁵ The submitter added that their share of

⁶⁶⁴ 07,33,35,C06.

⁶⁶⁵ 33,35,C06.

⁶⁶⁶ 07,35,C06.

⁶⁶⁷ 07.

⁶⁶⁸ 33

⁶⁶⁹ 30,31,36,42.

⁶⁷⁰ 42.

⁶⁷¹ 36.

⁶⁷² 30,36.

⁶⁷³ 36.

⁶⁷⁴ 42.

⁶⁷⁵ 30.

the levy is not affected by the different weightings proposed, but any higher weighting for presentations than 10/90 could distort future levy assessments should this change.⁶⁷⁶

4.2.4. Some submitters supported increasing the expenditure weighting closer to 50 percent

Two submitters (one NCGM submitter and one service provider) argued for increased weighting of expenditure, both submitters advocated for a weighting closer to 50/50.⁶⁷⁷ However, each considered this would achieve different results.

The service provider argued for the NCGM sector to pay a larger proportion of the levy and Lotto/TAB a smaller proportion. Writing “the amount paid out by the NCGM sector is nowhere near offset by the harm caused by pokie machines”. They argued “there needs to be equal weighting of presentations and expenditure as they are both measures of harm”.⁶⁷⁸

The NCGM submitter considered an expenditure weighting closer to 50 percent would see all four gambling providers paying a more equal share for research and treatment of online gambling. They described a higher weighting of presentations as being: inappropriately subjective, potentially influenced by service provider biases, and as not rewarding venue staff for proactively encouraging players to seek help.⁶⁷⁹

4.2.5. One NCGM submitter advocated for a 100/0 weighting

One NCGM submitter advocated for a 100 percent weighting on expenditure alongside “a directive that high presentation numbers are seen as a positive, not negative”.⁶⁸⁰ They argued that each gambling sector should be encouraged to increase its presentation numbers, and “operators who show real improvement be rewarded with future regulatory concessions”.⁶⁸¹

4.2.6. No submitters supported the 20/80 weighting

No submitters supported the 20/80 weighting.

4.2.7. Some submitters suggested amendments to the levy formula (i.e., that MVEs could be considered as a weighting)

Three submitters (one service provider, one health and social services submitter, and an individual) described MVEs as a proxy for harm reduction and argued this could be included as another consideration for the levy weighting.⁶⁸² The service provider added this would be relatively easy to capture and incorporate.⁶⁸³

⁶⁷⁶ 30.

⁶⁷⁷ 10,41.

⁶⁷⁸ 41.

⁶⁷⁹ 10.

⁶⁸⁰ 17.

⁶⁸¹ 17.

⁶⁸² 07, 35, C06.

⁶⁸³ 07.

4.2.8. One service provider argued that the levy should be adjusted to return money taken from gambling to communities

One service provider and one health and social services submitter argued for adjusting the levy so that “money taken from communities for gambling is returned to those communities to support harm reduction”.⁶⁸⁴ They wrote “this current gambling levy formula miscalculates and underestimates the amount of harm done”. They considered the number of people using services an outdated measure of harm as it ignores the harm done to people who do not seek treatment and described the stigma surrounding seeking help and support for gambling harm as a key area to be addressed.⁶⁸⁵

Hope for equity and equality in distribution of the levy

One service provider recalled the following proverbs in reaction to the levy:⁶⁸⁶

E tua le fale tele ile faleoo. Even the mighty need others.

Ole ala ile pule le tautua. The path to leadership is service.

E togi le moa ae uu le afa. Throw the chicken but still hold the string.

The service provider described the Ministry as the authority of distribution with regards to the levy and advocated for equity and equality in its distribution. They sought further clarification from the Ministry on what the levy, the formula, and the levy distribution would mean in practice for them.⁶⁸⁷

To promote long-term harm reduction the Ministry should reconsider how expenditure is determined

One health and social services submitter questioned the government on how transformational change could be achieved by only spending approximately the same amount on harm prevention.⁶⁸⁸ They described the need to reconsider how expenditure is determined and argued “it would be more effective for sustainability and long-term harm reduction to have a policy where any over-recovery is retained and under-recovery is added to the following cycle’s levy structure”.⁶⁸⁹

The Ministry should encourage DIA and other government agencies to review the Act

One service provider urged the Ministry to encourage DIA and other government agencies to review the Act to factor online gambling and gaming into the levy formula.⁶⁹⁰ They described gaming convergence as a growing concern, noting games are not covered under the Act despite gambling products in games being associated with problematic gambling behaviour.⁶⁹¹

⁶⁸⁴ 25,33.

⁶⁸⁵ 25,33.

⁶⁸⁶ 46.

⁶⁸⁷ 46.

⁶⁸⁸ 48.

⁶⁸⁹ 27.

⁶⁹⁰ 27.

⁶⁹¹ 27.

Disaggregated presentation data per sector would illustrate how priority populations are being affected

One health and social services submitter wrote:⁶⁹²

“It would be useful to see estimates of the expenditure against presentation data per sector disaggregated by priority populations. That would allow analysis of how priority populations are being affected and whether presentations are proportional to the amount being spent by that population.”

Lotto, TAB, and SKYCITY should pay extra until online gambling is included in the levy

An individual, who did not specify a weighting preference, argued that Lotto, TAB, and SKYCITY should contribute extra to the levy until online and offshore gambling organisations are made to contribute to the levy.⁶⁹³

4.3. The degree of support for the levy rates

Fifteen submitters including seven service providers, four health and social services sector submitters, three NCGM submitters, and one gambling industry submitters commented on the proposed levy rates.⁶⁹⁴

4.3.1. There was various support for further increases to the levy rate beyond the proposed level

Five submitters (three service providers and two health and social services submitters) advocated for further increases to the levy rates.⁶⁹⁵ They noted support for the proposed increase but considered it insufficient to recover the cost of developing, managing, and delivering the strategy.⁶⁹⁶

Two service providers wrote “considering Māori are over-represented in statistics relating to gambling harm, we are in support of future redirection of funding to both Māori specific clinical and public health services.”⁶⁹⁷ One service provider noted the community had questioned whether the Ministry can increase levies on all four sectors and apply more pressure to the gambling sector, as well as what the Ministry’s plans are regarding online gambling and the levies.⁶⁹⁸

One service provider described the inequity in funding community programmes and sporting interests through gambling losses.⁶⁹⁹ They wrote of NCGMs:

“nearly a billion dollars per year is transferred from less than three percent of New Zealanders into the general tax take and to community groups. Many of those community groups are either trying to help with problems that are being exacerbated by the gambling

⁶⁹² 48.

⁶⁹³ C09.

⁶⁹⁴ 02,03,04,05,13,25,27,29,33,34,36,46,48,50,C08.

⁶⁹⁵ 02,13,34,50,C08.

⁶⁹⁶ 30.

⁶⁹⁷ 34,50.

⁶⁹⁸ 50.

⁶⁹⁹ 13.

among the populations with disproportionate gambling problems or to professionally based sports.”

The service provider also stated, “there is an opportunity to begin righting this type of imbalance” but did not consider the three-year service plan to address “the wider issue of dependency on community funding through gambling harm among Māori and Pacific communities”. They suggested an increase in the levy could support targeted health services and campaigns.⁷⁰⁰

One health and social services submitter was disappointed in the size of the increase given the Governments support of the racing industry.⁷⁰¹

One health and social services submitter argued for increasing the levy rate and contributing some portion of the funding to the wider mental health sector.⁷⁰² They noted mental illness and addiction are frequently co-existing conditions.

4.3.2. NCGM submitters and a gambling industry submitter described the proposed increase as inappropriate unless it results in improved services and results

Three NCGM submitters⁷⁰³ and one gambling industry submitter⁷⁰⁴ argued the increased levy rates were inappropriate if it resulted in ‘more of the same’. The NCGMs described increasing service providers’ FTE rates as inappropriate and argued decreasing measures of harm and the broader environment did not warrant an increase.⁷⁰⁵

One NCGM submitter commented:⁷⁰⁶

“We are not opposed to an increased budget if this results in a new, more effective strategy being put in place. We are, however, opposed to the funding increase if the bulk of the increase will be used for salary increases for the existing staff (funding the same providers to undertake the same work, during the same hours, in the same narrow geographical areas, which we know has not produced the required results).”

One NCGM submitter argued the current environment suggests a reduction in service providers FTE is warranted.⁷⁰⁷ They cited a downward trend in gambling participation, a decrease in presentation numbers accessing Ministry-funded services, and service providers decreased workloads. They considered the increased FTE inconsistent with the directive from the government to freeze public service wages for three years and did not accept that the Ministry has no control over the wages paid to individual treatment providers. They suggested the Ministry could prohibit any new funding from being used to increase wages.⁷⁰⁸

One NCGM submitter argued for a conservative budget and described the current increases as contrary to all other trends and indicators.⁷⁰⁹ They wrote they would support “highly skilled providers who can address co-morbidities being paid an higher FTE rate” but were “opposed to the current dedicated gambling providers receiving a large increase when their workloads have

⁷⁰⁰ 13.

⁷⁰¹ 02.

⁷⁰² C08.

⁷⁰³ 03,04,05.

⁷⁰⁴ 36.

⁷⁰⁵ 03,04,05.

⁷⁰⁶ 05.

⁷⁰⁷ 05.

⁷⁰⁸ 05.

⁷⁰⁹ 03.

decreased, the amount of time actually spent treating people is very low and has decreased further, and the service provided has not produced the desired results.”⁷¹⁰

One NCGM submitter described increasing service providers FTE rates without requiring an improved service as a missed opportunity.⁷¹¹

The gambling industry submitter argued that the consultation document shows presentations have decreased, suggesting previous strategies have made an impact. They noted, given an increased budget they “would reasonably expect a proportionate improvement in the Ministry’s performance”.⁷¹²

4.3.3. One service provider in support of the proposed levy rates noted the risk to Pacific peoples from NCGMs and the growing harm caused by online gambling

One service provider supported the proposed levy and highlighted “that for Pacific, Class 4 poses the greatest risk”.⁷¹³ They noted the inability to impose levies on online gambling and gaming businesses despite the growing harm caused.

They suggested “Vote Health could be used to top up the resources needed to provide counselling and public health for overseas online gambling and gaming”.⁷¹⁴

4.3.4. Key themes from consultation hui

Comments from hui on the levy and levy weightings

- Stakeholders across most of the hui expressed a desire for the levy to be extended so that it would cover online gambling and gaming. Stakeholders highlighted that much of the harm experiencing by gamblers these days is in the online space, and so the Ministry must be forward thinking in how to frame the levy so that online gambling can be taken seriously. Stakeholders at the Industry-focused hui wanted to know if the government was or planned to get reimbursement from outside or off-shore gambling agencies and wanted to know how online gamblers are categorised and where their funding is allocated from.
- Stakeholders at the Industry-focused hui wanted to know detailed breakdowns of the problem gambling levy spend and stated that this should be readily available outside of OIA request.
- Stakeholders highlighted that the Ministry needs to be able to show the PMGH sector that the levy spend is being used to appropriately address gambling harm.
- Stakeholders at Māori hui stated that if it is known that gambling harm is disproportionately experienced by Māori, then the levy and levy spending could be shaped to address this as having generic presentation levels may just reinforce an inequitable response.

⁷¹⁰ 03.
⁷¹¹ 04.
⁷¹² 36.
⁷¹³ 29.
⁷¹⁴ 29.

5. THEMATIC ANALYSIS BY SECTOR

Section 5 describes the way different sectors addressed the common themes throughout the submissions.

5.1. The current strategy was not seen to be working by some submitters

NCGM and gambling industry submitters

Eleven NCGM submitters and one other gambling industry submitter strongly considered that the current strategy was not working, as funding had been high, and the prevalence of problem gambling had not decreased.⁷¹⁵

5.2. Submitters from across all sectors wanted to see more of a focus on online gambling and gaming

Submitters from across all sectors emphasised the growing importance of online gambling, and the growing presence of online gaming with monetary components, such as 'loot boxes'. All sectors agreed that increased prioritisation of the harms of online gambling was needed.

Service providers

Service providers considered that the draft strategy had a long way to go before it adequately reflected the current environment, particularly in regard to online gambling and electronic gaming, where it was noted that details around mitigation were missing.⁷¹⁶ Service providers were concerned with the lack of leadership and commented that the strategy needed to show leadership and outline how services should navigate the online gambling space.⁷¹⁷

Service providers also considered that online gambling and gaming needed to be more of a priority in terms of research, as the sector was reported as struggling to respond with almost no data/information available to support decision-making.⁷¹⁸ Specialist services targeted specifically at harm created online need to be created and funded - with the current levy formula, only onshore online gambling provides funds for gambling harm prevention services.⁷¹⁹

One service provider commented that online gambling required the strongest regulation possible - there was a concern that online platforms could lead to disproportionate harm for Pacific communities, particularly if the online gambling industry is allowed to grow and freely target Pacific communities.⁷²⁰

Health and social services submitters

Health and service submitters wanted to see more work to assess need for those gambling in the online environment and to understand rangatahi engaged in gambling-related behaviours such as

⁷¹⁵ 03,04,05,10,17,19,20,21,22,32,40,51.

⁷¹⁶ 18,C07.

⁷¹⁷ 41.

⁷¹⁸ 18.

⁷¹⁹ 25.

⁷²⁰ 29.

youth gaming,⁷²¹ and clear intention to understand the impact of online gambling and its reach.⁷²² Health and social services submitters also wanted to see regulation that future-proofed and considered the impact of COVID-19, and in particular the dramatic increase of online gambling during the pandemic – the ease of access in online gambling not only exposes gambling behaviour to tamariki at home but increases risk of child neglect.⁷²³ One health and social services submitter also considered that controls should be put on online gambling, including all banks following Kiwibank’s lead and putting voluntary blocks on customer’s access to online gambling sites.⁷²⁴

NCGM submitters

NCGM submitters wanted to see more work to address the unregulated online gambling industry and the negative effects that this form of gambling has on the wider community,⁷²⁵ and noted that best practice would ensure that spend and time limits and exclusion orders are not subverted by players gambling online.⁷²⁶ NCGM submitters also considered that despite the evidence that online gambling was growing, there did not yet seem to be any focus on the identification and support of problem gamblers in this sector.⁷²⁷

Gambling industry submitters

Gambling industry submitters wanted increased recognition of the growth of online offshore gambling and the ‘gamblification’ of sports and gaming,⁷²⁸ and noted that online gambling is an area where more could be done as it is a known and increasing risk.⁷²⁹ One gambling industry submitter commented that the Ministry should actively advocate for regulation of the offshore online casino market.⁷³⁰

Local government submitters

Local government submitters agreed that there was a need to consider how there could be better regulatory management of online offshore gambling sites.⁷³¹

Government submitter

The government submitter recommended that the Ministry work with Māori from a Kaupapa Māori perspective to work with DIA to explore regulation of the emerging technologies that result in gambling harm or addictive behaviours such as in-app purchasing by young people in games and other online platforms, with a view to including them in the definition of gambling and seeking to obtain a levy.⁷³² This submitter also considered that the strategy needed to be more agile and responsive to new emerging harms from technologies that mimic gambling – anything that triggers gambling should fit the definition of what the levy can be spent on, rather than limiting it to activities associated with levy funders.⁷³³

⁷²¹ 35.

⁷²² C08.

⁷²³ 37.

⁷²⁴ 45.

⁷²⁵ C01.

⁷²⁶ 19.

⁷²⁷ 43.

⁷²⁸ 42.

⁷²⁹ 30.

⁷³⁰ 36.

⁷³¹ 12.

⁷³² 55.

⁷³³ 55.

Individuals

Individuals considered that the approach towards online gambling was too slow,⁷³⁴ and that more discussion was needed about the increasingly blurred lines between online gaming and gambling – loot boxes are only one aspect of the issue, with other aspects of gambling relating to gaming including opportunities for gambling within online games.⁷³⁵

5.3. Service providers considered that online service provision could be improved

Service providers

Two service providers commented that there was a need to expand services into the online space.⁷³⁶ One provider referenced the changing nature of face-to-face services due to COVID-19 and the associated increase in online gambling and stated that this has not been acknowledged in the draft service plan.⁷³⁷ The other provider stated that there need to be more self-help groups or forums accessible face-to-face and online in New Zealand as these are scarce and push tangata whaiora to seek these forums on overseas websites.⁷³⁸

5.4. Submitters from across sectors considered that more culturally appropriate services are required

Service providers, health and social services submitters, individuals and a local government submitter all considered that culturally appropriate services were required for Māori, Pacific, and Asian population groups.

Service providers

Nine service providers considered that more culturally appropriate services were required for Māori, Pacific, and Asian population groups.⁷³⁹

Four of these service providers specified issues with the national Gambling Helpline for Pacific people and Asian communities.⁷⁴⁰ Two submitters called for the Asian Helpline run by Asian Family Services to be extended so it could run as a 24/7 service, while the other two highlighted that having dedicated Pacific staff for the Pacific helpline is essential.⁷⁴¹

Four service providers considered that more work should be done to ensure that general PMGH service providers are equipped to offer culturally appropriate services, as priority populations often access general services as well as culturally specific ones.⁷⁴²

⁷³⁴ C09.

⁷³⁵ 01.

⁷³⁶ 18,25.

⁷³⁷ 18.

⁷³⁸ 25.

⁷³⁹ 07,13,18,27,29,33,34,41,47.

⁷⁴⁰ 13,29,33,47.

⁷⁴¹ 13,29,33,47.

⁷⁴² 18,32,33,34.

Three service providers commented on the need for more Kaupapa Māori services and support of alternative support staff in the form of kaiawhina/mataora or Māori approaches to treatment such as of wānanga.⁷⁴³

Two service providers stated that it was important to integrate culturally specific and per support services.⁷⁴⁴

Health and social services submitters

Four health and social services submitters commented on the need for culturally appropriate services.⁷⁴⁵

Two submitters stated that the Ministry should ensure there is a culturally appropriate peer support workforce.⁷⁴⁶

One of these submitters called for specific funding commitments for Kaupapa Māori, Pacific, and Asian services, and another called for culturally mandated services as first referral options.⁷⁴⁷

Individual submitters

Two individual submitters supported more culturally appropriate services.⁷⁴⁸ One of these submitters stated that consideration should be given to tikanga practices relative to iwi and hapū regions as Māori in isolated communities know their own and thus should be supported in what they do with their community.⁷⁴⁹

5.5. NCGM submitters wanted to see a complete overhaul of service provision

NCGM submitters

NCGM submitters wanted to see an overhaul of service provision, including targets for service providers, and integration of addiction services. Eleven NCGM sector submitters commented that the strategy should include clear targets which should be considered during the allocation of levy money.⁷⁵⁰

Ten NCGM submitters commented on the need for more accessible face-to-face counselling and longer-term support.⁷⁵¹

Nine of these NCGM sector submitters were critical of current PMGH service providers and stated that despite the funding available, current providers are not equipped or willing to travel to clients who cannot come to the office or see clients after hours/on weekends.⁷⁵² These submitters stated that the Ministry must move away from funding services in set geographical areas Monday to

⁷⁴³ 07,27,34.

⁷⁴⁴ 13,47.

⁷⁴⁵ 48,52,C04,C08.

⁷⁴⁶ 52,C08.

⁷⁴⁷ 48,C04.

⁷⁴⁸ C03,C06.

⁷⁴⁹ C03.

⁷⁵⁰ 03,04,05,10,17,21,32,38,40,43,51.

⁷⁵¹ 04,05,10,17,19,21,22,32,40,51.

⁷⁵² 05,21,38,40,51.

Friday 9am-5pm, and instead require providers to be on call, provide afterhours and weekend support and travel to clients if necessary.⁷⁵³

Seven of these NCGM sector submitters wanted the draft service plan to shift focus to long term treatment and support models and stated that the Ministry should require service providers to take reasonable steps to maintain contact with client for a three-year period.⁷⁵⁴ These submitters stated that statistics show most clients receive less than 10 hours of support in total which is insufficient to prevent relapse.⁷⁵⁵

5.6. NCGM sector submitters thought increased funding was inappropriate, while other submitters thought it would not be enough

NCGM sector submitters, service providers, health and social services sector submitters and a gambling industry submitter had mixed views on the increase in funding proposed in the draft service plan.

Service providers

Four service providers considered more funding and investment was needed to actualise the goals of the draft service plan, as current investments were insufficient to drive real change.⁷⁵⁶ One service provider commented that as a culturally specific service, they received limited support from the NCS and often had to fund their own culturally specific resources, meaning they were unfairly burdened compared to mainstream services.⁷⁵⁷

Health and social services submitters

One health and social services submitter considered that more investment was necessary to achieve set outcomes if society was serious about equity and public health approached to gambling harm prevention and minimisation.⁷⁵⁸

NCGM submitters

Five NCGM sector submitters considered the increase in funding unwarranted for the following reasons:⁷⁵⁹

- increasing the FTE rates is inconsistent with the government wage freeze
- money must be spent on preventing, minimising, treating or reducing harm, not paying existing providers more for office overheads or administration
- gambling participation and presentations to PMGH services have decreased, indicating a reduced workload for these services, thus making an increase to FTE rates unwarranted.

⁷⁵³ 04,05,10,17,18,19,21,22,25,40,51.

⁷⁵⁴ 04,05,10,17,18,19,21,22,25,40,51.

⁷⁵⁵ 05,19,21,22,32,40,51.

⁷⁵⁶ 09,13,18,23,25.

⁷⁵⁷ 13.

⁷⁵⁸ 23.

⁷⁵⁹ 05,21,38,40,51.

Gambling industry

One gambling industry submitter commented that while they expected an increase in funding given trends in previous strategies, the size of this increase was surprising given the significant past investment from both the Ministry and the industry.⁷⁶⁰

5.7. Submitters expressed a range of views on the proposed new services, innovation pilots and investments

NCGM submitters, service providers, health and social services submitters and gambling industry submitters had varying opinions on the proposed new services, innovation pilots and investments.

Service providers

Two service providers commented that there was ambiguity around how and in what context the proposed NZQA level 7 qualification would benefit prospective students and raised concerns that this level qualification level may create further inequities for priority populations.⁷⁶¹ Three service providers supported the creation of an entry-level gambling harm qualification (levels 1-4) to help build pathway to and increase the accessibility of the level 7 qualification.⁷⁶²

Three service providers considered that rather than developing a standalone level 7 qualification on gambling harm and gambling intervention competencies, these should be embedded into current qualifications in the addiction space.⁷⁶³

Three service providers commented that additional scholarships should be made available for the existing gambling workforce as well as lived experience Kaimahi to upskill and develop their knowledge beyond the regional and national training forums.⁷⁶⁴

Two service providers supported the intensive support pilot, stating that at present there are no contracted residential beds for people where their addiction does not include alcohol and/or other drugs or mental health issues despite the significant benefits this type of programme could have for those experiencing gambling harm.⁷⁶⁵

One service provider stated that they were delighted to see the proposed investment into innovation pilots but noted that they do not seem to be adequately resourced – for example, the total budget for the technology pilot across the strategy period was not enough when considering the infrastructure support needed to sustain technological innovations.⁷⁶⁶ Another service provider commented that while they supported the pilots to address inequity, it was unclear how funding will be divided between public health and intervention services.⁷⁶⁷

One service provider stated that in order to address the challenges faced by the Asian community in this equity pilot, the nuances and many different cultures and ethnicities covered in the Asian population must be accounted for in these equity pilots.⁷⁶⁸

⁷⁶⁰ 30.

⁷⁶¹ 27,29.

⁷⁶² 34,37,50

⁷⁶³ 13,27,29.

⁷⁶⁴ 34,47,50.

⁷⁶⁵ 25,33.

⁷⁶⁶ 27.

⁷⁶⁷ 27.

⁷⁶⁸ 13.

Health and social services submitters

One health and social services submitter recommended lived experience leadership to support the de-stigmatisation initiative. This submitter also suggested that funding for grassroots support services is more effective in generating meaningful change, rather than expensive anti-stigma campaigns.⁷⁶⁹

One health and social services submitter referenced a comment regarding those with lived experience moving into leadership roles, and considered that to support this vision, provisions for scholarships to attain NZQA qualifications should extend beyond level 7.⁷⁷⁰

One health and social services submitter commented that a level 5 qualification may be a useful pathway for peer support, cultural or support worker workforce.⁷⁷¹ This submitter and another health and social services submitter considered that rather than developing a standalone level 7 qualification on gambling harm and gambling intervention competencies, these should be embedded into current qualifications in the addiction space.⁷⁷²

One health and social services submitter commented that while they were supportive of scholarships as a way to build the workforce, these scholarships should be attached to employers already committed to building the PMGH workforce and who have specific skills to support and mentor scholarship recipients and could provide a way for providers to identify promising staff. This submitter also considered that priority populations should be privileged in scholarship allocation, but if supply exceeded interest from other population groups, then this should be allowed and encouraged.⁷⁷³

NCGM submitters

Eight NCGM submitters suggested that additional to the proposed qualification, funding should be allocated for a new NZQA qualification and harm leader minimisation leadership course, such as those proposed and run by Hospitality New Zealand.⁷⁷⁴

Seven NCGM submitters commented that the Ministry should consider whether a level 7 qualification would be a barrier to those the Ministry is trying to target with this initiative and whether there would be high uptake at this level.⁷⁷⁵ One NCGM submitter went on to say that few people would be likely to attempt a level 7 qualification, and even fewer would complete or pass.⁷⁷⁶ Another NCGM submitter suggested a level 5 or 6 qualification may have higher uptake and pass/completion rates.⁷⁷⁷

Five NCGM submitters supported the new scholarships aimed at priority populations but suggested that access to scholarships should be extended to anyone that would like to provide help for problem gambling, including society and hospitality staff.⁷⁷⁸

⁷⁶⁹ 48.

⁷⁷⁰ 48.

⁷⁷¹ C08.

⁷⁷² 13,27,29,39,C08.

⁷⁷³ C08.

⁷⁷⁴ 03,05,10,19,21,38,40,51.

⁷⁷⁵ 03,04,05,10,21,51.

⁷⁷⁶ 04.

⁷⁷⁷ 03.

⁷⁷⁸ 03,05,21,32,51.

Four NCGM submitters commented that no detail was given as to what was proposed in the equity pilots despite a budget of \$1.962 million, and suggested an alternative use for this budget.⁷⁷⁹

Gambling industry

One gambling industry submitter supported the level 7 pathway as proposed, expressed broad support for new scholarships and supported the technology pilot in particular, stating that technology-based innovation generally receives universal support across the PMGH sector.⁷⁸⁰

5.8. Submitters from across all sectors generally supported the proposed research priorities

NCGM sector submitters, service providers, health and social services submitters, an individual and an gambling industry submitter generally agreed with the Ministry's research priorities but made other suggestions.

Service providers

Nine service providers suggested additional research priorities across NCGMs, MVEs, online gambling and online interventions as well as research into the effects of COVID-19, to understand gambling stigma.⁷⁸¹

Five service providers encouraged the Ministry to ensure all research with priority populations includes these groups not only as participants, but as leaders and co-leaders of research to allow for the voices of these populations to be captured and inform the development of appropriate supports.⁷⁸² Three providers specified that research on Pacific populations should be undertaken with and led by Pacific peoples.⁷⁸³ One other service provider commented that there needed to be support for community led projects, with funding, and a fostering of acceptance of whānau, hapū, iwi and hāpori Māori centric knowledge, evidence and research.⁷⁸⁴ Two service providers supported qualitative research methods to aid in cultural responsiveness.⁷⁸⁵

One service provider suggested that in future the Ministry may assess barriers to equitable service access and outcomes for subgroups e.g., those in the Asian community who are young and new migrants, and broader subgroups that intersect with the disability community.⁷⁸⁶

One service provider noted that the annual researcher-initiated research round appears to have been removed, and while the Ministry's research priorities are commendable and currently topical, research priorities change quickly and by only updating these priorities every three years without annual rounds there is risk of missing key research opportunities.⁷⁸⁷

⁷⁷⁹ 05,21,40,51.

⁷⁸⁰ 42.

⁷⁸¹ 07,09,13,27,29,41,46,47,C07.

⁷⁸² 27,29,41,46,47.

⁷⁸³ 29,46,47.

⁷⁸⁴ 41.

⁷⁸⁵ 27, 41.

⁷⁸⁶ 13.

⁷⁸⁷ 09.

Health and social services submitters

Five health and social services submitters offered additional research priorities across NCGMs, MVEs, online gambling and online interventions as well as research into the effect of loan sharks and what support works for affected others.⁷⁸⁸

One health and social services submitter encouraged research and evaluation to be targeted in areas where there were high rates of gambling to ensure data reflects the wider persistent impacts and disadvantages.⁷⁸⁹

NCGM submitter

One NCGM submitter expressed concerns that research underpinning Ministry strategies lacked long-term monitoring and reporting on NCGM societies and stated that the actions of these societies are largely ignored in research. This submitter called for better consultation with the NCGM sector, as well as research into the effectiveness of service providers alongside the NCGM sector to assess current performance.⁷⁹⁰

Gambling industry

One gambling industry submitter commented that dedicated research, data collection and evaluation was required into unregulated offshore online gambling specifically, given the lack of harm minimisation controls in this area.⁷⁹¹

Individual

One individual submitter commented that there was a need for more effective research at a grassroots level, suggesting that researchers regularly cite NCGMs as the most harmful gambling product, but a researcher had never visited a venue to understand the workings of one.⁷⁹²

5.9. Submitters had differing views on the levy and expenditure

Service providers

Relatively few service providers⁷⁹³ commented to support a levy weighting. Those that did supported different options but almost all argued the NCGM sector should contribute the most to the levy.⁷⁹⁴

Service providers supported the proposed increase in the levy rate, and many noted the need for further increases beyond this to fully 'recover the cost of developing, managing, and delivering the integrated problem gambling strategy'.⁷⁹⁵ These service providers further discussed the need for targeted health services in relation to the levy.

⁷⁸⁸ 23,37,45,48,52,

⁷⁸⁹ C04.

⁷⁹⁰ 44

⁷⁹¹ 31.

⁷⁹² C09.

⁷⁹³ 07,09,27,41.

⁷⁹⁴ 07,27,41.

⁷⁹⁵ 13,34,50.

Health and social service submitters

Five health and social service submitters commented regarding the levy weighting and proposed rates.⁷⁹⁶ Comments included:

- further increases to the levy rate beyond proposed levels are needed⁷⁹⁷
- NCGMs are the most harmful form of gambling and should contribute the most to the levy⁷⁹⁸
- the levy is no longer fit-for-purpose⁷⁹⁹
- exclusions (MVEs) could be used as a proxy for harm.⁸⁰⁰

NCGM submitters

Ten NCGM submitters favoured a 30/70 levy weighting.⁸⁰¹ They argued a 30/70 weighting would:

- reflect the Act's wide definition of harm⁸⁰²
- recognise help-seeking is not a good indication of gambling harm⁸⁰³
- acknowledge that levy funding is used for research and evaluation⁸⁰⁴
- recognise the NCGM sector has no online offering⁸⁰⁵
- protect against adverse incentives⁸⁰⁶
- and recognise indicators of harm show reduced levels of harm.⁸⁰⁷

Two NCGM submitters did not support a 30/70 weighting and suggested further increasing the weighting towards expenditure,⁸⁰⁸ with one suggesting a 100 percent expenditure weighting.⁸⁰⁹

Three NCGM submitters considered an increase in the levy rate to be inappropriate if it resulted in 'more of the same'.⁸¹⁰ They did not support increasing the FTE rate of existing individual providers for their work, which they described as having not achieved the desired results.

Gambling industry submitters

Some gambling industry submitters supported a return to the 10/90 levy weighting.⁸¹¹ They considered the shift to a 30/70 weighting as part of the previous strategy unjustified⁸¹² and argued the sectors which are the root cause to problem gambling should bear the largest proportion of

⁷⁹⁶ 02,33,48,55,C08.

⁷⁹⁷ 34,C08.

⁷⁹⁸ 33,

⁷⁹⁹ 33.

⁸⁰⁰ 35.

⁸⁰¹ 03,04,05,22,26,32,38,40,51,C01.

⁸⁰² 03,04,05,15,22,26,32,38,51.

⁸⁰³ 03,05,22,26,32,38,40,51.

⁸⁰⁴ 03,04,05,22,26,32,51.

⁸⁰⁵ 04,05,26,32,38,51.

⁸⁰⁶ 05,26,32,51.

⁸⁰⁷ 03,04,05.

⁸⁰⁸ 10,17.

⁸⁰⁹ 17.

⁸¹⁰ 03,04,05.

⁸¹¹ 30,31,36,42.

⁸¹² 31,42.

the costs of the strategy.⁸¹³ They considered a 10/90 weighting would best reflect the purpose of the levy.⁸¹⁴

⁸¹³ 31,36.

⁸¹⁴ 30,31,42.

6. STORIES OF LIVED EXPERIENCE

Some submitters gave specific examples of lived experience, either of their own gambling harm, or that of their whānau or clients. Some of these stories are summarised below.

Personal lived experience stories

- A case of problem gambling in China. A trillion-dollar gambling corporation was sued by the mother of a young man who became addicted to online gambling after playing games online and ended up burning down his grandma's apartment after his mother refused to give him more money to gamble with.
- Internet gaming was particularly dangerous for children, especially young boys. Addiction is created deliberately by teams of professionals, psychologists, and software experts to design addictive games for profit.
- A story of lived experience of gambling harm that began overseas and continued when the person came to New Zealand and started investing and trading cryptocurrencies. After few months, the person could not gain control and highlighted how in these spaces there are often stories of people becoming billionaires through trading and investment. The person almost lost everything due to the addiction and became seriously depressed. The person was referred to gambling harm services by a GP.
- The damage of exposure to online casinos and gambling, highlighting that NCGMs have a limit of \$2.50 per bet, whereas online pokies have no limit whatsoever. This person explained that gambling harm is a big problem for migrants in particular, who come into the culture in New Zealand where gambling is legal and lose their jobs, fall into debt and have to run away.

Whānau lived experience stories

- A member of the stakeholder's family had a gambling problem which affected both of their wellbeing. The person shared that counselling helped them learn how to better communicate with each other, change their lifestyle and set small goals.
- Another person shared a family experience of problem gambling, explaining that there was a lack of support in the family regarding intergenerational gambling harm. This person raised the importance of destigmatising gambling harm and mental health support.

Client lived experience stories

- A person shared a story of a client who used to go to casinos before COVID-19 but had since moved to gambling online and found that on one gambling app, over 35 different ads popped up for other gambling apps. The client highlighted how even if they deleted the app, they would always download it later. The client explained that counselling had helped them to see gambling as harmful and wanted to highlight how online gambling is a big risk for gambling harm in the Asian community.
- Another person shared a client lived experience story. They highlighted the need for support for the Fijian Indian community in particular and called for a forum for those with lived experience to share their stories and learn from their peers. In this

stakeholder's experience as a counsellor, client numbers from the South Asian community were increasing, and there was a need to understand the culture and family system where there are many expectations of being without flaws, of academic excellence etc, and of family duties. Indian problem gamblers were seen as more likely to self-stigmatise, and latest SkyCity data showed that many self-exclusions were in the Indian population.

Additional client comments included:

- following self-exclusion from venues and COVID-19, a client turned to online gambling as an alternative method but found they could not control their usage
- a client had lost all of their money through their gambling problem and had presented to a GP, but the GP did not intervene
- a client did not want to ask for help for their family member's addiction, and so cut off peer ties and ties with extended family due to shame and stigma
- a client wished they had been educated about gambling harm before or while in New Zealand
- a client highlighted the importance of having support available in your own language.

7. OTHER ISSUES RAISED BY SUBMITTERS

Section 7 outlines issues raised by submitters that did not directly relate to the draft strategic plan, the draft service plan or the proposed levy. These issues are relevant to the policy or legislative settings for preventing and minimising gambling harm and are included here for completeness.

Submitters' role in the gambling industry

Nine submissions included details about their role in the gambling industry including client experiences and case studies or information about gambling in their area.⁸¹⁵

Legislation

Six submissions expressed concerns about the Act or the need for increased regulation (particularly of NCGMs and online gambling).⁸¹⁶ Content relevant to the draft strategy is included in *section 2* and *section 3*. Other comments included that five submitters wanted to see strengthened host responsibility regulation.⁸¹⁷ One submitter wanted to see advertising and promotion of the benefits and rewards of gambling minimised.⁸¹⁸

Development of the strategy to date

Five submissions expressed concern with the process used to develop the draft strategy, and specifically the lack of co-design with communities during the drafting process of the consultation document.⁸¹⁹ One submission critiqued aspects of the Needs Assessment, such as using outdated expenditure data, which was seen to undervalue the total expenditure in relation to offshore online sports betting.⁸²⁰ One submission noted that the draft strategy on the Ministry's website did not include versions in a range of accessible formats.⁸²¹ One submission expressed concern that some industry groups may use power to try and undermine the change of direction.⁸²²

Information about comorbidities

Two submissions provided detailed statistics about gambling comorbidities.⁸²³ One submission noted gambling co-factors, particularly gangs, drugs, and alcohol abuse.⁸²⁴ One submission, when commenting on de-stigmatisation, provided a detailed example of the approach taken to the provisioning of alcohol in terms of de-stigmatisation.⁸²⁵

Other comments about gambling in Aotearoa

A range of comments about gambling in general were made. These are summarised below.

⁸¹⁵ 12,13,15,18,28,39,46,49,C04.

⁸¹⁶ 18,23,27,34,42,50.

⁸¹⁷ 11,15,27,37.

⁸¹⁸ 49.

⁸¹⁹ 05,08,18,41,51.

⁸²⁰ 42.

⁸²¹ 48.

⁸²² 18.

⁸²³ 05,51.

⁸²⁴ 28.

⁸²⁵ 44.

- Three gambling industry submissions argued that gambling should be seen as having a net positive wellbeing benefit for society.⁸²⁶
- One submission stated that data needs to be disaggregated by disability to align with the government’s commitment to providing data that is disaggregated by disability.⁸²⁷
- One submission called for consistency in healthy gambling policy across local government, as well as measures to see how effective NCGM policies have been (e.g., sinking lid, capping, relocation).⁸²⁸
- One submission considered the proposed strategy “suggests if you are ‘Pakeha’ you are unable to work with other ethnicities’.⁸²⁹
- One submission requested the addition of a reduction of the density of NCGMs in the communities most affected by gambling harm.⁸³⁰

Other issues raised by stakeholders at consultation hui

Discussions at the consultation hui were wide-ranging and covered a number of issues that were relevant to gambling harm generally, but did not fall under the draft strategy, or are not controlled by the Ministry.

Legislation changes

Participants asked whether there would be any consideration of a review of the Act, and particularly addressing local government processes for gambling policy to meet the needs of Māori.

NCGM prevalence

Participants were concerned about the number of NCGMs, particularly in poorer communities, and considered that local government also has a role to play in controlling NCGM and TAB gambling. People were particularly concerned about ‘sinking lid’ policies, and considered that there needed to be a significant policy change to get numbers down. Participants also questioned why NCGMs were still allowed to be designed in a way that attracted spending (i.e. flashing lights, colours etc.).

Online gambling

Participants expressed interest in the future regulation of online gambling, and in the Bill being developed by DIA to enable regulated New Zealand providers to move into the online space. They were concerned that this Bill was potentially heading in the wrong direction, and that DIA should be focused instead on reducing or banning online gambling and gaming. Participants at the general hui considered that restrictions for online advertising should be stronger for TAB and Lotto. In addition, they questioned how online gambling data (from overseas websites was

⁸²⁶ 05,38,51.

⁸²⁷ 48.

⁸²⁸ 24.

⁸²⁹ 06.

⁸³⁰ 49.

collected), particularly with respect to online gambling trending upwards due to COVID-19 lockdowns.

APPENDIX A: LIST OF SUBMITTERS

List of submitters, sorted by submitter unique ID

1	Individual	36	SkyCity
2	New Zealand Medical Association (NZMA)	37	Whānau Āwhina Plunket
3	Four Winds Foundation	38	Lion Foundation
4	Air Rescue and Community Services	39	Te Hiringa Hauora
5	GMANZ	40	New Zealand Community Trust (NZCT)
6	Addiction Advice and Assessment Services (AAAS)	41	Hāpai te Hauora
7	Te Rangihaeata Oranga Trust	42	TAB NZ
8	Advisory Group Lived Experience	43	ILT Foundation
9	AUT Gambling and Addictions Research Centre	44	Aotearoa Gaming Trust
10	First Light Community Foundation	45	Midcentral DHB
11	Nelson Marlborough Health	46	Taeaomanino Trust
12	Ōpōtiki District Council	47	Tupu Services
13	Asian Family Services	48	Mental Health and Wellbeing Commission
14	INDIVIDUAL	49	Royal Australasian College of Physicians
15	Christchurch City Council	50	Tui Ora
16	INDIVIDUAL	51	Grassroots Trust
17	BlueSky Community Trust	52	Addiction Nurses Branch of Te Ao Māramatanga
18	The Salvation Army Oasis	53	RNZCGP
19	One Foundation	54	Nga Manga Puriri
20	COMS Systems Limited	55	Office Of The Children's Commissioner
21	Hospitality NZ	C01	Petone Working Men's Club
22	Akarana Community Trust	C02	Stronger Waitaki - Community Development Support
23	New Zealand Council Of Christian Social Services (NZCCSS)	C03	Individual
24	The Southern District Health Board (Southern DHB)	C04	Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO)
25	Odyssey	C05	Group: Safer Napier Strategic Group
26	Dragon Community Trust	C06	INDIVIDUALS
27	PGF Group	C07	Ngā Tai o te Awa
28	Public Service Association (PSA)	C08	Dapaanz
29	Mapu Maia	C09	Individual
31	Lotto NZ		
32	Kiwi Gaming Foundation Ltd		
33	Platform Charitable Trust		
34	Hauora Tairāwhiti		
35	Hawke's Bay District Health Board		

List of submitters, sorted alphabetically

6	Addiction Advice and Assessment Services (AAAS)	48	Mental Health and Wellbeing Commission
52	Addiction Nurses Branch of Te Ao Māramatanga	45	Midcentral DHB
8	Advisory Group Lived Experience	11	Nelson Marlborough Health
4	Air Rescue and Community Services	40	New Zealand Community Trust (NZCT)
22	Akarana Community Trust	23	New Zealand Council Of Christian Social Services (NZCCSS)
44	Aotearoa Gaming Trust	2	New Zealand Medical Association (NZMA)
13	Asian Family Services	54	Nga Manga Puriri
9	AUT Gambling and Addictions Research Centre	C07	Ngā Tai o te Awa
17	BlueSky Community Trust	25	Odyssey
15	Christchurch City Council	55	Office Of The Children's Commissioner
20	COMS Systems Limited	19	One Foundation
C08	Dapaanz	12	Ōpōtiki District Council
26	Dragon Community Trust	C01	Petone Working Men's Club
10	First Light Community Foundation	27	PGF Group
3	Four Winds Foundation	33	Platform Charitable Trust
5	GMANZ	28	Public Service Association (PSA)
51	Grassroots Trust	53	RNZCGP
C05	Group: Safer Napier Strategic Group	49	Royal Australasian College of Physicians
41	Hāpai te Hauora	36	SkyCity
34	Hauora Tairāwhiti	C02	Stronger Waitaki - Community Development Support
35	Hawke's Bay District Health Board	42	TAB NZ
21	Hospitality NZ	46	Taeaomanino Trust
43	ILT Foundation	39	Te Hiringa Hauora
1	Individual	7	Te Rangihaeata Oranga Trust
14	Individual	18	The Salvation Army Oasis
16	Individual	24	The Southern District Health Board (Southern DHB)
C03	Individual	C04	Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO)
C09	Individual	50	Tui Ora
C06	Individual	47	Tupu Services
32	Kiwi Gaming Foundation Ltd	37	Whānau Āwhina Plunket
38	Lion Foundation		
31	Lotto NZ		
29	Mapu Maia		

APPENDIX B: CONSULTATION QUESTIONS

Proposed strategic plan

1. Do you agree with the proposed strategic goal, objective and action areas?
2. Does the draft strategic plan adequately reflect changes in the gambling environment?
3. Do you have any comments to make on the priority populations including how we will address inequities?
4. Do you have any comment to make on the matters covered under 'what needs to change'?

Draft service plan

5. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?
6. Do you consider the proposed funding mix for services and supports appropriate?
7. Do you agree with the proposed new services (including the de-stigmatisation initiative), innovations pilots and investments?
8. Do you agree with the priorities for research and evaluation that have been outlined?

Problem gambling levy

9. Are the player expenditure forecasts for each gambling sector (D) realistic?
10. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?
11. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please keep in mind that the levy weighting options only affect the proportion of levy to be paid by each gambling sector and do not affect the total amount of the levy.
12. Do you have any comment on the estimated rates for each sector, keeping in mind that the levy formula itself is set out in legislation and is not under consideration this consultation?

Anything else?

13. Is there anything else you would like to tell us about the draft strategy or preventing and minimising gambling harm more generally?